CHAPTER 62E

COMPREHENSIVE HEALTH INSURANCE

62E.01 CITATION.

Sections 62E.01 to 62E.17 may be cited as the "Minnesota Comprehensive Health Insurance Act of 1976."

History: *1976 c 296 art 1 s 1*

62E.02 DEFINITIONS.

Subdivision 1. **Application.** For the purposes of sections 62E.01 to 62E.19, the terms and phrases defined in this section have the meanings given them.

Subd. 2. **Employer.** "Employer" means any person, partnership, association, trust, estate or corporation, including the state of Minnesota or any agency, instrumentality or governmental subdivision thereof, which employs ten or more individuals who are residents of this state.

Subd. 2a. **Essential health benefits.** "Essential health benefits" has the meaning given under section 62Q.81, subdivision 4.

Subd. 3. **Health maintenance organization.** "Health maintenance organization" means a corporation licensed and operated as provided in chapter 62D.

Subd. 4. **Qualified plan.** "Qualified plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by section 62E.06 or the actuarial equivalent of those benefits.

Subd. 5. **Qualified Medicare supplement plan.** "Qualified Medicare supplement plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by section 62E.07.

Subd. 6. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 7. [Repealed, 2013 c 84 art 1 s 94]

Subd. 8. **Employee.** "Employee" means any Minnesota resident who has entered into the employment of or works under contract or service or apprenticeship with any employer. "Employee" does not include a person who has been employed for less than 30 days by that person's present employer, nor one who is employed less than 30 hours per week by that person's present employer, nor an independent contractor.

Subd. 9. **Plan of health coverage.** "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of self insurance, individual accident and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health service plan, or coverage under a health maintenance organization subscriber contract.

Subd. 10. **Insurer.** "Insurer" means those companies operating pursuant to chapter 62A or 62C and offering, selling, issuing, or renewing policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations or community integrated service networks.

Subd. 11. **Accident and health insurance policy or policy.** "Accident and health insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical and medical care. "Policy" does not include coverage which is (1) limited to disability or income protection coverage, (2) automobile medical payment coverage, (3) supplemental to liability insurance, (4) designed solely to provide payments on a per diem, fixed indemnity or nonexpense incurred basis, (5) credit accident and health insurance issued pursuant to chapter 62B, (6) designed solely to provide dental or vision care, (7) blanket accident and sickness insurance as defined in section 62A.11, or (8) accident only coverage issued by licensed and tested insurance agents or solicitors which provides reasonable benefits in relation to the cost of covered services. The provisions of clause (4) shall not apply to hospital indemnity coverage which is sold by an insurer to an applicant who is not then currently covered by a qualified plan.

Subd. 12. **Health benefits.** "Health benefits" means benefits offered to employees on an indemnity or prepaid basis which pay the costs of or provide medical, surgical or hospital care.

Subd. 13. **Eligible person.** (a) "Eligible person" means an individual who:

(1) is currently and has been a resident of Minnesota for the six months immediately preceding the date of receipt by the association or its writing carrier of a completed certificate of eligibility;

(2) meets the enrollment requirements of section 62E.14; and

(3) is not otherwise ineligible under this subdivision.

For purposes of eligibility under section 62E.14, subdivision 4c, paragraph (b), this definition is modified as provided in that paragraph.

(b) No individual is eligible for coverage under a qualified or a Medicare supplement plan issued by the association for whom a premium is paid or reimbursed by the medical assistance program as of the first day of any term for which a premium amount is paid or reimbursed.

Subd. 14. **Minnesota Comprehensive Health Association or association.** "Minnesota Comprehensive Health Association" or "association" means the association created by section 62E.10.

Subd. 15. **Medicare.** "Medicare" means the Health Insurance for the Aged Act, title XVIII of the Social Security Amendments of 1965, United States Code, title 42, sections 1395 to 1395hhh, as amended, or title I, part I, of Public Law 89-97, as amended.

Subd. 16. **Medicare supplement plan.** "Medicare supplement plan" means any plan of insurance protection which provides benefits for the costs of medical, surgical or hospital care and which is marketed as providing benefits which complement or supplement the benefits provided by Medicare.

Subd. 17. **State plan premium.** "State plan premium" means the premium determined pursuant to section 62E.08.

Subd. 18. **Writing carrier.** "Writing carrier" means the insurer or insurers, health maintenance organization or organizations, community integrated service network or networks, or other entity selected by the association and approved by the commissioner to administer the comprehensive health insurance plan.

Subd. 19. **Fraternal benefit society or fraternal.** "Fraternal benefit society" or "fraternal" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance in accordance with chapter 64B.

Subd. 20. **Comprehensive health insurance plan or state plan.** "Comprehensive health insurance plan" or "state plan" means policies of insurance and contracts of health maintenance organization or community integrated service network coverage offered by the association through the writing carrier.

Subd. 21. **Self-insurer.** "Self-insurer" means an employer or an employee welfare benefit fund or plan which directly or indirectly provides a plan of health coverage to its employees and administers the plan of health coverage itself or through an insurer, trust or agent except to the extent of accident and health insurance premium, subscriber contract charges or health maintenance organization contract charges. "Self-insurer" does not include an employer engaged in the business of providing health care services to the public which provides health care services directly to its employees at no charge to them.

Subd. 22. **Self-insurance.** "Self-insurance" means a plan of health coverage offered by a self-insurer.

Subd. 23. **Contributing member.** "Contributing member" means those companies regulated under chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance; health maintenance organizations regulated under chapter 62D; nonprofit health service plan corporations regulated under chapter 62C; community integrated service networks regulated under chapter 62N; fraternal benefit societies regulated under chapter 64B; the Minnesota employees insurance program established in section 43A.317, effective July 1, 1993; and joint self-insurance plans regulated under chapter 62H. For the purposes of determining liability of contributing members pursuant to section 62E.11 payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization or community integrated service network shall be considered to be accident and health insurance premiums.

History: *1976 c 296 art 1 s 2; 1977 c 409 s 4-7; 1979 c 272 s 1,2; 1981 c 318 s 13; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1985 c 49 s 41; 1986 c 444; 1987 c 268 art 2 s 17; 1987 c 384 art 2 s 1; art 3 s 47; 1988 c 612 s 27; 1992 c 549 art 3 s 13; 1992 c 564 art 1 s 34,54; 1994 c 625 art 8 s 7-10; art 10 s 50; 1995 c 258 s 40; 1997 c 175 art 1 s 1; 1997 c 225 art 2 s 62; art 6 s 1,2; 1999 c 177 s 44; 1999 c 245 art 10 s 10; 2007 c 147 art 12 s 2; 2010 c 384 s 21; 2013 c 84 art 1 s 37; 2016 c 158 art 2 s 12; 2017 c 2 art 2 s 9*

62E.03 Subdivision 1. [Repealed, 2005 c 132 s 38]

Subd. 2. [Repealed, 1Sp1985 c 14 art 1 s 59]

62E.035 [Repealed, 2005 c 77 s 8]

62E.04 DUTIES OF INSURERS.

Subdivision 1. **Individual policies.** For each type of qualified plan described in section 62E.06, an insurer or fraternal issuing individual policies of accident and health insurance in this state, other than group conversion policies, shall develop and file with the commissioner an individual policy which meets the minimum standards of that type of qualified plan. An insurer or fraternal issuing individual policies of accident and health insurance in this state shall offer each type of qualified plan to each person who applies and is eligible for accident and health insurance from that insurer or fraternal.

Subd. 2. **Medicare supplement plan.** An insurer or fraternal issuing Medicare supplement plans in this state shall develop and file with the commissioner a Medicare supplement policy which meets the minimum standards of a qualified Medicare supplement plan. An insurer or fraternal issuing Medicare supplement plans in this state shall offer a qualified medicare supplement plan to each person who is eligible for coverage and who applies for a Medicare supplement plan.

Subd. 3. **Group policies.** For each type of qualified plan described in section 62E.06, an insurer or fraternal issuing group policies of accident and health insurance in this state shall develop and file with the commissioner a group policy which provides for each member of the group the minimum benefits required by that type of qualified plan. An insurer or fraternal issuing group policies of accident and health insurance in this state shall offer each type of qualified plan to each eligible applicant for group accident and health insurance.

Subd. 4. **Major medical coverage.** Each insurer and fraternal shall affirmatively offer coverage of major medical expenses to every applicant who applies to the insurer or fraternal for a new unqualified policy, which has a lifetime benefit limit of less than $1,000,000, at the time of application and annually to every holder of such an unqualified policy of accident and health insurance renewed by the insurer or fraternal. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any co-payment authorized by the commissioner, and shall not contain a lifetime maximum on essential health benefits. The offer of coverage of major medical expenses may consist of the offer of a rider on an existing unqualified policy or a new policy which is a qualified plan.

Subd. 5. **Effect of noncompliance.** No policy of accident and health insurance may be issued or renewed in this state 180 days after July 1, 1976 by an insurer or a fraternal which has not complied with the requirements of this section.

Subd. 6. **Reinsurance allowed.** An insurer or fraternal may fulfill its obligations under this section by issuing the required coverages in their own name and reinsuring the risk and administration of the coverages with the association in accordance with section 62E.10, subdivision 7, clauses (e) and (f).

Subd. 7. **Underwriting standards may apply.** Nothing in this section shall require an insurer or fraternal to offer or issue a policy to any person who does not meet the underwriting or membership requirements of the insurer or fraternal.

Subd. 8. **Reduction of benefits because of other services.** No policy of accident and health insurance shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving benefits pursuant to chapters 256B and 256D, or sections 252.27; 260B.331, subdivision 2; 260C.331, subdivision 2; 393.07, subdivision 1 or 2.

Subd. 9. [Repealed, 1995 c 207 art 10 s 25]

Subd. 10. [Repealed, 1995 c 207 art 10 s 25]

Subd. 11. **Affordable Care Act compliant plans.** For any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, 2018, the requirements of this section do not apply.

History: *1976 c 296 art 1 s 4; 1977 c 409 s 9,10; 1979 c 174 s 3; 1979 c 272 s 4; 1988 c 689 art 2 s 14,15; 1988 c 704 s 1; 1996 c 305 art 1 s 21; 1999 c 139 art 4 s 2; 2000 c 483 s 14; 2001 c 215 s 18; 2013 c 84 art 1 s 38,39; 1Sp2017 c 6 art 5 s 5*

62E.05 INFORMATION ON QUALIFIED PLANS.

Subdivision 1. **Certification.** Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified Medicare supplement plan for the purposes of sections 62E.01 to 62E.19, the commissioner shall make a determination within 90 days as to whether the plan is qualified. All plans of health coverage, except Medicare supplement policies, shall be labeled as "qualified" or "nonqualified" on the front of the policy or contract, or on the schedule page. All qualified plans shall indicate whether they are number one, two, or three coverage plans. For any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, 2018, the requirements of this section do not apply.

Subd. 2. **Annual report.** The state of Minnesota or any of its departments, agencies, programs, instrumentalities, or political subdivisions, shall report in writing to the association and to the commissioner of commerce no later than September 15 of each year regarding the number of persons and the amount of premiums, deductibles, co-payments, or coinsurance that it paid for on behalf of enrollees in the Comprehensive Health Association. This report must contain only summary information and must not include any individually identifiable data. The report must cover the 12-month period ending the preceding June 30.

History: *1976 c 296 art 1 s 5; 1987 c 384 art 2 s 1; 1994 c 485 s 34; 1995 c 234 art 7 s 8; 1996 c 446 art 1 s 41; 1999 c 177 s 45; 2000 c 398 s 1; 2005 c 77 s 2; 1Sp2017 c 6 art 5 s 6*

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 not be subject to a lifetime maximum on essential health benefits.

The prohibition on lifetime maximums for essential health benefits and $3,000 limitation on total annual out-of-pocket expenses 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.

Subd. 2. **Number two plan.** A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by subdivision 1 except that the deductible shall not exceed $500 per person.

Subd. 3. **Number one plan.** A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by subdivision 1 except that the deductible shall not exceed $1,000 per person.

Subd. 4. **Health maintenance plans.** A health maintenance organization which provides the services required by chapter 62D shall be deemed to be providing a number three qualified plan.

Subd. 5. **Affordable Care Act compliant plans.** For any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, 2018, the requirements of this section do not apply.

History: *1975 c 359 s 23; 1976 c 296 art 1 s 6; 1977 c 409 s 11; 1979 c 272 s 5; 1980 c 496 s 3; 1981 c 265 s 2; 1Sp1985 c 9 art 2 s 2; 1986 c 444; 1987 c 202 s 2; 1987 c 337 s 66; 1988 c 704 s 2; 1989 c 330 s 24; 2001 c 215 s 19; 1Sp2003 c 14 art 7 s 10; 2013 c 84 art 1 s 40; 1Sp2017 c 6 art 5 s 7*

62E.07 QUALIFIED MEDICARE SUPPLEMENT PLAN.

(a) Any plan which provides benefits may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 100 percent of the deductibles required under Medicare, with exclusion under paragraph (b) for any part of the Medicare Part B deductible, and 80 percent of the charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by Medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services.

(b) Any plan sold or issued to a newly eligible individual, as defined in section 62A.3099, subdivision 18a, that provides benefits may be certified as a qualified Medicare supplemental plan if the plan is designed to supplement Medicare and provides coverage of 100 percent of the deductibles, with the exception of coverage of:

(1) 100 percent or any portion of the Medicare Part B deductible; and

(2) 80 percent of the charges for covered services, as provided under section 62E.06, subdivision 6, that are charges not paid by Medicare.

The coverage must include a $1,000 per person limitation on total annual out-of-pocket expenses for the covered services.

History: *1976 c 296 art 1 s 7; 1989 c 258 s 12; 1992 c 554 art 1 s 14; 2019 c 26 art 5 s 12*

NOTE: The amendment to this section by Laws 2019, chapter 26, article 5, section 12, regarding coverage requirements applies to Medicare supplemental policies or certificates sold or issued on or after January 1, 2020, to a newly eligible individual. Laws 2019, chapter 26, article 5, section 13.

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 be determined by calculating and applying the weighted average of the rate increases approved for the period for which the association premiums are to be effective for the three insurers or health maintenance organizations with the most 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; or

(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.

(f) Notwithstanding the provisions of this section, in calculating premiums to be effective January 1, 2014, and thereafter, the association may utilize rates for individual plans of insurance, individual health maintenance organization contracts, and other individual plans of coverage that are similar to plans offered by the association based upon generally accepted actuarial principles, so long as such plans and contracts have been filed with the Department of Commerce and are reasonably anticipated to be in force and individuals are reasonably anticipated to be enrolled in them during the period for which the association premiums are to be effective, regardless of whether they are in force in Minnesota or have individuals enrolled in them at the time the association is engaged in the rate-setting process mandated by this section and section 62E.091. For purposes of determining a weighted average under paragraph (e), the association shall use generally accepted actuarial principles to project potential enrollment in plans of coverage for the period for which the association's premiums will be effective and for which no individuals have enrolled at the time the association engages in the premium setting process.

Subd. 2. **Self-supporting.** Subject to subdivision 1, the schedule of premiums for coverage under the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

Subd. 3. **Determination of rates.** Premium rates under this section must be determined annually. These rates are effective July 1 of each year and must be based on a survey of approved rates of insurers and health maintenance organizations in effect, or to be in effect, on April 1 of the same calendar year. These rates may be trended to the midpoint of the period for which the premium rates will apply in order to reflect economic and inflationary changes. Notwithstanding the provisions of this subdivision, the association may set rates to be effective for the 18-month period July 1, 2012, through December 31, 2013. For calendar years beginning January 1, 2014, and thereafter, premium rates shall be determined annually and effective January 1 of each year. Premium rates shall be prospective and trended forward to the midpoint of the period for which the premium rates apply to ensure that the association's rates are based upon individual market rates for insurers and health maintenance organizations that will be in effect during the period for which the association's rates will be effective.

Subd. 4. **Smoker's rates.** The association may establish smoker and nonsmoker premium rates that are based on generally accepted actuarial principles.

History: *1976 c 296 art 1 s 8; 1977 c 409 s 12; 1979 c 272 s 6; 1983 c 123 s 1; 1991 c 165 s 2; 1993 c 324 s 1; 2000 c 398 s 2; 2003 c 109 s 2; 2012 c 170 s 1,2*

62E.081 [Repealed, 1987 c 384 art 3 s 34]

62E.09 DUTIES OF COMMISSIONER.

The commissioner may:

(a) formulate general policies to advance the purposes of sections 62E.01 to 62E.19;

(b) supervise the creation of the Minnesota Comprehensive Health Association within the limits described in section 62E.10;

(c) approve the selection of the writing carrier by the association, approve the association's contract with the writing carrier, and approve the state plan coverage;

(d) appoint advisory committees;

(e) conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;

(f) contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmental assistance programs;

(g) undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of sections 62E.01 to 62E.15, so that the residents of this state may best avail themselves of the health care benefits provided by these sections;

(h) contract with insurers and others for administrative services; and

(i) adopt, amend, suspend and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of sections 62E.01 to 62E.19.

History: *1976 c 296 art 1 s 9; 1977 c 409 s 13; 1987 c 384 art 2 s 1; 1993 c 324 s 2; 1996 c 305 art 2 s 7; 1999 c 177 s 46; 2013 c 84 art 1 s 41*

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 projected to exist in the private marketplace for individual coverage through the use of accepted actuarial principles during the period to which the association's rates will apply;

(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 projected to exist through the use of accepted actuarial principles, in the private marketplace for individual coverage during the period to which the association's rates will apply;

(f) a comparison of the proposed increases with increases in the cost of medical care and increases projected to occur through the use of accepted actuarial principles in the private marketplace for individual coverage during the period to which the association's rates will apply;

(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: *1993 c 324 s 3; 2003 c 109 s 3; 2012 c 170 s 3*

62E.10 COMPREHENSIVE HEALTH ASSOCIATION.

Subdivision 1. **Creation; tax exemption.** There is established a Comprehensive Health Association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers; self-insurers; fraternals; joint self-insurance plans regulated under chapter 62H; the Minnesota employees insurance program established in section 43A.317, effective July 1, 1993; health maintenance organizations; and community integrated service networks licensed or authorized to do business in this state. The Comprehensive Health Association is exempt from the taxes imposed under chapter 297I and any other laws of this state and all property owned by the association is exempt from taxation.

Subd. 2. **Board of directors; organization.** The board of directors of the association shall be made up of 13 members as follows: six directors selected by contributing members, subject to approval by the commissioner, one of which must be a health actuary; two directors selected by the commissioner of human services, one of whom must represent hospitals and one of whom must represent health care providers; five public directors selected by the commissioner, at least two of whom must be enrollees in the individual market and one of whom must be a licensed insurance agent. At least two of the public directors must reside outside of the seven-county metropolitan area. In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Directors selected by contributing members may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services.

Subd. 2a. **Appeals.** A person may appeal to the commissioner within 30 days after notice of an action, ruling, or decision by the board.

A final action or order of the commissioner under this subdivision is subject to judicial review in the manner provided by chapter 14.

In lieu of the appeal to the commissioner, a person may seek judicial review of the board's action.

Subd. 3. **Mandatory membership.** All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, health maintenance organization, or community integrated service network business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 14.001 to 14.69.

Subd. 4. **Open meetings.** All meetings of the association, its board, and any committees of the association shall comply with the provisions of chapter 13D, except that during any portion of a meeting during which

an enrollee's appeal of an action of the writing carrier is being heard, that portion of the meeting must be closed at the enrollee's request.

Subd. 5. [Repealed, 1979 c 272 s 11]

Subd. 6. **Antitrust exemption.** In the performance of their duties as members of the association, the members shall be exempt from the provisions of sections 325D.49 to 325D.66.

Subd. 7. **General powers.** The association may:

(a) Exercise the powers granted to insurers under the laws of this state;

(b) Sue or be sued;

(c) Enter into contracts with insurers, similar associations in other states or with other persons for the performance of administrative functions including the functions provided for in clauses (e) and (f);

(d) Establish administrative and accounting procedures for the operation of the association;

(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by section 62E.04 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:

(1) individual qualified plans, excluding group conversions;

(2) group conversions;

(3) group qualified plans with fewer than 50 employees or members; and

(4) major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance; and

(f) Provide for the administration by the association of policies which are reinsured pursuant to clause (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.

Subd. 8. **Department of state exemption.** The association is exempt from the Administrative Procedure Act but, to the extent authorized by law to adopt rules, the association may use the provisions of section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.

Subd. 9. **Experimental delivery method.** The association may petition the commissioner of commerce for a waiver to allow the experimental use of alternative means of health care delivery. The commissioner may approve the use of the alternative means the commissioner considers appropriate. The commissioner may waive any of the requirements of this chapter and chapters 60A, 62A, and 62D in granting the waiver. The commissioner may also grant to the association any additional powers as are necessary to facilitate the specific waiver, including the power to implement a provider payment schedule.

Subd. 10. **Cost containment goals.** (a) By July 1, 2001, the association shall investigate managed care delivery systems, and if cost effective, enter into contracts with third-party entities as provided in section 62E.101.

(b) By July 1, 2001, the association shall establish a system to annually identify individuals insured by the Minnesota Comprehensive Health Association who may be eligible for private health care coverage, medical assistance, state drug programs, or other state or federal programs and notify them about their eligibility for these programs.

(c) The association shall endeavor to reduce health care costs using additional methods consistent with effective patient care. At a minimum, by July 1, 2001, the association shall:

(1) develop a focused chronic disease management and case management program;

(2) develop a comprehensive program of preventive care; and

(3) implement a total drug formulary program.

The association may establish an enrollee incentive based on enrollee participation in the chronic disease management and case management program developed under this section.

History: *1976 c 296 art 1 s 10; 1977 c 409 s 14-16; 1979 c 272 s 7; 1981 c 253 s 23; 1982 c 424 s 130; 1Sp1985 c 10 s 63; 1987 c 337 s 67-69; 1987 c 384 art 2 s 1; 1988 c 612 s 28; 1990 c 422 s 10; 1990 c 523 s 2; 1991 c 165 s 3,4; 1991 c 264 s 1; 1992 c 549 art 3 s 14; 1992 c 554 art 1 s 15; 1992 c 564 art 1 s 35; art 4 s 11; 1993 c 324 s 4; 1994 c 426 s 12; 1994 c 625 art 8 s 11-13; art 10 s 50; 1997 c 187 art 5 s 10; 1997 c 225 art 2 s 62; 2000 c 394 art 2 s 14; 2000 c 398 s 3; 2004 c 268 s 2,3; 2008 c 344 s 13; 2013 c 84 art 1 s 42; 2017 c 13 art 1 s 1*

62E.101 MANAGED CARE DELIVERY METHOD.

The association may form a preferred provider network or contract with an existing provider network, health maintenance organization, or nonprofit health service plan corporation to deliver the services and benefits provided for in the plans of health coverage offered. If the association does not contract with an existing provider network, health maintenance organization, or nonprofit health service plan corporation, the association may adopt a provider payment schedule and negotiate provider payment rates subject to the approval of the commissioner.

History: *1991 c 165 s 5; 2000 c 398 s 4*

62E.11 OPERATION OF COMPREHENSIVE PLAN.

Subdivision 1. **Enrollment.** Upon certification as an eligible person in the manner provided by section 62E.14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

Subd. 2. **Employer premium payment.** Any employer which has in its employ one or more eligible persons enrolled in the comprehensive health insurance plan may make all or any portion of the state plan premium payment to the state plan directly to the writing carrier.

Subd. 3. **Claims payments.** Not less than 85 percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than 15 percent shall be used for the payment of agent referral fees as authorized in section 62E.15, subdivision 3 and for payment of the writing carrier's direct and indirect expenses, as specified in section 62E.13, subdivision 7.

Subd. 4. **Net income.** Any income in excess of the costs incurred by the association in providing reinsurance or administrative services pursuant to section 62E.07, clauses (e) and (f) shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 5. **Allocation of losses.** Each contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the contributing member's total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium, received by all contributing members from or on behalf of Minnesota residents, as determined by the commissioner. Payments made by the state to a contributing member for medical assistance or MinnesotaCare services according to chapters 256 and 256B shall be excluded when determining a contributing member's total premium.

Subd. 6. **Member assessments.** The association shall make an annual determination of each contributing member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the contributing members whose aggregate assessments comprised a minimum of 90 percent of the most recent prior annual assessment, in the event that the association deems that methodology to be the most administratively efficient and cost-effective means of assessment, and as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment shall be due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days shall be grounds for termination of the contributing member's membership. A contributing member which ceases to do accident and health insurance business within the state shall remain liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment, as determined herein, would not exceed ten dollars.

Subd. 7. **Net gain.** Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 8. [Repealed, 1987 c 268 art 2 s 38]

Subd. 9. **Special assessment upon termination of individual health coverage.** Each contributing member that terminates individual health coverage for reasons other than (a) nonpayment of premium; (b) failure to make co-payments; (c) enrollee moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership; and does not provide or arrange for replacement coverage that meets the requirements of section 62D.121; shall pay a special assessment to the state plan based upon the number of terminated individuals who join the comprehensive health insurance plan as authorized under section 62E.14, subdivisions 1, paragraph (d), and 6. Such a contributing member shall pay the association an amount equal to the average cost of an enrollee in the state plan in the year in which the member terminated enrollees multiplied by the total number of terminated enrollees who enroll in the state plan.

The average cost of an enrollee in the state comprehensive health insurance plan shall be determined by dividing the state plan's total annual losses by the total number of enrollees from that year. This cost will be assessed to the contributing member who has terminated health coverage before the association makes the annual determination of each contributing member's liability as required under this section.

In the event that the contributing member is terminating health coverage because of a loss of health care providers, the commissioner may review whether or not the special assessment established under this subdivision will have an adverse impact on the contributing member or its enrollees or insureds, including but not limited to causing the contributing member to fall below statutory net worth requirements. If the commissioner determines that the special assessment would have an adverse impact on the contributing member or its enrollees or insureds, the commissioner may adjust the amount of the special assessment, or establish alternative payment arrangements to the state plan. For health maintenance organizations regulated under chapter 62D, the commissioner of health shall make the determination regarding any adjustment in the special assessment and shall transmit that determination to the commissioner of commerce.

Subd. 10. **Termination of individual plan without replacement coverage.** Any contributing members who have terminated individual health plans and do not provide or arrange for replacement coverage that meets the requirements of section 62D.121, and whose former insureds or enrollees enroll in the state comprehensive health insurance plan with a waiver of the preexisting conditions pursuant to section 62E.14, subdivisions 1, paragraph (d), and 6, will be liable for the costs of any preexisting conditions of their former enrollees or insureds treated during the first six months of coverage under the state plan. The liability for preexisting conditions will be assessed before the association makes the annual determination of each contributing member's liability as required under this section.

Subd. 11. **Rate increase or benefit change.** The association must provide notice and solicit public comment at least two weeks before filing a rate increase or benefit change with the commissioner. This requirement may be satisfied by written notice, public meeting, or electronic means. If the association holds a public meeting, notice of the public meeting to hear public comment must be mailed at least two weeks before the meeting to all plan enrollees.

Subd. 12. [Repealed, 1997 c 225 art 2 s 63]

Subd. 13. **State funding; effect on premium rates of members.** In approving the premium rates as required in sections 62A.65, subdivision 3; and 62L.08, subdivision 8, the commissioners of health and commerce shall ensure that any appropriation to reduce the annual assessment made on the contributing

members to cover the costs of the Minnesota comprehensive health insurance plan as required under this section is reflected in the premium rates charged by each contributing member.

History: *1976 c 296 art 1 s 11; 1977 c 409 s 17; 1979 c 272 s 8; 1982 c 426 s 1; 1984 c 514 art 2 s 2; 1986 c 444; 1988 c 434 s 17,18; 1991 c 54 s 1; 1991 c 264 s 2; 1992 c 549 art 3 s 15,16; 1992 c 564 art 1 s 36; 1993 c 345 art 8 s 5; 1997 c 225 art 2 s 8; 1999 c 245 art 10 s 1; 2002 c 330 s 13; 2010 c 363 s 1; 2016 c 158 art 2 s 13*

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 $5,000,000; and an extended basic Medicare supplement plan and a basic Medicare supplement plan as described in sections 62A.3099 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 $5,000,000 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 $5,000,000 maximum lifetime benefit. The association, subject to approval of the commissioner, may also offer plans that meet all other requirements of state law except those that are inconsistent with high deductible health plans as defined in sections 220 and 223 of the Internal Revenue Code and supporting regulations. As of January 1, 2006, the association shall no longer be required to offer an extended basic Medicare supplement plan.

(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 home care nurse other than on an inpatient basis and any charges for treatment in a hospital or other inpatient facility 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: *1976 c 296 art 1 s 12; 1980 c 565 s 1; 1Sp1985 c 10 s 64; 1991 c 165 s 6; 1992 c 554 art 1 s 16; 1992 c 564 art 4 s 12; 1995 c 96 s 1; 1995 c 258 s 41; 1998 c 293 s 2; 1999 c 130 s 1; 2000 c 398 s 5; 2003 c 109 s 4; 2004 c 268 s 4; 2005 c 17 art 1 s 14; 2005 c 132 s 13; 2007 c 104 s 16; 2010 c 363 s 2; 2014 c 291 art 9 s 5*

62E.13 ADMINISTRATION OF PLAN.

Subdivision 1. **Submission of plans of coverage.** Any member of the association may submit to the commissioner the policies of accident and health insurance or the health maintenance organization contracts

which are being proposed to serve in the comprehensive health insurance plan. The time and manner of the submission shall be prescribed by rule of the commissioner.

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 Medicare supplement plans, and the health maintenance organization contract.

Subd. 3. **Duties of writing carrier.** The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of five years, unless a request to terminate is approved by the commissioner. The commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. Six months prior to the expiration of each five-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of subdivision 2 in selecting a writing carrier for the subsequent five-year period.

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.

Subd. 4. **Policy or certificate of coverage to enrollees.** The writing carrier shall provide to all eligible persons enrolled in the plan an individual policy or certificate, setting forth a statement as to the insurance protection to which they are entitled, with whom claims are to be filed and to whom benefits are payable. The policy or certificate shall indicate that coverage was obtained through the association.

Subd. 5. **Monthly report on operation of state plan.** The writing carrier shall submit to the association and the commissioner on a monthly basis a report on the operation of the state plan. Specific information to be contained in this report shall be determined by the association prior to the effective date of the state plan.

Subd. 6. **Claims payments.** All claims shall be paid by the writing carrier pursuant to the provisions of sections 62E.01 to 62E.19, and shall indicate that the claim was paid by the state plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

Subd. 7. **Reimbursement of writing carriers expenses.** The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses. Direct and indirect expenses shall include, but need not be limited to, a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses which are assignable to the maintenance and administration of the state plan. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted

accounting principles. Direct and indirect expenses shall not include costs directly related to the original submission of policy forms prior to selection as the writing carrier.

Subd. 8. **Writing carrier as agent.** The writing carrier shall at all times when carrying out its duties under sections 62E.01 to 62E.19 be considered an agent of the association and the commissioner with civil liability subject to the provisions of section 3.751.

Subd. 9. [Repealed, 1987 c 268 art 2 s 38]

Subd. 10. **Premiums not subject to tax.** Premiums received by the writing carrier for the comprehensive health insurance plan are exempt from the taxes imposed under chapter 297I.

Subd. 11. **Classification of PPO agreement data.** If the writing carrier uses its own provider agreements for the association's preferred provider network in lieu of agreements exclusively between the association and the providers, then the terms and conditions of those agreements are nonpublic data as defined in section 13.02, subdivision 9.

History: *1976 c 296 art 1 s 13; 1977 c 409 s 18,19; 1979 c 272 s 9; 1986 c 444; 1987 c 384 art 2 s 1; 1988 c 719 art 2 s 3; 1991 c 165 s 7; 1997 c 225 art 6 s 3; 1999 c 177 s 47,48; 2000 c 394 art 2 s 15; 2000 c 398 s 6; 2003 c 109 s 5,6; 2005 c 132 s 14; 2006 c 255 s 19*

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.** A person who obtains coverage pursuant to this section is not 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 3a, 4, 4a, 4b, 4c, 4d, 4e, 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 the Health Insurance Portability and Accountability Act (HIPAA), 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 Health Coverage Tax Credit (HCTC) 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 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 or MinnesotaCare program.

Subd. 4f. **Waiver of preexisting conditions; persons covered by a community-based health care coverage program.** A person may enroll in the comprehensive plan, with a waiver of preexisting condition limitation in subdivision 3, if the following requirements are met:

(1) the person was formerly enrolled in a community-based health care coverage program under section 62Q.80;

(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 coverage under the community-based health care program is terminated. For purposes of this clause, termination of coverage includes exceeding the maximum lifetime or annual benefit on existing coverage, or moving out of an area served by the program.

Subd. 4g. **Waiver of preexisting conditions for persons covered by healthy Minnesota contribution program.** A person may enroll in the comprehensive plan with a waiver of the preexisting condition limitation in subdivision 3 if the person is eligible for the healthy Minnesota contribution program, and has been denied coverage. The six-month durational residency requirement specified in section 62E.02, subdivision 13, does not apply to individuals enrolled in the healthy Minnesota contribution 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, and who is a Minnesota resident and who is otherwise eligible, may enroll in the comprehensive health insurance plan, 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.

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: *1976 c 296 art 1 s 14; 1977 c 409 s 20; 1979 c 272 s 10; 1984 c 592 s 48; 1986 c 455 s 14; 1986 c 458 s 2; 1987 c 337 s 70; 1987 c 384 art 2 s 1; 1988 c 434 s 19-21; 1988 c 612 s 29,31; 1989 c 258 s 13; 1990 c 523 s 3-5; 1991 c 165 s 8; 1991 c 325 art 21 s 6; 1992 c 564 art 1 s 37; 1997 c 175 art 1 s 2,3; 1997 c 203 art 7 s 1; 1999 c 177 s 49; 2002 c 330 s 14-16; 2003 c 109 s 7; 2006 c 255 s 20; 2010 c 384 s*

22; 2011 c 108 s 34,35; 1Sp2011 c 9 art 6 s 2; 2012 c 247 art 1 s 1; 2013 c 108 art 1 s 67; 2016 c 158 art 2 s 14

62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.

No employee of an employer that offers a health plan, under which the employee is eligible for coverage, is eligible to enroll, or continue to be enrolled, in the Comprehensive Health Association, except for enrollment or continued enrollment necessary to cover a condition that is subject to an unexpired preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under the employer's health plan. This section does not apply to persons enrolled in the Comprehensive Health Association as of June 30, 1993. With respect to persons eligible to enroll in the health plan of an employer that has more than 29 current employees, as defined in section 62L.02, this section does not apply to persons enrolled in the Comprehensive Health Association as of December 31, 1994.

History: *1992 c 549 art 3 s 17; 1994 c 625 art 10 s 14; 1995 c 234 art 7 s 9; 2010 c 363 s 3*

62E.15 SOLICITATION OF ELIGIBLE PERSONS.

Subdivision 1. **Commissioner's duty.** The association pursuant to a plan approved by the commissioner shall disseminate appropriate information to the residents of this state regarding the existence of the comprehensive health insurance plan and the means of enrollment. Means of communication may include use of the press, radio and television, as well as publication in appropriate state offices and publications.

Subd. 2. **Association's duty.** The association shall devise and implement means of maintaining public awareness of the provisions of sections 62E.01 to 62E.19 and shall administer these sections in a manner which facilitates public participation in the state plan.

Subd. 2a. **Annual verification.** The association may annually verify the uninsurability of each policyholder to insure that only eligible persons are enrolled in the plan.

Subd. 3. **Agent's referral fee.** The writing carrier shall pay an agent's referral fee of $50 to each insurance agent who refers an applicant to the state plan, if the application is accepted. Selling or marketing of qualified state plans shall not be limited to the writing carrier or its agents. The referral fees shall be paid by the writing carrier from money received as premiums for the state plan.

Subd. 4. **Rejection or underwriting restrictions.** Every insurer and health maintenance organization which rejects or applies underwriting restrictions to an applicant for a plan of health coverage shall: (1) provide the applicant with a written notice of rejection or the underwriting restrictions applied to the applicant in a manner consistent with the requirements in section 72A.499; (2) notify the applicant of the existence of the state plan, the requirements for being accepted in it, and the procedure for applying to it; and (3) provide the applicant with written materials explaining the state plan in greater detail. This written material shall be provided by the association to every insurer at no charge.

Subd. 5. **Initial notification.** Every insurer and health maintenance organization before issuing a conversion policy or contract of health insurance shall:

(1) notify the applicant of the existence of the state plan, the requirements for being accepted in it, the procedure for applying to it, and the plan rates; and

(2) provide the applicant with written materials explaining the state plan in greater detail. This written material shall be provided by the association to every insurer and health maintenance organization at no charge.

Subd. 6. **Annual notification.** Every insurer and health maintenance organization which provides health coverage to an insured through a conversion plan shall annually:

(1) notify the insured of the existence of the state plan, the requirements for being accepted in it, the procedure for applying to it, and the plan rates; and

(2) provide the applicant with written materials explaining the state plan in greater detail. This written material shall be provided by the association to every insurer and health maintenance organization at no charge.

Subd. 7. **Conversion rates.** For Medicare supplement conversion policies issued prior to August 1, 1992, the requirements of subdivisions 5 and 6 apply only when the conversion rates offered to the applicant by the insurer or health maintenance organization exceed the association rates.

History: *1976 c 296 art 1 s 15; 1984 c 592 s 49; 1990 c 523 s 6; 1992 c 564 art 1 s 38-41; 1999 c 177 s 50; 2000 c 398 s 7*

62E.16 [Repealed, 2013 c 84 art 1 s 94]

62E.17 [Repealed, 1Sp1985 c 9 art 2 s 104]

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: *1987 c 337 s 71; 2000 c 398 s 8; 2003 c 109 s 8*

62E.19 PAYMENTS FOR PREEXISTING CONDITIONS.

Subdivision 1. **Employer liability.** An employer is liable to the association for the costs of any preexisting conditions of the employer's former employees or their dependents during the first six months of coverage under the state comprehensive health insurance plan under the following conditions:

(1)(i) the employer has terminated or laid off employees and is required to meet the notice requirements under section 116L.976, subdivision 2;

(ii) the employer has failed to provide, arrange for, or make available continuation health insurance coverage required to be provided under federal or state law to employees or their dependents; and

(iii) the employer's former employees or their dependents enroll in the state comprehensive health insurance plan with a waiver of the preexisting condition limitation under section 62E.14, subdivision 4a or 5; or

(2)(i) the employer has terminated or allowed the employer's plan of health insurance coverage to lapse within 90 days prior to the date of termination or layoff of an employee; and

(ii) the employer's former employees or their dependents enroll in the state comprehensive health insurance plan with a waiver of the preexisting condition limitation under section 62E.14, subdivision 4a or 5.

The employer shall pay a special assessment to the association for the costs of the preexisting conditions. The special assessment may be assessed before the association makes the annual determination of each contributing member's liability as required under this chapter. The association may enforce the obligation to pay the special assessment by action, as a claim in an insolvency proceeding, or by any other method not prohibited by law.

If the association makes the special assessment permitted by this subdivision, the association may also make any assessment of contributing members otherwise permitted by law, without regard to the special assessment permitted by this subdivision. Contributing members must pay the assessment, subject to refund or adjustment in the event of receipt by the association of any portion of the special assessment.

Subd. 2. **Exemption.** Subdivision 1 does not apply to a termination of or failure to implement an employee health benefit plan which results from or occurs during a strike or lockout, nor does it apply to employee health benefit plans separately provided by an employee organization or bargaining agent, regardless of any financial contribution to the plan by the employer.

History: *1990 c 523 s 7; 1991 c 199 art 1 s 11; 1994 c 485 s 35; 2004 c 206 s 52*

62E.20 [Repealed, 2013 c 84 art 1 s 94]

62E.21 DEFINITIONS.

Subdivision 1. **Application.** For the purposes of sections 62E.21 to 62E.25, the terms defined in this section have the meanings given them.

Subd. 2. **Affordable Care Act.** "Affordable Care Act" means the federal act as defined in section 62A.011, subdivision 1a.

Subd. 3. **Attachment point.** "Attachment point" means an amount as provided in section 62E.23, subdivision 2, paragraph (b).

Subd. 4. **Benefit year.** "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

Subd. 5. **Board.** "Board" means the board of directors of the Minnesota Comprehensive Health Association created under section 62E.10.

Subd. 6. **Coinsurance rate.** "Coinsurance rate" means the rate as provided in section 62E.23, subdivision 2, paragraph (c).

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 8. **Eligible health carrier.** "Eligible health carrier" means all of the following that offer individual health plans and incur claims costs for an individual enrollee's covered benefits in the applicable benefit year:

(1) 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;

(2) a nonprofit health service plan corporation operating under chapter 62C; or

(3) a health maintenance organization operating under chapter 62D.

Subd. 9. **Individual health plan.** "Individual health plan" means a health plan as defined in section 62A.011, subdivision 4, that is not a grandfathered plan as defined in section 62A.011, subdivision 1b.

Subd. 10. **Individual market.** "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 11. **Minnesota Comprehensive Health Association or association.** "Minnesota Comprehensive Health Association" or "association" has the meaning given in section 62E.02, subdivision 14.

Subd. 12. **Minnesota premium security plan or plan.** "Minnesota premium security plan" or "plan" means the state-based reinsurance program authorized under section 62E.23.

Subd. 13. **Payment parameters.** "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the plan.

Subd. 14. **Reinsurance cap.** "Reinsurance cap" means the threshold amount as provided in section 62E.23, subdivision 2, paragraph (d).

Subd. 15. **Reinsurance payments.** "Reinsurance payments" means an amount paid by the association to an eligible health carrier under the plan.

History: *2017 c 13 art 1 s 2*

62E.22 DUTIES OF COMMISSIONER.

The commissioner shall require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the benefit year if the Minnesota premium security plan had not been established. The eligible health carrier must submit this information as part of its rate filing. The commissioner must consider this information as part of the rate review.

History: *2017 c 13 art 1 s 3*

62E.23 MINNESOTA PREMIUM SECURITY PLAN.

Subdivision 1. **Administration of plan.** (a) The association is Minnesota's reinsurance entity to administer the state-based reinsurance program referred to as the Minnesota premium security plan.

(b) The association may apply for any available federal funding for the plan. All funds received by or appropriated to the association shall be deposited in the premium security plan account in section 62E.25, subdivision 1. The association shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and insurance within ten days of receiving any federal funds.

(c) The association must collect or access data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements under subdivision 5, paragraph (c).

(d) The board must not use any funds allocated to the plan for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory changes.

(e) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) By August 15 of the year following the applicable benefit year, the association must disburse all applicable reinsurance payments to an eligible health carrier.

Subd. 2. **Payment parameters.** (a) The board must design and adjust the payment parameters to ensure the payment parameters:

(1) will stabilize or reduce premium rates in the individual market;

(2) will increase participation in the individual market;

(3) will improve access to health care providers and services for those in the individual market;

(4) mitigate the impact high-risk individuals have on premium rates in the individual market;

(5) take into account any federal funding available for the plan; and

(6) take into account the total amount available to fund the plan.

(b) The attachment point for the plan is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments. The attachment point shall be set by the board at $50,000 or more, but not exceeding the reinsurance cap.

(c) The coinsurance rate for the plan is the rate at which the association will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap. The coinsurance rate shall be set by the board at a rate between 50 and 80 percent.

(d) The reinsurance cap is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set by the board at $250,000 or less.

(e) The board may adjust the payment parameters to the extent necessary to secure federal approval of the state innovation waiver request in Laws 2017, chapter 13, article 1, section 8.

Subd. 3. **Operation.** (a) The board shall propose to the commissioner the payment parameters for the next benefit year by January 15 of the year before the applicable benefit year. The commissioner shall approve or reject the payment parameters no later than 14 days following the board's proposal. If the commissioner fails to approve or reject the payment parameters within 14 days following the board's proposal, the proposed payment parameters are final and effective.

(b) If the amount in the premium security plan account in section 62E.25, subdivision 1, is not anticipated to be adequate to fully fund the approved payment parameters as of July 1 of the year before the applicable benefit year, the board, in consultation with the commissioner and the commissioner of management and budget, shall propose payment parameters within the available appropriations. The commissioner must permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

(c) Notwithstanding paragraph (a), the payment parameters for benefit year 2020 are:

(1) an attachment point of $50,000;

(2) a coinsurance rate of 80 percent; and

(3) a reinsurance cap of $250,000.

Subd. 4. **Calculation of reinsurance payments.** (a) Each reinsurance payment must be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance payment is $0. If the claims costs exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of:

(1) the claims costs minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

(b) The board must ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for any eligible claim. "Total amount paid of an eligible claim" means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data are submitted or made accessible under subdivision 5, paragraph (c).

Subd. 5. **Eligible carrier requests for reinsurance payments.** (a) An eligible health carrier may request reinsurance payments from the association when the eligible health carrier meets the requirements of this subdivision and subdivision 4.

(b) An eligible health carrier must make requests for reinsurance payments in accordance with any requirements established by the board.

(c) An eligible health carrier must provide the association with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under United States Code, title 42, section 18063. Eligible health carriers must submit an attestation to the board asserting compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(d) An eligible health carrier must provide the access described in paragraph (c) for the applicable benefit year by April 30 of each year of the year following the end of the applicable benefit year.

(e) An eligible health carrier must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least six years. An eligible health carrier must also make those documents and records available upon request from the commissioner for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

(f) An eligible health carrier may follow the appeals procedure under section 62E.10, subdivision 2a.

(g) The association may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section. The eligible health carrier must ensure that its contractors, subcontractors, or agents cooperate with any audit under this section. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding within 30 days. Within 30 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier must:

(1) provide a written corrective action plan to the association for approval;

(2) implement the approved plan; and

(3) provide the association with written documentation of the corrective action once taken.

Subd. 6. **Data.** Government data of the association under this section are private data on individuals, or nonpublic data, as defined under section 13.02, subdivision 9 or 12.

History: *2017 c 13 art 1 s 4; 1Sp2019 c 9 art 8 s 6*

62E.24 ACCOUNTING, REPORTS, AND AUDITS OF THE ASSOCIATION.

Subdivision 1. **Accounting.** The board must keep an accounting for each benefit year of all:

(1) funds appropriated for reinsurance payments and administrative and operational expenses;

(2) requests for reinsurance payments received from eligible health carriers;

(3) reinsurance payments made to eligible health carriers; and

(4) administrative and operational expenses incurred for the plan.

Subd. 2. **Reports.** (a) The board must submit to the commissioner and to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and make available to the public quarterly reports on plan operations and an annual report summarizing the plan operations for each benefit year. All reports must be made public by posting the report on the Minnesota Comprehensive Health Association website. The annual summary must be made available by November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

(b) The reports must include information about:

(1) the reinsurance parameters used;

(2) the metal levels affected;

(3) the number of claims payments estimated and submitted for payment per products offered on-exchange and off-exchange and per eligible health carrier;

(4) the estimated reinsurance payments by plan type based on carrier-submitted templates;

(5) funds appropriated for reinsurance payments and administrative and operational expenses for each year, including the federal and state contributions received, investment income, and any other revenue or funds received;

(6) the total amount of reinsurance payments made to each eligible health carrier; and

(7) administrative and operational expenses incurred for the plan, including the total amount incurred and as a percentage of the plan's operational budget.

Subd. 3. **Legislative auditor.** The Minnesota premium security plan is subject to audit by the legislative auditor. The board must ensure that its contractors, subcontractors, or agents cooperate with the audit.

Subd. 4. **Independent external audit.** (a) The board must engage and cooperate with an independent certified public accountant or CPA firm licensed or permitted under chapter 326A to perform an audit for

each benefit year of the plan, in accordance with generally accepted auditing standards. The audit must at a minimum:

(1) assess compliance with the requirements of sections 62E.21 to 62E.25; and

(2) identify any material weaknesses or significant deficiencies and address manners in which to correct any such material weaknesses or deficiencies.

(b) The board, after receiving the completed audit, must:

(1) provide the commissioner the results of the audit;

(2) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board intends to correct any such material weakness or significant deficiency in compliance with subdivision 5; and

(3) make public the results of the audit, to the extent the audit contains government data that is public, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency, by posting the audit results on the Minnesota Comprehensive Health Association website and making the audit results otherwise available.

Subd. 5. **Actions on audit findings.** (a) If an audit results in a finding of material weakness or significant deficiency with respect to compliance by the association with any requirement under sections 62E.21 to 62E.25, the board must:

(1) provide a written corrective action plan to the commissioner for approval within 60 days of the completed audit;

(2) implement the corrective action plan; and

(3) provide the commissioner with written documentation of the corrective actions taken.

(b) By December 1 of each year, the board must submit a report to the standing committees of the legislature having jurisdiction over health and human services and insurance regarding any finding of material weakness or significant deficiency found in an audit.

History: *2017 c 13 art 1 s 5; 1Sp2019 c 9 art 8 s 7*

62E.25 ACCOUNTS.

Subdivision 1. **Premium security plan account.** The premium security plan account is created in the special revenue fund of the state treasury. Funds in the account are appropriated annually to the commissioner of commerce for grants to the Minnesota Comprehensive Health Association for the operational and administrative costs and reinsurance payments relating to the start-up and operation of the Minnesota premium security plan. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the premium security plan account shall be credited to the premium security plan account.

Subd. 2. **Deposits.** Except as provided in subdivision 3, funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in Laws 2017, chapter 13, article 1, section 8, shall be deposited in the premium security plan account in subdivision 1.

Subd. 3. **Basic health plan trust account.** Funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in Laws 2017, chapter 13, article 1, section 8,

that are attributable to the basic health program shall be deposited in the basic health plan trust account in the federal fund.

History: *2017 c 13 art 1 s 6*

62E.51 [Repealed, 1994 c 625 art 10 s 49]

62E.52 [Repealed, 1994 c 625 art 10 s 49]

62E.53 [Repealed, 1994 c 625 art 10 s 49]

62E.531 [Repealed, 1994 c 625 art 10 s 49]

62E.54 [Repealed, 1994 c 625 art 10 s 49]

62E.55 [Repealed, 1994 c 625 art 10 s 49]