CHAPTER 264 — S.F.No. 34

An act relating to public welfare; allowing the commissioner of public welfare to grant a variance related to certain license holders whose licenses have been previously revoked; amending Minnesota Statutes 1980, Section 245.801, Subdivision 6.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1980, Section 245.801, Subdivision 6, is amended to read:

Subd. 6. An operator whose license has been revoked or not renewed because of noncompliance with applicable laws, or rules and regulations may not be granted a new license for five years following the revocation or denial of renewal except that the commissioner may grant a variance to this provision for family day care after two years following the revocation or denial of a family day care license and issue a license according to criteria established by rules adopted under section 15.0412, subdivision 5. The commissioner may grant variances immediately upon the effective date of and in accordance with the rules.

Approved May 27, 1981

CHAPTER 265 — S.F.No. 56

An act relating to insurance; broadening the scope of mandated group accident and health coverage for ambulatory mental health services; modifying certain comprehensive health insurance benefit requirements; amending Minnesota Statutes 1980, Sections 62A.152; and 62E.06, Subdivision 1.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1980, Section 62A.152, is amended to read:

62A.152 **BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES.**

Subdivision 1. **SCOPE.** The provisions of this section ~~shall~~ apply (a) to all group policies or subscriber contracts which provide benefits for at least 100 certificate holders who are residents of this state or groups of which more than 90 percent are residents of this state and are issued, delivered, or renewed ~~within this state after August 1, 1975~~ by accident and health insurance companies regulated under this chapter, ~~and~~ or by nonprofit health service plan corporations regulated under chapter 62C and (b), unless waived by the

commissioner to the extent applicable to holders who are both nonresidents and employed outside this state, to all group policies or subscriber contracts which are issued, delivered, or renewed within this state by accident and health insurance companies regulated under this chapter, or by nonprofit health service plan corporations regulated under chapter 62C.

Subd. 2. **MINIMUM BENEFITS.** All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage, to at least the extent of ~~90~~ 80 percent of the first ~~$600~~ $750 of the cost of the usual and customary charges incurred over a 12-month period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient in a hospital, if ~~such~~ the services are furnished by (1) a licensed or accredited hospital, (2) a community mental health center or mental health clinic approved or licensed by the commissioner of public welfare or other authorized state agency, or (3) ~~by~~ a licensed consulting psychologist licensed under the provisions of sections 148.87 to 148.99, or ~~by~~ a psychiatrist licensed under chapter 147.

Sec. 2. Minnesota Statutes 1980, Section 62E.06, Subdivision 1, is amended to read:

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 and 62C, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall be subject to a maximum lifetime benefit of not less than $250,000.

The $3,000 limitation on total annual out-of-pocket expenses and the $250,000 maximum lifetime benefit shall not be subject to change or substitution by use of an actuarially equivalent benefit.

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

(1) Hospital services;

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his 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;

(10) Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;

(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; and

(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.

(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 law;

(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 semi-private room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semi-private rooms, its most common semi-private 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 ~~the following services~~ well baby care, effective July 1, 1980, subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

~~(1) Well baby care, effective July 1, 1980;~~

~~(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician, effective July 1, 1982;~~

~~(3) Multiphasic screening and other diagnostic testing, effective July 1, 1982. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for services listed in this clause.~~

(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.

Sec. 3. **EFFECTIVE DATE.**

Section 1 is effective for all policies and contracts issued, renewed, or delivered on or after August 1, 1981.

Approved May 27, 1981

CHAPTER 266 — S.F.No. 72

An act relating to elections; providing a penalty for preparing or disseminating certain false information; exempting certain broadcasters; amending Minnesota Statutes 1980, Section 210A.04.

Changes or additions are indicated by underline, deletions by ~~strikeout~~.