days following notice of the expiration of the continued coverage and upon payment of the appropriate fee. A contract providing reduced benefits at a reduced fee may be accepted by the former spouse and dependent children in lieu of the optional coverage otherwise required by this subdivision. The individual health maintenance contract shall be renewable at the option of the former spouse as long as the former spouse is not covered under another qualified plan as defined in section 62E.02, subdivision 4, ~~up to age 65 or to the day before the date of eligibility for coverage under title XVIII of the Social Security Act, as amended~~. Any revisions in the table of rate for the individual contract shall apply to the former spouse's original age at entry, and shall apply equally to all similar contracts issued by the health maintenance organization.

Sec. 11. **EFFECTIVE DATES.**

Sections 1 to 6 and 8 to 10 are effective the day following final enactment. The first supplement to an annual report required to be filed under section 7 must be for annual statements required to be submitted on or after January 1, 1991.

Presented to the governor April 3, 1990

Signed by the governor April 6, 1990, 10:30 a.m.

CHAPTER 404—H.F.No. 1984

An act relating to insurance; accident and health; providing for coordination of benefits between group and individual contracts; amending Minnesota Statutes 1989 Supplement, section 62A.046.

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

Section 1. Minnesota Statutes 1989 Supplement, section 62A.046, is amended to read:

62A.046 **COORDINATION OF BENEFITS.**

(1) No group contract providing coverage for hospital and medical treatment or expenses issued or renewed after August 1, 1984, which is responsible for secondary coverage for services provided, may deny coverage or payment of the amount it owes as a secondary payor solely on the basis of the failure of another group contract, which is responsible for primary coverage, to pay for those services.

(2) A group contract which provides coverage of a claimant as a dependent of a parent who has legal responsibility for the dependent's medical care pursuant to a court order under section 518.171 must make payments directly to the

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provider of care. In such cases, liability to the insured is satisfied to the extent of benefit payments made to the provider.

(3) This section applies to an insurer, a vendor of risk management services regulated under section 60A.23, a nonprofit health service plan corporation regulated under chapter 62C and a health maintenance organization regulated under chapter 62D. Nothing in this section shall require a secondary payor to pay the obligations of the primary payor nor shall it prevent the secondary payor from recovering from the primary payor the amount of any obligation of the primary payor that the secondary payor elects to pay.

(4) Payments made by an enrollee or by the commissioner on behalf of an enrollee in the children's health plan under section 256.936, or a person receiving benefits under chapter 256B or 256D, for services that are covered by the policy or plan of health insurance shall, for purposes of the deductible, be treated as if made by the insured.

(5) The commissioner of human services shall recover payments made by the children's health plan from the responsible insurer, for services provided by the children's health plan and covered by the policy or plan of health insurance.

(6) Insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations may coordinate benefits to prohibit greater than 100 percent coverage when an insured, subscriber, or enrollee is covered by both an individual and a group contract providing coverage for hospital and medical treatment or expenses. Benefits coordinated under this paragraph must provide for 100 percent coverage of an insured, subscriber, or enrollee. To the extent appropriate, all coordination of benefits provisions currently applicable by law or rule to insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations, shall apply to coordination of benefits between individual and group contracts, except that the group contract shall always be the primary plan. This paragraph does not apply to specified accident, hospital indemnity, specified disease, or other limited benefit insurance policies.

Presented to the governor April 3, 1990

Signed by the governor April 6, 1990, 10:34 a.m.

CHAPTER 405—H.F.No. 1919

An act relating to ethnic Minnesotans; designating Ethnic American Day; proposing coding for new law in Minnesota Statutes, chapter 10.

New language is indicated by underline, deletions by ~~strikeout~~.

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