CHAPTER 4685
DEPARTMENT OF HEALTH
HEALTH MAINTENANCE ORGANIZATIONS

DEFINITIONS

4685.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 4685.0100 to 4685.3400 the terms used have the meanings given to them in this part and in Minnesota Statutes, chapter 62D.

Subp. 2. **Accepted actuarial principles.** "Accepted actuarial principles" means those prevailing statistical rules relating to the calculation of risks and premiums or prepayment charges of health maintenance organizations, prepaid group practice plans or commercial health insurance carriers.

Subp. 3. **Act.** "Act" means the Health Maintenance Act of 1973, Minnesota Statutes, chapter 62D.

Subp. 3a. **Ancillary services.** "Ancillary services" means laboratory services, radiology services, durable medical equipment, pharmacy services, rehabilitative services, and similar services and supplies dispensed by order or prescription of the primary care physician, specialty physician, or other provider authorized to prescribe those services.

Subp. 4. [Repealed, L 1999 c 239 s 43]

Subp. 4a. [Repealed, L 1999 c 239 s 43]

Subp. 5. **Comprehensive health maintenance service.** "Comprehensive health maintenance service" means a group of services which includes at least all of the types of services defined below:

A. "Emergency care" means medically necessary care which is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the enrollee in serious jeopardy.

B. "In-patient hospital care" means necessary hospital services affording residential treatment to patients. Such services shall include room and board, drugs and medicine, dressings, nursing care, X-rays, and laboratory examination, and other usual and customary hospital services.

C. "In-patient physician care" means those health services performed, prescribed or supervised by physicians within a hospital, for registered bed patients therein, which services shall include diagnostic and therapeutic care.

D. "Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment.

E. "Preventive health services" means health education, health supervision including evaluation and follow-up, immunization and early disease detection.

Subp. 5a. **Cosmetic services.** "Cosmetic services" means surgery and other services performed primarily to enhance or otherwise alter an enrollee's physical appearance without correcting or improving a physiological function.

Subp. 5b. **Custodial care.** "Custodial care" means assistance with meeting personal needs or the activities of daily living that does not require the services of a physician, registered nurse, licensed practical nurse, chiropractor, physical therapist, occupational therapist, speech therapist, or other health care professional, and includes bathing, dressing, getting in and out of bed, feeding, walking, elimination, and taking medications.

Subp. 6. **Enrollee copayment provisions.** "Enrollee copayment provisions" means those contract clauses requiring charges to enrollees, in addition to fixed, prepaid sums, to supplement the cost of providing covered comprehensive health maintenance services; "enrollee copayment provisions" also means the difference between an indemnity benefit and the charge of a provider for health services rendered.

Subp. 6a. **Experimental, investigative, or unproven.** "Experimental, investigative, or unproven" means a drug, device, medical treatment, diagnostic procedure, technology, or procedure for which reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes.

Subp. 7. **Formal procedural requirements.** "Formal procedural requirements" means those rules governing the conduct of administrative hearings applicable to and affecting the rights, duties, and privileges of each party of a contested case, as the term is defined and as the rules are set forth in Minnesota Statutes, chapter 14.

Subp. 7a. **Formulary.** "Formulary" means a current list of covered outpatient prescription drug products that is subject to periodic review and update.

Subp. 8. **Governing body.** "Governing body" means the board of directors, or if otherwise designated in the basic organizational document and/or bylaws, those persons vested with the ultimate responsibility for the management of the corporate entity that has been issued a certificate of authority as a health maintenance organization.

Subp. 8a. [Repealed, 17 SR 2858]

Subp. 9. **In-area services.** "In-area services" are those services provided within the geographical areas served by the health maintenance organization as described in its

application for a certificate of authority and any subsequent changes therein filed with the commissioner of health.

Subp. 9a. **NAIC Blank.** "NAIC Blank" means the most recent version of the National Association of Insurance Commissioners' Blank for Health Maintenance Organizations published by the Brandon Insurance Service Company, Nashville, Tennessee. The NAIC Blank is incorporated by reference and is available for inspection at the State Law Library, Judicial Center, 25 Constitution Avenue, Saint Paul, Minnesota 55155. The NAIC Blank is subject to annual changes by the publisher. Health maintenance organizations must use the version current on December 31 of the year preceding the filing of a required report.

Subp. 9b. **Medically necessary care.** "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must:

A. be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and

B. help restore or maintain the enrollee's health; or

C. prevent deterioration of the enrollee's condition; or

D. prevent the reasonably likely onset of a health problem or detect an incipient problem.

Subp. 9c. **Member.** "Member" means enrollee, as defined by Minnesota Statutes, section 62D.02, subdivision 6. "Member" also means "subscriber," and the terms may be used interchangeably.

Subp. 10. **Open enrollment.** "Open enrollment" means the acceptance for coverage by health plans of group enrollees without regard to underwriting restrictions, and coverage of individual or nongroup enrollees with regard only to those underwriting restrictions permissible under Minnesota Statutes, section 62D.10, subdivision 4.

Subp. 11. **Out-of-area health care services.** "Out-of-area health care services" are those services provided outside of the health maintenance organization's geographic service area, as such area is described in the health maintenance organization's application for a certificate of authority, and any subsequent changes therein filed with the commissioner of health.

Subp. 12. **Period of confinement.** "Period of confinement" means a period of time specified in a health maintenance contract relating to the amount of days of inpatient hospital care and defining a period during which an enrollee may not receive any inpatient hospital care in order to become entitled to a renewed period of hospital coverage. This term means the same as "spell of illness" and similar terms as they may be used in provisions to limit hospital care.

Subp. 12a. **Primary care physician.** "Primary care physician" means a licensed physician, either employed by or under contract with the health maintenance organization, who is in general practice, or who has special education, training, or experience, or who is board-certified or board-eligible and working toward certification in a board approved by the American Board of Medical Specialists or the American Board of Osteopathy in family practice, pediatrics, internal medicine, or obstetrics and gynecology.

Subp. 12b. **Primary care provider.** "Primary care provider" means a primary care physician as defined in subpart 12a or a licensed practitioner such as a licensed nurse, optometrist, or chiropractor who, within that practitioner's scope of practice as defined under the relevant state licensing law, provides primary care services.

Subp. 13. **Provide.** "Provide" as that word is used in Minnesota Statutes, section 62D.09, means to send by United States postal service, by alternative carrier, or by other method to the place of residence or employment of each enrollee or, if such

enrollee is a member of a specified group covered by a health maintenance contract, to the office of the authorized representative of any such group.

Subp. 13a. **Referral.** "Referral" means a prior written authorization for specified services that is issued by a health maintenance organization or an authorized provider and that identifies the provider to which an enrollee is referred and the type, number, frequency, and duration of services to be covered as a benefit under the enrollee's health maintenance organization contract.

Subp. 13b. **Specialty physician.** "Specialty physician" means a licensed physician, either employed by or under contract with the health maintenance organization, who has specialized education, training, or experience, or who is board-certified or board-eligible and working toward certification in a specialty board approved by the American Board of Medical Specialists or the American Board of Osteopathy.

Subp. 14. **Summary of current evidence of coverage.** "Summary of current evidence of coverage" means written notice to be provided to enrollees by every health maintenance organization as prescribed in the act. Such notice shall describe changes in health maintenance contract coverage but need not necessarily be specific as to changes respecting the coverage of any individual enrollee.

Subp. 15. **Underwriting restrictions.** "Underwriting restrictions" means those internal predetermined standards within a health maintenance organization which specify and exclude from coverage certain health conditions or persons with certain health conditions which, if such persons or conditions were enrolled or covered, would obligate the health maintenance organization to provide a greater amount, kind or intensity of service than that required by the general population or that contemplated in the process of setting the prepayment amount.

Subp. 16. **Urgently needed care.** "Urgently needed care" means medically necessary care which does not meet the definition of emergency care but is needed as soon as possible, usually within 24 hours.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.08; 62D.11; 62D.182; 62D.20; 62D.21*

History: *10 SR 2159; 14 SR 901; 14 SR 903; 17 SR 2858; 23 SR 1238; L 1999 c 239 s 43*

4685.0200 AUTHORITY, SCOPE AND PURPOSE.

Parts 4685.0100 to 4685.3400 are adopted pursuant to Minnesota Statutes, sections 62D.03, subdivision 4, clause (m); 62D.04, subdivision 1, clauses (c), (d), and (g); 62D.06, subdivision 2; 62D.08, subdivisions 1 and 3; 62D.12, subdivision 2, clause (g); and 62D.20 relating to health maintenance organizations in particular, and Minnesota Statutes, sections 14.02, 14.04 to 14.36, and 14.38 relating generally to the adoption of administrative rules. Parts 4685.0100 to 4685.3400 and all future changes herein apply to all health maintenance organizations operating in Minnesota at the time of their adoption, to all health maintenance organizations hereafter certified, and to all community integrated service networks currently and hereafter licensed, with the exceptions specified in Minnesota Statutes, chapter 62N, and are adopted to carry out the Health Maintenance Act of 1973 and to facilitate the full and uniform implementation and enforcement of that law.

Statutory Authority: *MS s 62D.20*

History: *23 SR 1238*

4685.0300 APPLICATION.

Subpart 1. **Forms.** Application for certificates of authority shall be submitted on forms provided by the commissioner of health which shall include, but not be limited to the matters covered in this part.

Subp. 2. **Disclosure in applications.** Each application for a certificate of authority shall include disclosure of the following:

A. Any contractual or financial arrangements between members of the board of directors/principal officers and the health maintenance organization including: a description of any obligations, specified by contract or otherwise, to be met by each party in accordance with any such arrangement; and a listing of the dollar amounts of any consideration to be paid each party in accordance with any such arrangements.

B. Any financial arrangements between members of the board of directors/principal officers and any provider or other person, which provider or other person also has a financial relationship with the health maintenance organization. This disclosure shall include:

(1) a description of the obligations to be met by each party in accordance with any such arrangements;

(2) a listing of the dollar amounts of the consideration to be paid each party in accordance with any such arrangements; and

(3) a listing and description of any circumstances under which a director/principal officer is employed by or engages in a substantial commercial or professional relationship with any provider/other person.

Subp. 3. **Insurance.** Each application for a certificate of authority shall attach pertinent documents, including copies of insurance contracts, in verification of compliance with Minnesota Statutes, sections 62D.04, subdivision 1, clause (f), 62D.05, 62D.12, subdivisions 4 and 9, and 62D.13 with respect to assumption of risks and insurance against risks.

Subp. 4. **Financial responsibility.** Each application shall state which option for demonstrating financial responsibility has been elected pursuant to Minnesota Statutes, section 62D.04, subdivision 1, clause (e) and any pertinent documents which demonstrate financial responsibility shall be attached to the application.

Subp. 5. **Statistics.** The application shall detail procedures established to develop, compile, evaluate, and report statistics which shall include the collection and maintenance of at least the following data:

A. operational statistics sufficient to meet the requirements of Minnesota Statutes, section 62D.08, subdivision 3, clause (a), relating to annual financial reports;

B. gross utilization aggregates, including hospital discharges, surgical hospital discharges, hospital bed days, outpatient visits, laboratory tests and x-rays;

C. demographic characteristics, including the age and sex of enrollees;

D. disease-specific and age-specific mortality rates; and

E. enrollment statistics compiled in accordance with Minnesota Statutes, section 62D.08, subdivision 3, clause (b).

Subp. 6. **Provider agreements.** The application shall include copies of all types of agreements with providers by virtue of which enrollees will receive health care from the providers, and a description of any other relationships with providers who might attend enrollees together with a statement describing the manner in which these other relationships assure availability and accessibility of health care.

Subp. 7. **Other requirements.** Each application must also include documentation or evidence of compliance with all of the requirements of the act and parts 4685.0100 to 4685.3400, and the commissioner of health may require such other information in applications for certificates of authority as the commissioner feels is necessary to make a determination on the application.

Statutory Authority: *MS s 62D.20*

History: *23 SR 1238*

4685.0400 OPERATING REQUIREMENTS AND REQUIREMENTS FOR ISSUANCE OF A CERTIFICATE OF AUTHORITY.

Each health maintenance organization must submit the information required in part 4685.0300 and Minnesota Statutes, chapter 62D, and the commissioner must find that each health maintenance organization meets the statutory requirements and the

standards of parts 4685.0100 to 4685.3400 before the commissioner may issue a certificate of authority. The failure of an operating health maintenance organization to comply with the requirements is proper basis for disciplinary action under Minnesota Statutes, sections 62D.15 to 62D.17.

Statutory Authority: *MS s 62D.20*

History: *23 SR 1238*

4685.0500 INSURANCE.

A health maintenance organization may provide for the payment for the cost of emergency services, out-of-area services or other services which go beyond the minimum services required herein through a policy of insurance.

Statutory Authority: *MS s 62D.20*

4685.0600 FINANCIAL RESPONSIBILITY.

In making its determination of financial responsibility, the commissioner will apply the following guidelines as appropriate:

A. a reasonable period of time for the continued availability of health care services is 60 days;

B. financial soundness can be demonstrated by showing the capacity of the applicant to produce a cash flow sufficient to cover normal operating expenses for 60 days, plus all initial organizational and promotional expenses;

C. adequate working capital can be shown by the availability of an amount of money sufficient to cover normal operating expenses for 60 days, plus any and all initial organizational and promotional expenses;

D. the comparability to the charges for similar services used by other health maintenance organizations and other health delivery systems will be used in considering the proposed schedule of charges; and

E. a determination of financial responsibility shall include consideration of a health maintenance organization's insurance coverage of its own risks and the risks it may bear in agreeing to provide services to enrollees relative to the organization's own financial reserves and surplus.

These considerations must give full force and effect to Minnesota Statutes, sections 62D.04, subdivision 1, clause (f); 62D.05, subdivision 3; 62D.12, subdivisions 4 and 9; 62D.13, and parts 4685.0300, subpart 3, and 4685.0500.

Statutory Authority: *MS s 62D.20*

4685.0700 COMPREHENSIVE HEALTH MAINTENANCE SERVICES.

Subpart 1. **Providing health maintenance services.** All health maintenance organizations shall provide comprehensive health maintenance services, as defined in part 4685.0100, subpart 5, to enrollees.

Subp. 2. **Minimum services.** Such comprehensive health maintenance services shall include but need not be limited to:

A. provisions for emergency in area health care services which shall be available 24 hours a day, seven days a week; be provided either directly through health maintenance organization facilities or through arrangements with other providers; be provided by a physician and other licensed and ancillary health personnel, as appropriate, readily available at all times; and be covered for enrollees requiring such services but who, for reasons of medical necessity and not convenience, are unable to obtain them directly from the health maintenance organization in which they are enrolled or from providers or other persons with whom the health maintenance organization in which they are enrolled has arrangements for the provision of services;

B. provisions covering out-of-area services which must include out-of-area emergency care;

C. all inpatient hospital care, including mental health and chemical dependency care, except as exclusions or limitations are hereafter permitted;

D. all inpatient physician care except as exclusions or limitations are hereafter permitted;

E. all outpatient health services, including mental health and chemical dependency services, except as exclusions or limitations are hereafter permitted; and

F. procedures for providing preventive health services.

Subp. 3. **Permissible limitations.** A health service that may be excluded under subpart 4 may instead be limited. The following health services may be limited, but cannot be excluded:

A. A health maintenance organization may limit outpatient prescription drug benefits through the use of a formulary.

(1) The formulary must be periodically reviewed and updated by physicians and pharmacists to determine that formulary drugs are, at a minimum, safe and effective.

(2) The formulary must contain all prescription drugs needed to provide medically necessary care.

(3) A health maintenance organization shall promptly grant an exception to the formulary when the formulary drug causes an adverse reaction, when the formulary drug is contraindicated, or when the prescriber demonstrates that a prescription drug must be dispensed as written to provide maximum medical benefit to the enrollee.

(a) A health maintenance organization shall have written guidelines and procedures for granting an exception to the formulary that shall be available to the enrollee and prescriber upon request.

(b) When a health maintenance organization grants an exception to the formulary, it may charge the enrollee the approved flat fee copayment or a copayment that does not exceed 25 percent of the provider's charge, in accordance with part 4685.0801.

B. A health maintenance organization may limit durable medical equipment, orthotics, prosthetics, and nondurable medical supplies.

C. A health maintenance organization may limit home health care services.

D. A health maintenance organization may limit inpatient hospital care as defined in part 4685.0100, subpart 5, item B, and required in subpart 2, item C, as specifically authorized by this item. Each health maintenance organization may have limitations upon the number of days of inpatient hospital care that at least correspond with the following minimum provisions:

(1) For health maintenance contracts issued to a specified group or groups, the coverage may be limited to 365 days of care in a given period of confinement for a condition arising from a single illness or injury, provided that if this coverage is exhausted the benefit must be renewed, or a new period of confinement commenced, upon the occurrence of a separate illness or injury or upon the passage of no more than 90 days without utilization of inpatient hospital care; and provided further, that if an enrollee group rejects in writing the limits of coverage in favor of lesser limits, the coverage may be limited to no less than 180 days, with no more than 90 days between periods of confinement.

(2) For individual health maintenance contracts, the coverage may be limited to 90 days of care in a given period of confinement for a condition arising from a single illness or injury, provided that if this coverage is exhausted the benefit must be renewed or a new period of confinement commenced, upon the occurrence of a separate illness or injury or upon the passage of no more than 90 days without utilization of inpatient hospital care.

(3) For inpatient hospital care out of the service area of the health maintenance organization as defined in parts 4685.1010, subpart 1, item B, and

4685.0100, subpart 11, and as required in subpart 2, item B, the coverage may be limited to 60 days of care in each contract year.

These provisions relate to the aggregate number of days of both acute care and convalescent care, both of which must be rendered to enrollees by the health maintenance organization, but which may be limited, as indicated. These provisions do not relate to custodial care that may be limited or excluded completely pursuant to subpart 4, item H, nor do these provisions allow limitations relative to the spectrum of service during a covered day, which is provided for in subpart 4.

Subp. 4. **Permissible exclusions.** The following services may be excluded:

A. personal convenience devices;

B. cosmetic services, except for reconstructive surgery as required under Minnesota Statutes, section 62A.25;

C. dental services;

D. nonemergency ambulance services and special transportation services, except as provided by Minnesota Statutes, section 62J.48;

E. the fitting and provision of contact lenses, eyeglasses, and hearing aids;

F. a drug, device, medical treatment, diagnostic procedure, technology, or procedure that is experimental, investigative, or unproven as defined in part 4685.0100, subpart 6a. The health maintenance organization shall make its determination of experimental, investigative, or unproven based upon a preponderance of evidence after the examination of the following reliable evidence, none of which shall be determinative in and of itself:

(1) whether there is final approval from the appropriate government regulatory agency, if approval is required;

(2) whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals, or the reports of clinical trial committees and other technology assessment bodies; and

(3) whether there are consensus opinions of national and local health care providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these providers;

G. custodial care;

H. care for injuries incurred while on military duty, to the extent that care for the injuries is covered or available in another program of coverage;

I. services and other items not prescribed, recommended, or approved by a provider who is providing services through the enrollee's health maintenance organization or a provider to whom the enrollee is referred;

J. the following services relating to inpatient hospitalization:

(1) television, telephone, and similar convenience or amenity items that are available in connection with inpatient hospital care but that are not medically necessary as a part of the enrollee's care;

(2) hospital private room accommodations unless medically necessary; and

(3) inpatient hospital care under any circumstances where inpatient physician care or the procedure is not otherwise covered; and

K. services for those conditions subject to underwriting restrictions when the imposition of the restrictions is otherwise proper, provided that underwriting restrictions may only relate to preexisting health conditions, and those acute health conditions for which an applicant is being treated at the time of the proposed enrollment.

Statutory Authority: *MS s 62D.20*

History: *23 SR 1238*

4685.0800 [Repealed, 16 SR 2478]

4685.0801 COPAYMENTS.

Subpart 1. **Copayments on specific services.** Copayments on comprehensive health maintenance organization services, as defined in part 4685.0700, are allowed provided the copayment does not exceed 25 percent of the provider's charge for the specific service or good received by the enrollee, except as provided in subparts 2 and 6.

For the purposes of this part, "provider's charge" for a specific service or good means the fees charged by the provider which do not exceed the fees that provider would charge any other person regardless of whether the person is a member of the health maintenance organization. This is typically known as the provider's fee schedule or billed charge for such service or good. The service must be based on a specific diagnosis or procedure code such as the codes defined by the Physicians' Current Procedural Terminology (CPT), published by the American Medical Association for physician charges, or the Diagnosis Related Groups (DRGs) used by the Health Care Financing Administration, or any similar coding system used for billing purposes. For example, an enrollee who receives brief office medical services at a specific clinic may be charged up to 25 percent of that clinic's charge for brief office medical services.

Subp. 2. **Flat fee copayments.** The health maintenance organization may establish predetermined flat fee copayments for categories of similar services or goods. Flat fee copayments based on categories of similar services or goods must be calculated independently for Medicare plans, individual plans, and group plans. For example, calculations may be made by combining data from all individual plans but data from individual plans may not be combined with data from group plans. The flat fee copayment cannot exceed 25 percent of the median provider's charges for similar services or goods received by enrollees. For example, if the median charge for all prescription drugs received by enrollees is $20, the health maintenance organization may determine a flat fee copayment of up to $5 for any prescription drug that is purchased by an enrollee.

A health maintenance organization may request a copayment which exceeds the 25 percent limitation for prescription drug benefits for Medicare related products. The request must be made in writing to the Department of Health and must include sufficient documentation to demonstrate to the department that the requested copayment is reasonable under the general provisions described in this part.

Any copayment for prescription drugs approved by the Department of Health prior to the publication of this part in the State Register for an administrative hearing, even though it exceeds the 25 percent maximum copayment provisions of this part, shall remain approved until the health maintenance organization submits the copayment for reapproval for any reason. At that time, the copayment must conform to all of the requirements of this part. Any prescription drug copayment submitted for approval after the date of publication and prior to the effective date of this part may be approved but must be resubmitted for approval within 30 days after the effective date.

The categories of similar services or goods must be determined according to subpart 3. The median provider's charges for a category of similar services or goods must be determined according to subpart 4.

Subp. 3. **Categories.** For the purposes of this part, a category of similar services or goods is any group of related services for which a single copayment is sought. Examples of categories include the following or any subset of the following:

A. inpatient hospital care;

B. inpatient physician care;

C. outpatient health services (or typically, "office visit") which may include outpatient laboratory, and radiology;

D. outpatient surgery which may include provider and facility charges;

E. emergency services which may include provider and facility charges;

F. outpatient prescription drugs;

G. skilled nursing care; and

H. any other nonphysician service categorized singly according to provider.

For example, there may be one flat fee copayment for a physical therapy service and another flat fee copayment for a speech therapy service. Nonphysician services may include such services as chemical dependency services, speech therapy services, mental health services, or physical therapy services.

Services or goods used to calculate the copayment for a category of services or goods may not be included in any other category. Services or goods used in this way must be eliminated from any other category in which they would otherwise be included, before the copayment is calculated. For example, if there is a copayment specifically for infertility or hormone therapy drugs, they must be eliminated from the category of outpatient prescription drugs.

Subp. 4. **Determination and filing of median charge.** To determine the median aggregate charge for a category of similar services, the health maintenance organization must follow the following steps and submit the results to the Department of Health with the request for approval of the copayment:

A. Identify all charges for the service or good for the relevant type of product, Medicare, individual, or group. The health maintenance organization may use all charges or may choose a sample of charges from the total population. Any sample used must be randomly selected and large enough to be statistically reliable. "Statistically reliable" means that any other sample drawn in the same manner would produce essentially the same results.

(1) If the entire health maintenance organization population is used, describe the population including the size of the total population, the range of charges, the mean, the median, the quartiles, and the standard deviation for each category submitted.

(2) If a sample of the population is used, describe the sample including the size of the sample, the range of charges, the mean, the median, the quartiles, and standard deviation for each category submitted.

(3) If a health maintenance organization wants to use a flat fee copayment but has an insufficient population size for its data to be statistically reliable, the health maintenance organization may submit copayment requests based on statistically reliable data from other populations within the health maintenance organization.

B. If the health maintenance organization does not use charges that span 12 months, the health maintenance organization must explain how the time period used is sufficient to include seasonal fluctuations in the utilization of services.

C. A statement that the sample is statistically reliable, with an explanation of how the sample is drawn so that it is representative of the larger health maintenance organization population.

D. A narrative description of the services included in the category, including diagnosis or procedure codes if applicable.

E. If costs are adjusted for inflation, the health maintenance organization must base its inflation adjustments on changes in the medical care component of the consumer price index or a similar national or regional index.

Subp. 5. **Required disclosure.** The health maintenance organization must include a notice which describes the copayment charges in its Medicare, individual, and master group contracts and certificates or evidences of coverage. The notice must include the following language or similar language approved by the commissioner: "THE AMOUNT CHARGED AS A COPAYMENT IS BASED ON THE PROVIDER CHARGES FOR THAT SERVICE."

If the copayment is a flat fee copayment based upon a category of services, the notice must include a general, narrative description of the types of services which were included in determining the median charge. For example, if the health maintenance organization is imposing a copayment upon office visits, the contract must disclose what

types of services, such as laboratory services and radiology services, are included in the office visit copayment.

Subp. 6. **Exclusions.** Any amount or form of copayment shall be deemed reasonable when imposed on services which, according to parts 4685.0400 to 4685.1300, may be excluded completely, provided that the copayment is not greater than the provider's charge for that particular service.

Subp. 7. **Out-of-plan services.** Copayments may be imposed on out-of-plan emergency care, including inpatient, by providers who do not have arrangements with the health maintenance organization, in the form of a reasonable deductible not to exceed $150, plus a 25 percent copayment, plus all charges which exceed a specified annual aggregate amount not less than $90,000.

Subp. 8. **Preventive health care services.** No copayment may be imposed on preventive health care services as defined in part 4685.0100, subpart 5, item E, including child health supervision, periodic health screening, and prenatal care.

Statutory Authority: *MS s 62D.05; 62D.20*

History: *16 SR 2478*

4685.0805 UNCOVERED EXPENDITURES.

Subpart 1. **Defined.** Uncovered expenditures as referred to in Minnesota Statutes, section 62D.041, are expenditures by a health maintenance organization or a contracting provider for health care services by a provider who is not a participating entity and who is not under agreement with the health maintenance organization. Examples of providers not under such an agreement may include those providing out-of-area services, in-area emergency services, and certain referral services.

Subp. 2. **Documentation required.** If a health maintenance organization claims certain expenditures that meet the criteria of subpart 1 are covered because they are guaranteed, insured, or assumed, the health maintenance organization must give to the commissioner, with its annual report, documentation of the arrangements. If the arrangements are unchanged from the previous year, the health maintenance organization may reference previously filed documents. Documentation means applicable contracts between the health maintenance organization and the entity guaranteeing, and an explanation thereof.

Subp. 3. **When insured.** An uncovered expenditure may be considered insured within the applicable coverage limitation and covered if the health maintenance organization can demonstrate to the commissioner that:

A. the health maintenance organization has reinsurance under Minnesota Statutes, section 62D.04, subdivision 1, for nonelective emergency services and services provided outside the service area if those services were provided by nonparticipating providers and any other services provided by nonparticipating providers; or

B. the health maintenance organization has insolvency insurance that expressly covers enrollee obligations incurred before and after the date of insolvency, including obligations to nonparticipating providers.

Subp. 4. **When guaranteed.** An uncovered expenditure may be considered guaranteed and covered if the health maintenance organization demonstrates to the commissioner that the guarantor has agreed to guarantee obligations of the health maintenance organization to nonparticipating providers and if:

A. the guarantor has demonstrated to the commissioner that it has set aside an amount of money in a restricted reserve or other method acceptable to the commissioner equal to the amount of deposit that it is guaranteeing; the guarantor has issued a letter of credit; or the guarantor has demonstrated to the commissioner that it is a governmental entity with the power to tax;

B. according to its terms, the guarantee cannot expire without written notice from the guarantor to the commissioner and the notice must occur at least 60 days before the expiration date;

C. the guarantee is irrevocable, unconditional, and may be drawn upon after the insolvency of the health maintenance organization; and

D. the guarantee may be drawn upon by the commissioner.

Subp. 5. **When assumed.** An uncovered expenditure may be considered assumed and covered if the health maintenance organization can demonstrate to the commissioner any other arrangement for uncovered expenditures to be paid by an entity other than the health maintenance organization even in the event of the insolvency of the health maintenance organization. The commissioner shall require financial information relating to the capability of the entity to assume the risk of uncovered expenditures.

Subp. 6. **Calculating uncovered expenditures.** The health maintenance organization must make an annual calculation of uncovered expenditures according to items A to E.

A. The health maintenance organization shall determine the amount of annual uncovered expenditures in the relevant year before adjustments for guarantees, insurance, or assumptions.

B. The health maintenance organization shall adjust the amount of uncovered expenditures in item A by subtracting:

(1) reinsurance receipts that are described in subpart 3, item A, that are accrued to the relevant year, and that reduced those expenditures; and

(2) any relevant assumptions of risk.

C. The health maintenance organization shall multiply the adjusted amount in item B by 33 percent.

D. The health maintenance organization may subtract from the amount in item C the amounts of any guarantees and insolvency insurance that would reduce uncovered expenditures in the event of insolvency or nonpayment.

E. The health maintenance organization shall use forms supplied by the commissioner in annual reports to report uncovered expenditures.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.0815 INCURRED BUT NOT REPORTED LIABILITIES.

Subpart 1. **Written records of claims.** A health maintenance organization shall keep written records of claims, according to items A to C.

A. A health maintenance organization shall establish and maintain files and records that accurately document its process for calculating claim liabilities, including incurred but not reported claims, that are submitted in annual and quarterly reports to the commissioner.

B. Written records pertaining to claims incurred but not reported shall be maintained separately from other records pertaining to claims payable.

C. The health maintenance organization must have complete and accurate claim data available for the commissioner to audit as required under Minnesota Statutes, section 62D.14.

Subp. 2. **Calculation of incurred but not reported claims.** The liability for incurred but not reported claims shall be calculated in conformity with generally accepted accounting principals and actuarial standards. The health maintenance organization shall calculate its incurred but not reported claims by taking past actual claims experience and then adjusting this base figure for changing trends. Factors that shall be considered reasonable adjustments to the base figure include the following:

A. changes in enrollment mix, provider mix, and product mix;

B. changes in claims or billing procedures;

C. changes in utilization;

D. organizational changes;

E. medical advancements and new procedures; and

F. any other factors the health maintenance organization can demonstrate have an effect on incurred but not reported claims experience.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.0900 SUBROGATION AND COORDINATION OF BENEFITS.

The health maintenance organization may require an enrollee to reimburse it for the reasonable value of health maintenance services provided to an enrollee who is injured through the act or omission of a third person or in the course of employment to the extent the enrollee collects damages or workers' compensation benefits for the diagnosis, care, and treatment of an injury. The subrogation clause in an evidence of coverage must contain the information required by Minnesota Statutes, section 62A.095, subdivision 2. The health maintenance organization may be subrogated to the enrollee's rights against the third person or the enrollee's employer to the extent of the reasonable value of the health maintenance services provided including the right to bring suit in the enrollee's name.

The health maintenance organization shall provide covered health services first, and coordinate benefits according to parts 4685.0905 to 4685.0950.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 23 SR 1238*

COORDINATION OF BENEFITS

4685.0905 PURPOSE AND APPLICABILITY.

The purpose of parts 4685.0905 to 4685.0950 is to:

A. permit, but not require, plans to include a coordination of benefits provision;

B. establish the order in which plans pay claims;

C. provide the authority for the orderly transfer of information needed to pay claims promptly;

D. reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan does not have to pay its benefits first;

E. reduce delays in payment of claims; and

F. make all contracts that contain a coordination of benefits provision consistent with this regulation.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.0910 DEFINITIONS.

Subpart 1. **Scope.** The following words and terms, when used in parts 4685.0905 to 4685.0950, have the following meanings unless the context clearly indicates otherwise.

Subp. 2. **Allowable expense.**

A. "Allowable expense" means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

B. Notwithstanding this definition, items of expense under coverages such as dental care, vision care, or prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A plan that provides benefits only for such items of expense may limit its definition of allowable expenses to those items of expense.

C. When a plan provides benefits in the form of service, the reasonable cash value of each service is both an allowable expense and a benefit paid.

D. The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

E. When coordination of benefits is restricted to specific coverage in a contract, for example, major medical or dental, the definition of allowable expense must include the corresponding expenses or services to which coordination of benefits applies.

F. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(1) Only benefit reductions based upon provisions similar in purpose to those described above and which are contained in the primary plan may be excluded from allowable expenses.

(2) This provision shall not be used by a secondary plan to refuse to pay benefits because a health maintenance organization enrollee has elected to have health care services provided by a nonhealth maintenance organization provider and the health maintenance organization, pursuant to its contract is not obligated to pay for providing those services.

Subp. 3. **Claim.** "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

A. services, including supplies;

B. payment for all or a portion of the expenses incurred;

C. a combination of items A and B; or

D. an indemnification.

Subp. 4. **Claim determination period.**

A. "Claim determination period" means the period of time over which allowable expenses are compared with total benefits payable in the absence of coordination of benefits, to determine whether overinsurance exists and how much each plan will pay or provide. The claim determination period must not be less than 12 consecutive months.

B. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

C. As each claim is submitted, each plan must determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. The determination may be adjusted as allowable expenses are incurred later in the same claim determination period.

Subp. 5. **Coordination of benefits.** "Coordination of benefits" means a provision establishing the order in which plans pay their claims.

Subp. 6. **Hospital indemnity benefits.** "Hospital indemnity benefits" are not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Subp. 7. **Plan.** "Plan" means a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage that will be considered in applying the coordination of benefits provision of that contract. The right to include a type of coverage is limited by the rest of this definition.

A. The definition shown in the Model Coordination of Benefits Provisions in part 4685.0950 is an example of what may be used. Any definition that satisfies this subpart may be used.

B. Instead of "plan," a group contract may use "program" or some other term.

C. Plan includes:

(1) Group insurance and group subscriber contracts.

(2) Uninsured arrangements of group or group-type coverage.

(3) Group or group-type coverage through health maintenance organizations and other prepayment, group practice, and individual practice plans.

(4) Group-type contracts. Group-type contracts are contracts that are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts may be included in the definition of plan, at the option of the insurer or the service provider and the contract client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated, for example, franchise or blanket. Individually underwritten and issued guaranteed renewable policies are not group-type even though purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

(5) The amount by which group or group-type hospital indemnity benefits exceed $100 a day.

(6) The medical benefits coverage in group, group-type, and individual automobile no-fault and traditional automobile fault-type contracts.

(7) Medicare or other governmental benefits, except as provided in item D, subitem (7). That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

D. Plan does not include:

(1) individual or family insurance contracts;

(2) individual or family subscriber contracts;

(3) individual or family coverage through health maintenance organizations;

(4) individual or family coverage under other prepayment, group practice, and individual practice plans;

(5) group or group-type hospital indemnity benefits of $100 a day or less;

(6) school accident-type coverages that cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a to and from school basis; and

(7) a state plan under Medicaid, or a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

Subp. 8. **Primary plan.** "Primary plan" means a plan that requires benefits for a person's health care coverage to be determined without taking into consideration the existence of any other plan. A plan is a primary plan if either of the following is true:

A. The plan either has no order of benefit determination rules or it has provisions that differ from those permitted by parts 4685.0905 to 4685.0950. There may be more than one primary plan.

B. All plans that cover the person use the order of benefit determination rules required by parts 4685.0905 to 4685.0950 and, under those rules, the plan determines its benefits first.

Subp. 9. **Secondary plan.** "Secondary plan" means a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules in parts 4685.0905 to 4685.0950 determine the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan or plans and the benefits

of any other plan which under these rules has its benefits determined before those of that secondary plan.

Subp. 10. **This plan.** In a coordination of benefits provision, "this plan" refers to the part of the group contract providing the health care benefits to which the coordination of benefits provision applies and that may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from this plan. A group contract may apply one coordination of benefits provision to certain of its benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate coordination of benefits provisions to coordinate other benefits.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 2004*

4685.0915 COORDINATION OF BENEFITS; PROCEDURES.

Subpart 1. **General.** The general order of benefits is as follows:

A. The primary plan must pay or provide its benefits as if the secondary plan or plans do not exist. A plan that does not include a coordination provision may not take into account the benefits of another plan as defined in part 4685.0910 when it determines its benefits. The one exception is that a contract holder's coverage designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

B. A secondary plan may take the benefits of another plan into account only when, under this part, it is secondary to that other plan.

C. The benefits of the plan that covers the person as an employee, member, or subscriber, that is, other than as a dependent, are determined before those of the plan that covers the person as a dependent.

Subp. 2. **Dependent child: parents not separated or divorced.** Benefits for a dependent child when the parents are not separated or divorced must be coordinated according to the procedures in items A to E.

A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year.

B. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter time.

C. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

D. A group contract that includes coordination of benefits and is issued or renewed or that has an anniversary date on or after 60 days after October 9, 1989, must include the substance of the provisions in items A to C. Until October 9, 1989, the group contract may contain wording such as: "Except as stated in subpart 3, the benefits of a plan that covers a person as a dependent of a male are determined before those of a plan that covers the person as a dependent of a female."

E. If one parent's plan contains the coordination plan described in items A to C, and the other parent's plan contains the coordination plan based on the gender of the parent, and if, as a result, the parents' plans do not agree on the coordination of benefits, the coordination plan based on the gender of the parent determines the order of benefits.

Subp. 3. **Dependent child: separated or divorced parents.** If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are coordinated according to this subpart. If a court orders one of the parents to pay the health care expenses of the child, and the entity that pays or provides the parent's plan knows of the order, the benefits of that parent's plan are determined first. The plan of the other parent is the secondary plan. This paragraph does not apply to any claim determination period or plan year during which benefits are actually paid or

provided before the entity knows of the order. If a court order does not require one of the parents to pay the child's health care expenses, benefits are coordinated according to items A to C.

A. The benefits of the plan of the parent with custody of the child are determined first.

B. The benefits of the plan of the spouse of the parent with the custody of the child are determined second.

C. The benefits of the plan of the parent without custody of the child are determined last.

D. In the case of joint custody, the primary plan will be determined according to subpart 2.

Subp. 4. **Active/inactive employee.** The benefits of a plan that covers a person as an employee, who is neither laid off nor retired, or as a dependent of that employee are determined before benefits of a plan that covers that person as a laid-off or retired employee or as a dependent of that employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

Subp. 5. **Longer/shorter length of coverage.** If none of these rules determines the order of benefits, the benefits of the plan that covered an employee, member, or subscriber longer are determined before those of the plan that covered that person for the shorter term.

A. To determine the length of time a person has been covered under a plan, two plans are treated as one if the claimant was eligible under the second plan within 24 hours after the first ended.

B. The start of a new plan does not include:

(1) a change in the amount of scope of a plan's benefits;

(2) a change in the entity that pays, provides, or administers the plan's benefits; or

(3) a change from one type of plan to another, such as from a single employer plan to that of a multiple employer plan.

C. The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group is the date used to determine the length of time the claimant's coverage under the present plan has been in force.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.0925 PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN.

Subpart 1. **Total allowable expenses.** When a plan is a secondary plan under part 4685.0915, its benefits may be reduced so that the total benefits paid or provided by all plans during a claim determination period are not more than total allowable expenses. The amount by which the secondary plan's benefits have been reduced shall be used by the secondary plan to pay allowable expenses, not otherwise paid, that were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the secondary plan determines its obligation to pay for allowable expenses based on all claims that were submitted up to that time during the claim determination period.

Subp. 2. **Reducing benefits of a secondary plan.** The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of coordination of benefits provisions in parts 4685.0905 to 4685.0950 and the benefits that would be payable for the allowable expenses under the other plans, in the absence of coordination of benefits provisions in parts 4685.0905 to 4685.0950, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of the

secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

A. When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

B. Item A may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 2004*

4685.0930 MISCELLANEOUS PROVISIONS.

Subpart 1. **Reasonable cash values of services.** A secondary plan that provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan, if benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this subpart shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

Subp. 2. **Coordination of benefits with a noncomplying plan.**Some plans contain a coordination provision that violates parts 4685.0905 to 4685.0950 by declaring that the plan's coverage is excess to all others, or is always secondary. This occurs because certain plans may not be subject to insurance regulation, or because some group contracts have not yet been conformed with this regulation under part 4685.0905. A plan may coordinate its benefits with a plan that does not comply with parts 4685.0905 to 4685.0950 according to items A to D.

A. If the complying plan is the primary plan, it must pay or provide its benefits on a primary basis.

B. If the complying plan is the secondary plan, it must pay or provide its benefits first, but the benefits payable are determined as if the complying plan is the secondary plan, and are limited to the complying plan's liability.

C. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall pay benefits as if the benefits of the noncomplying plan are identical to its own. However, the complying plan must adjust its payments when it receives information on the actual benefits of the noncomplying plan.

D. If the noncomplying plan reduces its benefits so that the member receives less in benefits than the member would have received had the complying plan paid benefits as the secondary plan and the noncomplying plan paid benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall pay to or on behalf of the member an amount equal to the difference.

The complying plan shall not pay more than the complying plan would have paid had it been the primary plan less any amount it previously paid. The complying plan is subrogated to all rights of the member against the noncomplying plan. A payment by the complying plan under this item does not prejudice any claim against the noncomplying plan in the absence of subrogation.

Subp. 3. **Allowable expense.** A term such as "usual and customary," "usual and prevailing," or "reasonable and customary" may be substituted for the term "necessary," "reasonable," or "customary." A term such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the coordination provisions apply.

Subp. 4. **Subrogation.** Provisions for coordination or subrogation may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 2004*

4685.0935 EFFECTIVE DATE; EXISTING CONTRACTS.

Subpart 1. **Applicability of coordination rules.** Coordination requirements in parts 4685.0905 to 4685.0950 apply to every group contract that provides health care benefits issued on or after October 9, 1989.

Subp. 2. **Deadline for compliance.** A group contract that provides health care benefits and that was issued before October 9, 1989, shall be brought into compliance with this regulation by the later of:

A. the next anniversary date or renewal date of the group contract; or

B. the expiration of any applicable collectively bargained contract under which it was written.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.0940 MODEL COORDINATION OF BENEFITS CONTRACT PROVISION.

Subpart 1. **General.** Use of the model coordination of benefits provision for group contracts in part 4685.0950 is subject to subparts 2 and 3 and part 4685.0915.

Subp. 2. **Flexibility.** A group contract's coordination provision does not have to use the words and format shown in part 4685.0950. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans that provide services, that pay benefits for expenses incurred, and that indemnify. No other substantive changes are allowed.

Subp. 3. **Prohibited coordination and benefit design.**

A. A group contract may not reduce benefits on the basis that:

(1) another plan exists;

(2) a person is or could have been covered under another plan, except with respect to Part B of Medicare; or

(3) a person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

B. No contract may contain a provision that its benefits are excess or always secondary to any plan, except as allowed in parts 4685.0905 to 4685.0950.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 2004*

4685.0950 TEXT OF MODEL COORDINATION OF BENEFITS PROVISIONS FOR GROUP CONTRACTS.

Group contracts must contain language on coordination of benefits that is substantially similar to the following model provisions.

COORDINATION OF THE GROUP CONTRACT'S
BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY.

(A) This coordination of benefits (COB) provision applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan. "Plan" and "this plan" are defined below.

(B) If this coordination of benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

(1) shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but

(2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in section IV.

II. DEFINITIONS.

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the group contract that provides benefits for health care expenses.

C. "Primary Plan/Secondary plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

* When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care: when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES.

A. General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Nondependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in Paragraph (B)(3) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents:"

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering follow the order of benefit determination rules outlined in Paragraph B(2).

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (4) is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN.

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these COB rules. [health maintenance organization] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. [health maintenance organization] need not tell, or get the consent of, any person to do this. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under This Plan must give [health maintenance organization] any facts it needs to pay the claim.

VI. FACILITY OF PAYMENT.

A payment made under another plan may include an amount which should have been paid under this plan. If it does, [health maintenance organization] may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. [health maintenance organization] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY.

If the amount of the payments made by [health maintenance organization] is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 2004*

4685.1000 [Repealed, 17 SR 2858]

ACCESSIBILITY OF SERVICES

4685.1010 AVAILABILITY AND ACCESSIBILITY.

Subpart 1. **Definitions.** For the purpose of this part, the terms in items A and B have the meanings given them.

A. "Referral centers" means medical facilities that provide specialized medical care such as organ transplants and coronary artery bypass surgery. Examples of criteria the health maintenance organization may use in designating a facility as a referral center are volume of services provided annually and the case mix and severity adjusted mortality and morbidity rates. Referral centers may be located within or outside the health maintenance organization's service area.

B. "Service area" means the geographic locations in which the health maintenance organization is approved by the commissioner to sell its health maintenance

organization products. Geographic locations shall be identified according to recognized political subdivisions such as cities, counties, and townships.

Subp. 2. **Basic services.** The health maintenance organization shall have available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of its enrollees for covered health care services. The health maintenance organization, in coordination with participating providers, shall develop and implement written standards or guidelines that assess the capacity of each provider network to provide timely access to health care services in accordance with subpart 6.

A. Primary care services.

(1) Primary care physician services shall be available and accessible 24 hours per day, seven days per week within the health maintenance organization's service area. The health maintenance organization shall fulfill this requirement through written standards for:

(a) regularly scheduled appointments during normal business hours;

(b) after hours clinics;

(c) use of a 24-hour answering service with standards for maximum allowable call-back times based on what is medically appropriate to each situation;

(d) back-up coverage by another participating primary care physician; and

(e) referrals to urgent care centers, where available, and to hospital emergency care.

(2) The health maintenance organization shall provide or contract with a sufficient number of primary care physicians to meet the projected needs of its enrollees for primary care physician services.

(3) The health maintenance organization shall ensure that there are a number of primary care physicians with hospital admitting privileges at one or more participating general hospitals within the health maintenance organization's service area so that necessary admissions are made on a timely basis consistent with generally accepted practice parameters.

(4) To the extent that primary care services are provided through primary care providers other than physicians, and to the extent permitted under applicable scope of practice in state licensing laws for a given provider, these services shall be available and accessible as required by subitems (1) to (3).

B. Specialty physician services.

(1) The health maintenance organization shall provide directly, contract for, or otherwise arrange for specialty physician services which are covered benefits and to which enrollees have continued access in the health maintenance organization's service area. These services shall be available and accessible 24 hours per day, seven days per week. The health maintenance organization shall fulfill this requirement through written standards for:

(a) regularly scheduled appointments during normal business hours;

(b) after hours clinics;

(c) use of a 24-hour answering service with standards for maximum allowable call-back times based on what is medically appropriate to each situation;

(d) back-up coverage by another participating specialty physician; and

(e) referrals to urgent care centers, where available, and to hospital emergency care.

(2) Specialty physician services to which enrollees do not have continued access, for example referrals for consultation or second opinions, shall be provided by the health maintenance organization through contracts or other arrangements with specialty physicians.

(3) The health maintenance organization shall ensure that there are a number of specialty physicians with hospital admitting privileges so that necessary admissions are made on a timely basis consistent with generally accepted practice parameters.

C. Services of facilities licensed as general hospitals under chapter 4640 (general hospital services) shall be provided through contracts between the health maintenance organization and hospitals. These services shall be available and accessible, on a timely basis consistent with generally accepted practice parameters, 24 hours per day, seven days per week within the health maintenance organization's service area. Services of facilities licensed as specialized hospitals under chapter 4640 (specialized hospital services), including chemical dependency and mental health services, shall be provided through contracts between the health maintenance organization or its contracted providers and hospitals, either within or outside the health maintenance organization's service area. These services shall be available during normal business hours consistent with generally accepted practice parameters.

D. The health maintenance organization shall contract with or employ sufficient numbers of providers of ancillary services to meet the projected needs of its enrollees. The services shall be available during normal daytime business hours consistent with generally accepted practice parameters.

E. The health maintenance organization shall contract with or employ sufficient numbers of qualified providers of outpatient mental health and chemical dependency services to meet the projected needs of its enrollees consistent with generally accepted practice parameters.

(1) Services for people with alcohol and other chemical dependency problems shall be provided by outpatient treatment programs licensed by the Minnesota Department of Human Services under parts 9530.5000 to 9530.6500 or by hospitals licensed under chapter 4640.

(2) Outpatient chemical dependency treatment programs serving adolescents must meet all of the requirements of the Minnesota Department of Human Services contained in part 9530.6400.

(3) Outpatient mental health services shall be provided by licensed psychiatrists, psychologists, social workers, marriage and family therapists, and psychiatric nurses, as appropriate in each case, and by mental health centers and mental health clinics licensed by the Minnesota Department of Human Services under chapter 9520.

(4) The health maintenance organization, either directly or through its contracted mental health or chemical dependency provider, shall have available services that are culturally specific or appropriate to a specific age, gender, or sexual preference, to the extent reasonably possible. If any of these services cannot be provided by licensed providers and programs, the health maintenance organization shall file a request for an exception to the requirements of subitems (1) to (4). A request for an exception shall be considered a filing under part 4685.3300. The health maintenance organization shall submit specific data in support of its request.

F. The health maintenance organization shall provide directly, contract for, or otherwise arrange for residential treatment programs licensed by the Department of Human Services under parts 9530.4100 to 9530.4450 to provide services to people with alcohol and other chemical dependency problems.

G. The health maintenance organization shall provide directly, contract for, or otherwise arrange for emergency care and urgently needed care to be available and accessible within the health maintenance organization's service area 24 hours per day, seven days per week. Contracts may be with hospitals, urgent care centers, and after hours clinics. Emergency care and urgently needed care provided by noncontracted providers shall be covered in accordance with subpart 7.

H. If a specific health maintenance organization provider refuses to continue to provide care to a specific health maintenance organization enrollee, the health maintenance organization shall furnish the enrollee with the name, address, and telephone number of other participating providers in the same area of medical

specialty. Examples of reasons for refusal to continue to provide care to an enrollee are: unpaid bills incurred by that individual before enrollment in the health maintenance organization; unpaid copayments or coinsurance incurred by the enrollee after enrollment in the health maintenance organization; an enrollee who is uncooperative or abusive toward the provider; and the inability of the enrollee and the provider to agree on a course of treatment.

I. The health maintenance organization is responsible for implementing a system that, to the greatest possible extent, assures that routine referrals, either by the health maintenance organization or by a participating provider, are made to participating providers. An enrollee cannot be held liable if the health maintenance organization provider, in error, gives a referral to a nonparticipating provider. This issue may be addressed in contracts between the health maintenance organization and its providers.

J. Referral procedures must be described in an enrollee's evidence of coverage and must be available to an enrollee upon request for information regarding referral procedures. Effective July 1, 1999, information regarding referral procedures shall clearly describe at least the following:

(1) under what circumstances and for what services a referral is necessary;

(2) how to request a referral;

(3) how to request a standing referral; and

(4) how to appeal a referral determination.

Subp. 3. [Repealed, L 1999 c 239 s 43]

Subp. 4. **Exceptions for access to care and geographic accessibility.** A request for an exception to the requirements of subparts 2 and 3 shall be considered a filing under part 4685.3300. The health maintenance organization shall submit specific data in support of its request. The commissioner shall consider the factors in items A to C in granting an exception if the health maintenance organization is unable to meet the requirements of subparts 2 and 3 in a particular service area or part of a service area:

A. the utilization patterns of the existing health care delivery system or the health maintenance organization's reasonably justified projections of utilization of health care services in the proposed service area;

B. the financial ability of the health maintenance organization to pay charges for health care services that are not provided under contract or by employees of the health maintenance organization. The commissioner shall determine what information must be submitted by the health maintenance organization in order to demonstrate its financial ability to pay charges and may require an analysis of the impact on minimum loss ratio requirements; and

C. the health maintenance organization's system of documentation of authorized referrals to nonparticipating providers. This system of documentation of authorized referrals shall explain how, under certain circumstances, enrollees will be given referrals to nonparticipating providers, either by the health maintenance organization or by a provider acting on behalf of the health maintenance organization.

Subp. 5. **Coordination of care.**

A. The health maintenance organization shall arrange for the services of primary care providers to provide initial and basic care to enrollees.

(1) An enrollee who is dissatisfied with the assigned or selected primary care provider shall be allowed to change primary care providers in accordance with the health maintenance organization's procedures and policies.

(2) If requested by an enrollee, or if determined necessary because of a pattern of inappropriate utilization of services, an enrollee's health care may be supervised and coordinated by the primary care provider.

B. In plans in which referrals to specialty providers and ancillary services are required:

(1) the primary care or other authorized provider or the health maintenance organization shall initiate the referrals; and

(2) the health maintenance organization shall inform its primary care and other authorized providers of their responsibility to provide written referrals and any specific procedures that must be followed in providing referrals.

C. The health maintenance organization shall provide for the coordination of care for enrollees given a referral or standing referral. When possible, the health maintenance organization shall provide this coordination of care through the enrollee's primary care or other authorized provider.

Subp. 6. **Timely access to health care services.**

A. The health maintenance organization, either directly or through its provider contracts, shall arrange for covered health care services, including referrals to participating and nonparticipating providers, to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted practice parameters.

B. The health maintenance organization, in coordination with its participating providers, shall develop and implement written appointment scheduling guidelines based on type of health care service. Examples of types of health care services include well baby and well child examinations, prenatal care appointments, routine physicals, follow up appointments for chronic conditions such as high blood pressure, and diagnosis of acute pain or injury.

Subp. 7. **Access to emergency care.**

A. In accordance with the requirements of Minnesota Statutes, section 62D.07, the health maintenance organization shall inform its enrollees, through the evidence of coverage or contract, as well as through other forms of communication, how to obtain emergency care.

B. The health maintenance organization may require enrollees to notify it of nonreferred emergency care, including mental health and chemical dependency care, as soon as possible after emergency care is initially provided, and no later than 48 hours after becoming physically or mentally able to give notice. However, the health maintenance organization shall make exceptions in situations in which:

(1) the enrollee is physically or mentally unable to give notice within 48 hours; and

(2) emergency care would have been covered under the contract had notice been provided within the 48-hour time period.

C. Emergency care shall be covered whether provided by participating or nonparticipating providers.

D. Emergency care shall be covered whether provided within or outside the health maintenance organization's service area.

E. In determining whether care is reimbursable as emergency care, the health maintenance organization shall take the following factors into consideration:

(1) a reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment;

(2) the time of day and day of week the care was provided;

(3) the presenting symptoms, to ensure that the decision to reimburse as emergency care shall not be made solely on the basis of the actual diagnosis;

(4) the enrollee's efforts to follow the health maintenance organization's established procedures for obtaining emergency care; and

(5) any circumstances which precluded use of the health maintenance organization's established procedures for obtaining emergency care.

In processing the claim, the health maintenance organization shall obtain sufficient information from the provider of emergency care, including the presenting symptoms,

to enable the health maintenance organization to make an informed determination as to whether reimbursement as emergency care is appropriate.

Subp. 8. **Continuity of care in the event of contract termination.**

A. The health maintenance organization shall prepare a written plan that provides for continuity of care in the event of contract termination between the health maintenance organization and any of its contracted primary care providers or general hospital providers, or in the event of site closings involving a primary care provider with more than one location of service.

B. The written plan shall explain how:

(1) if the health maintenance organization has received at least 120 days' prior notice of the termination or site closing, the health maintenance organization will inform the affected enrollees about the termination or site closing at least 30 days before the termination or closing is effective. The health maintenance organization will also inform the affected enrollees what other participating providers are available to assume their care; and

(2) the health maintenance organization will facilitate an orderly transfer of its enrollees from the terminating provider or closing provider site to the new provider so that continuity of care is maintained.

C. The written plan shall explain the procedures by which enrollees will be transferred to other participating providers unless special circumstances require them to be transferred to nonparticipating providers.

D. The written plan shall explain who will identify enrollees with special medical needs or at special risk and what criteria will be used for this determination.

E. The written plan shall explain how continuity of care will be provided for enrollees identified as having special medical needs or at special risk. The health maintenance organization can assign this responsibility to its contracted primary care providers.

F. The written plan shall explain how, if the contract termination was not for cause, enrollees will be informed that they can request a referral to the terminating provider if medical circumstances warrant. The health maintenance organization can require medical records and other supporting documentation in support of the requested referral. Each request for referral to a terminating provider shall be considered by the health maintenance organization on a case-by-case basis.

G. The written plan shall explain how, if the contract termination was for cause, enrollees will be notified of the change and transferred to participating providers in a timely manner so that health care services remain available and accessible to the affected enrollees. If the contract was terminated by the health maintenance organization for cause, the health maintenance organization shall not be required to refer an enrollee back to the terminating provider.

Statutory Authority: *MS s 62D.20*

History: *17 SR 2858; 23 SR 1238; L 1999 c 239 s 43*

4685.1100 [Repealed, 23 SR 1238]

QUALITY ASSURANCE

4685.1105 DEFINITIONS.

Subpart 1. **Scope.** The following definitions apply to parts 4685.1105 to 4685.1130, unless the context clearly requires another meaning.

Subp. 2. **Criteria.** "Criteria" means standards that can be used to determine attainment of quality health care. Criteria may be explicit or implicit. Explicit criteria are a set of norms or indicators that are developed by health care professionals and are predetermined. Implicit criteria are the judgments of health care professionals regarding information related to quality of care.

Subp. 3. **Data.** "Data" refers to the following and similar types of information: patient charts, reports, records, enrollee surveys, staff surveys, staff concerns, performance appraisals, research, financial information, observation, professional organization credentialing reviews, and complaints registered.

Subp. 4. **Focused study.** "Focused study" means a study that begins with a hypothesis and includes systematic data collection, to provide information to identify or resolve problems or potential problems with quality of care. Focused studies include a written methodology and corrective action strategies when appropriate.

Subp. 5. **Monitoring.** "Monitoring" means collection of information relating to quality of care. Monitoring may be in the form of prospective, concurrent, or retrospective audits; reports; surveys; observation; interviews; complaints; peer review; or evaluation of claims or encounter level data.

Subp. 6. **Outcome.** "Outcome" means the end result of care, or a change in patient health status. Examples of outcomes of care include a hospital admission or readmission, an advanced stage of a disease, recovery, alleviation of symptoms, or death.

Subp. 7. **Process.** "Process" means the nature of events and activities in the delivery of health care.

Subp. 8. **Structure.** "Structure" means the institutional or organizational aspects of care. Structure includes the organizing framework that brings the provider and patient together, organizational processes, policies, financial resources, and staff qualifications.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903; 23 SR 1238*

4685.1110 PROGRAM.

Subpart 1. **Written quality assurance plan.** The health maintenance organization shall have a written quality assurance plan that includes the following:

A. mission statement;

B. philosophy;

C. goals and objectives;

D. organizational structure;

E. staffing and contractual arrangements;

F. a system for communicating information regarding quality assurance activities;

G. the scope of the quality assurance program activities; and

H. a description of peer review activities.

Subp. 2. **Documentation of responsibility.** Quality assurance authority, function, and responsibility shall be delineated in specific documents, including documents such as bylaws, board resolutions, and provider contracts. These documents shall demonstrate that the health maintenance organization has assumed ultimate responsibility for the evaluation of quality of care provided to enrollees, and that the health maintenance organization's governing body has periodically reviewed and approved the quality assurance program activities.

Subp. 3. **Appointed entity.** The governing body shall designate a quality assurance entity that may be a person or persons to be responsible for operation of quality assurance program activities. This entity shall maintain records of its quality assurance activities and shall meet with the governing body at least quarterly.

Subp. 4. **Physician participation.** A physician or physicians designated by the governing body shall advise, oversee, and actively participate in the implementation of the quality assurance program.

Subp. 5. **Staff resources.** There must be sufficient administrative and clinical staff with knowledge and experience to assist in carrying out quality assurance activities. In determining what is sufficient staff support, the commissioner shall consider the number of enrollees, types of enrollees, numbers of providers, the variety of health care

services offered by the health maintenance organization, the organizational structure of the health maintenance organization, and the quality assurance staffing levels used by other health care organizations that perform similar health care functions.

Subp. 6. **Delegated activities.** The health maintenance organization may delegate performance of quality assurance activities to other entities. The health maintenance organization shall retain responsibility for performance of all delegated activities. If the health maintenance organization delegates performance of quality assurance activities, the health maintenance organization shall develop and implement review and reporting requirements to ensure that the delegated entity performs all delegated quality assurance activities.

Subp. 7. **Information system.** The data collection and reporting system shall support the information needs of the quality assurance program activities. The quality assurance program shall have prompt access to necessary medical record data including data by diagnoses, procedure, patient, and provider.

Subp. 8. **Program evaluation.** An evaluation of the overall quality assurance program shall be conducted at least annually. The results of this evaluation shall be communicated to the governing body. The written quality assurance plan shall be amended when there is no clear evidence that the program continues to be effective in improving care.

Subp. 9. **Complaints.**

A. Effective July 1, 1999, a health maintenance organization shall conduct ongoing evaluation of all enrollee complaints as defined in part 4685.0100, subpart 4, including complaints filed with participating providers. Ongoing evaluations must be conducted according to the steps in part 4685.1120.

B. Evaluation methods must permit a health maintenance organization to track specific complaints, assess trends, and establish that corrective action is implemented and effective in improving the identified problem.

C. The quality assurance program shall conduct ongoing evaluation of enrollee complaints that are related to quality of care. The evaluations shall be conducted according to the steps in part 4685.1120. The data on complaints related to quality of care must be reported to and evaluated by the appointed quality assurance entity at least quarterly.

Subp. 10. **Utilization review.** The data from the health maintenance organization's utilization review activities shall be reported to the quality assurance program for analysis at least quarterly.

Subp. 11. **Provider selection and credentialing.** The health maintenance organization shall have policies and procedures for provider selection, credentialing, and recredentialing that, at a minimum, are consistent with accepted community standards.

Subp. 12. **Qualifications.** Any health maintenance organization staff or contractees conducting quality assurance activities must be qualified by virtue of training and experience.

Subp. 13. **Medical records.** The quality assurance entity appointed under subpart 3 shall conduct ongoing evaluation of medical records.

A. The health maintenance organization shall implement a system to assure that medical records are maintained with timely, legible, and accurate documentation of all patient interactions. Documentation must include information regarding patient history, health status, diagnosis, treatment, and referred service notes.

B. The health maintenance organization shall maintain a medical record retrieval system that ensures that medical records, reports, and other documents are readily accessible to the health maintenance organization.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903; 23 SR 1238*

4685.1115 ACTIVITIES.

Subpart 1. **Ongoing quality evaluation.** The health maintenance organization, through the health maintenance organization staff or contracting providers, shall conduct quality evaluation activities according to the steps in part 4685.1120. The quality evaluation activities must address each of the components of the health maintenance organization described in subpart 2.

Subp. 2. **Scope.** The components of the health maintenance organization subject to evaluation include the following:

A. Clinical components that include the following services:

(1) acute hospital services;

(2) ambulatory health care services;

(3) emergency services;

(4) mental health services;

(5) preventive health care services;

(6) pharmacy services;

(7) chemical dependency services;

(8) other professional health care services provided to enrollees, such as chiropractic, occupational therapy, and speech therapy;

(9) home health care, as applicable;

(10) durable medical equipment, as applicable; and

(11) skilled nursing care, as applicable.

B. Organizational components which are the aspects of the health plan that affect accessibility, availability, comprehensiveness, and continuity of health care, and which include the following:

(1) referrals;

(2) case management;

(3) discharge planning;

(4) appointment scheduling and waiting periods for all types of health care services;

(5) second opinions, as applicable;

(6) prior authorizations, as applicable;

(7) provider reimbursement arrangements; and

(8) other systems, procedures, or administrative requirements used by the health maintenance organization that affect delivery of care.

C. Consumer components that are the enrollees' perceptions regarding all aspects of the quality of the health plan's services, and that include:

(1) enrollee satisfaction surveys, which must meet validity standards in the following areas:

(a) assessment of enrollee health care experiences;

(b) statistical methodology for population sampling and analysis of the results, with a focus on membership affected by the issue being researched; and

(c) ease of completion and interpretation by enrollees;

(2) enrollee complaints; and

(3) enrollee written or verbal comments or questions.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903; 17 SR 2858; 23 SR 1238*

4685.1120 QUALITY EVALUATION STEPS.

Subpart 1. **Problem identification.** The health maintenance organization shall identify the existence of actual or potential quality problems or identify opportunities for improving care through:

A. ongoing monitoring of process, structure, and outcomes of patient care or clinical performance including the consumer components listed under part 4685.1115, subpart 2, item C; and

B. evaluation of the data collected from ongoing monitoring activities to identify problems or potential problems in patient care or clinical performance using criteria developed and applied by health care professionals.

Subp. 2. **Problem selection.** The health maintenance organization shall select problems or potential problems for corrective action or focused study based on the prevalence of the problem and its impact on patient care and professional practices.

Subp. 3. **Corrective action.** The health maintenance organization shall identify and document any recommendations for corrective action designed to address the problem. The documentation of corrective action shall include:

A. measurable objectives for each action, including the degree of expected change in persons or situations;

B. time frames for corrective action; and

C. persons responsible for implementation of corrective action.

Subp. 4. **Evaluation of corrective action.** The quality assurance entity shall monitor the effectiveness of corrective actions until problem resolution occurs. Results of the implemented corrective action must be documented and communicated to the governing body and involved providers.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903*

4685.1125 FOCUSED STUDY STEPS.

Subpart 1. **Focused studies.** As part of its overall quality evaluation activities, the health maintenance organization shall conduct focused studies to acquire information relevant to quality of care. The focused study must be directed at problems, potential problems, or areas with potential for improvements in care. The focused studies shall be included as part of the health maintenance organization's problem identification and selection activities.

Subp. 2. **Topic identification and selection.** The health maintenance organization shall select topics for focused study that must be justified based on any of the following considerations:

A. areas of high volume;

B. areas of high risk;

C. areas where problems are expected or where they have occurred in the past;

D. areas that can be corrected or where prevention may have an impact;

E. areas that have potential adverse health outcomes; and

F. areas where complaints have occurred.

Subp. 3. **Study.** The health maintenance organization shall document the study methodology employed, including:

A. the focused study question;

B. the sample selection;

C. data collection;

D. criteria; and

E. measurement techniques.

Subp. 4. **Corrective actions.** Any corrective actions implemented to address problems identified through focused studies shall follow the requirements defined in part 4685.1120, subparts 3 and 4.

Subp. 5. **Other studies.** An activity in which the health maintenance organization participates that meets any of the criteria in subparts 2 to 4 may satisfy in part or in

total the focused study requirements. Examples of other activities that may satisfy the focused study requirements include external audits conducted by the professional review organization or other review organizations, multiple health plan surveys, or quality assurance studies across the community.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903*

4685.1130 FILED WRITTEN PLAN AND WORK PLAN.

Subpart 1. **Written plan.** The health maintenance organization shall file its written quality assurance plan, as described in part 4685.1110, subpart 1, with the commissioner, before being granted a certificate of authority.

Subp. 2. **Annual work plan.** The health maintenance organization shall annually prepare a written work plan. The health maintenance organization shall file the work plan with the commissioner, as requested. The work plan must be approved by the governing body and meet the requirements of items A and B.

A. The work plan must give a detailed description of the proposed quality evaluation activities that will be conducted in the following year and a timetable for completion. The quality evaluation activities must address the components of the health care delivery system defined in part 4685.1115, subpart 2. The quality evaluation activities must be conducted according to the steps in part 4685.1120.

In determining the level of quality evaluation activities necessary to address each of the components of the health maintenance organization, the commissioner shall consider the number of enrollees, the number of providers, the age of the health maintenance organization, and the level of quality evaluation activities conducted by health care organizations that perform similar functions.

B. The work plan must describe the proposed focused studies to be conducted in the following year. The focused studies must be conducted according to the steps in part 4685.1125. Each proposed study must include the following elements:

(1) topic to be studied;

(2) rationale for choosing topic for study according to part 4685.1125, subpart 1;

(3) benefits expected to be gained by conducting the study;

(4) study methodology;

(5) sample size and sampling methodology;

(6) criteria to be used for evaluation; and

(7) approval by the health maintenance organization's medical director or qualified director of health services designated by the governing body.

Each health maintenance organization shall annually complete a minimum of three focused studies. The focused study sample must be representative of all health maintenance organization enrollees who exhibit characteristics of the issue being studied.

Subp. 3. **Amendments to plan.** The health maintenance organization may change its written quality assurance plan by filing notice with the commissioner 30 days before modifying its quality assurance program or activities. If the commissioner does not disapprove of the modifications within 30 days of submission, the modifications are considered approved.

Subp. 4. **Plan review.** Upon receipt of the filing, the commissioner shall review the health maintenance organization's annual proposed work plan to determine if it meets the criteria established in parts 4685.1105 to 4685.1130.

Subp. 5. [Repealed, 23 SR 1238]

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903; 23 SR 1238*

4685.1200 STATISTICS.

Each health maintenance organization shall establish and maintain procedures to develop, compile, evaluate, and report statistics which shall include the collection and maintenance of at least the following data:

A. operational statistics sufficient to meet the requirements of Minnesota Statutes, section 62D.08, subdivision 3, clause (a) relating to annual financial reports;

B. gross utilization aggregates, including hospital discharges, surgical hospital discharges, hospital bed days, outpatient visits, laboratory tests and x-rays;

C. demographic characteristics, including the age and sex of enrollees;

D. disease-specific and age-specific mortality rates; and

E. enrollment statistics compiled in accordance with Minnesota Statutes, section 62D.08, subdivision 3, clause (b).

Statutory Authority: *MS s 62D.20*

4685.1300 EFFECTIVE DATE OF OPERATING REQUIREMENTS.

When changes are required in existing evidences of coverage or health maintenance contracts in order to implement the provisions of parts 4685.0100 to 4685.3400, the changes shall be implemented upon the renewal date of the documents commencing with the first renewal after May 29, 1999. New contracts or evidences of coverage to be implemented after May 29, 1999, must be in compliance with parts 4685.0100 to 4685.3400 upon implementation.

Statutory Authority: *MS s 62D.20*

History: *23 SR 1238*

GOVERNING BODY; CONSUMER MEMBERS; ENROLLEE PARTICIPATION; COMPLAINT SYSTEM

4685.1400 SELECTION OF GOVERNING BODY.

Subpart 1. **Selection of nonconsumer members.** Nonconsumer members of the governing body shall be selected in accordance with procedures set forth in each health maintenance organization's basic organizational document and/or bylaws.

Subp. 2. **Selection of enrollee directors.** The basic organizational document and/or bylaws shall also provide a reasonable procedure by which the enrollee directors are to be elected. Such procedure must include notification:

A. to those entitled to vote for enrollee directors of the time, place, and method by which such nomination and election is to be conducted at least two weeks prior to the nomination and election;

B. to those entitled to vote for enrollee directors of the names of consumer nominees, a general description of their backgrounds and a description of the method by which a ballot may be cast; and

C. to all enrollees of the results of such election including a general description of the backgrounds of the enrollee directors, to be given not later than at the time of issuance of the next annual summary of information to enrollees.

Subp. 3. **Consumer representatives.** Consumer representatives on the governing body must be enrollees at the time of their election and during their term of office. Should a consumer representative be removed for failure to meet this qualification or for any other reason set forth in the bylaws, this person may be replaced only until the next election by another consumer elected by the remaining consumer representatives on the governing body.

Subp. 4. **Definitions for determination of whether enrollee is a consumer.** The terms below which appear in Minnesota Statutes, section 62D.02, subdivision 10 will be defined as follows in determining whether or not an enrollee is a consumer:

A. A "licensed health professional" is any person licensed under Minnesota Statutes to provide or administer health services.

B. A "health care facility" is any hospital, nursing home, or boarding care home required to be licensed as such under Minnesota Statutes, sections 144.50 to 144.56.

C. A "substantial financial interest in the provision of health care services" is a person's receipt or right to receive not less than 25 percent of gross annual income directly from the rendering of health service.

D. A "substantial managerial interest in the provision of health care services" is a person's supervisory or administrative responsibilities as an employee of a health care facility.

Statutory Authority: *MS s 62D.20*

History: *17 SR 1279*

4685.1500 ENROLLEE OPINION.

The commissioner of health will review the proposed mechanism for affording enrollees an opportunity to express their opinions on matters of policy and operation to see if it reasonably provides such an opportunity. Permissible alternatives to those mechanisms described in Minnesota Statutes, section 62D.06, subdivision 2 may include but are not limited to one or more of the following:

A. permitting enrollees to attend, after prior reasonable notice, and express their opinions at certain regular meetings of the governing body or special meetings called for the express purpose of affording enrollees an opportunity to express their opinions;

B. creating a special committee of the governing body which will hold meetings on at least a quarterly basis and which will be open to all enrollees to express their opinions;

C. designating a special administrative office within the health maintenance organization, responsible directly to the governing body, which will be open to enrollees to express their opinions on a regular basis;

D. creating enrollee councils, representing enrolled groups and groups of individual enrollees which will be afforded a reasonable opportunity to meet with the governing body or its designee to express enrollee opinion; and

E. such other mechanisms as the commissioner may authorize or approve.

Statutory Authority: *MS s 62D.20*

4685.1600 ENROLLEES WHO ARE CONTRACT HOLDERS.

All enrollees who are contract holders, without regard to any membership or other status in the health maintenance organization corporation, must be afforded the opportunity to participate in the nomination and election of the consumer board members pursuant to Minnesota Statutes, section 62D.06, subdivision 1. All enrollees must be afforded the benefits of the enrollee opinion mechanisms and the complaint system. For the purpose of this part, a "contract holder" is the member of the covered group through which coverage is acquired, such as the employed person in an employment group, or in the case of an individual contract, is the person named in the contract as the covered person, as distinguished from others who may be covered as dependents of the covered person.

Statutory Authority: *MS s 62D.20*

4685.1700 [Repealed, L 1999 c 239 s 43]

4685.1800 [Repealed, 14 SR 903]

4685.1900 RECORDS OF COMPLAINTS.

Subpart 1. **Record requirements.** Every health maintenance organization shall maintain a record of each complaint filed with it during the prior five years. The record must, where applicable, include:

A. the complaint or a copy of the complaint and the date of its filing;

B. documentation of all informal discussions, consultations, conferences, and correspondence relative to each complaint, including the date or dates of each interaction and the outcomes of each interaction;

C. a copy of the hearing or reconsideration findings given the complainant;

D. a copy of the arbitrator's decision; and

E. all documents that have been filed with a court relating to a complaint and all orders and judgments of a court relating to the complaint.

Subp. 2. **Log of complaints.**

A. A health maintenance organization shall keep retrievable documentation of complaints submitted to the health maintenance organization by complainants.

B. The retrievable documentation must include the date the complaint was initially submitted; the name, address, and telephone number of the complainant, if provided; the enrollee's identification number; and the location of the complainant's complaint records.

C. The retrievable documentation must include the following information regarding an enrollee who complains orally to the health maintenance organization:

(1) name;

(2) address;

(3) telephone number, if provided to the health maintenance organization;

(4) identification number;

(5) nature of the grievance; and

(6) dates when:

(a) the enrollee complained orally;

(b) the enrollee was provided the telephone number of the commissioner; and

(c) the complaint form was mailed, if applicable.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.11; 62D.20*

History: *14 SR 903; 23 SR 1238*

ANNUAL REPORTS

4685.1910 UNIFORM REPORTING.

Beginning April 1, 1989, health maintenance organizations shall submit as part of the annual report a completed NAIC Blank, subject to the amendments in parts 4685.1930, 4685.1940, 4685.1950, and 4685.1955.

Statutory Authority: *MS s 62D.05; 62D.08; 62D.182; 62D.20; 62D.21*

History: *10 SR 2159; 14 SR 901; 16 SR 2478*

4685.1920 ANNUAL REPORT FORMS.

By December 1, the commissioner shall notify health maintenance organizations of the manner in which the NAIC Blank may be obtained and provide a copy of those portions of the annual report to be completed as supplemental to the NAIC Blank.

Statutory Authority: *MS s 62D.08 subd 3; 62D.20; 62D.21*

History: *10 SR 2159*

4685.1930 NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, GENERAL INFORMATION, DEFINITIONS, AND INSTRUCTIONS.

Subpart 1. **Filing date.** The GENERAL INFORMATION, DEFINITIONS, AND INSTRUCTIONS section is amended by requiring the submission of the annual report on or before April 1 of each year.

Subp. 2. **Instructions for Report #2.** The instructions paragraph for Report #2: STATEMENT OF REVENUE AND EXPENSES in the GENERAL INFORMATION, DEFINITIONS, AND INSTRUCTION section is amended to require:

A. all revenue from the health maintenance organization's operations outside of Minnesota, and from business other than the operation of a health maintenance organization, conducted by the health maintenance organization, to be reported only under line 9, Other Revenue;

B. all nonadministrative expenses of these accounts to be reported only under line 19a, Other Expenses;

C. all administrative expenses of these accounts to be reported only under line 25a, Additional Administrative Expenses; and

D. health maintenance organizations, beginning with the annual report filed in 1987, to report revenue and expenses in the line items described by the definitions as amended and printed on Report #2, as amended.

Subp. 3. **Premium.** The definition of premium as used on line 1 of Report #2: STATEMENT OF REVENUES AND EXPENSES is amended in the GENERAL INFORMATION, DEFINITIONS, AND INSTRUCTIONS section to include only revenues from the health maintenance organization's Minnesota health maintenance contracts.

Subp. 4. **Other revenue.** The definition of Other Revenue as used on line 9 of Report #2: STATEMENT OF REVENUE AND EXPENSES is amended in the GENERAL INFORMATION, DEFINITIONS, AND INSTRUCTIONS section to include, in addition, revenue from the health maintenance organization's operations outside of Minnesota and from business other than the operation of a health maintenance organization, conducted by the health maintenance organization.

Subp. 5. **Reinsurance expenses.** The definition of Reinsurance Expenses as used on line 17 of Report #2: STATEMENT OF REVENUE AND EXPENSES is amended in the GENERAL INFORMATION, DEFINITIONS AND INSTRUCTIONS section to include, in addition, expenditures to insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract. These expenditures include premiums paid for indemnification against the risks incurred in providing nonelective emergency and out of area services and premiums paid for coverage which supplements the minimum coverage required of a health maintenance organization.

Subp. 6. **Other expenses and additional revenues.** GENERAL INFORMATION, DEFINITIONS, AND INSTRUCTIONS section for Report #2: STATEMENT OF REVENUES AND EXPENSES is amended by adding the following definitions:

A. Other expenses. Nonadministrative costs of the health maintenance organization's operations outside of Minnesota and of business other than the operation of a health maintenance organization, conducted by the health maintenance organization; and

B. Additional administrative expenses. Administrative costs of the health maintenance organization's operations outside of Minnesota and of business other than the operation of a health maintenance organization, conducted by the health maintenance organization.

Statutory Authority: *MS s 62D.08 subd 3; 62D.20; 62D.21*

History: *10 SR 2159*

4685.1940 NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, REPORT #2: STATEMENT OF REVENUE AND EXPENSES.

Subpart 1. **Separate statements.** The NAIC Blank for health maintenance organizations is amended by requiring the submission of a separate STATEMENT OF REVENUE AND EXPENSES for each of the following:

A. the health maintenance organization's total operations;

B. each demonstration project, as described under Minnesota Statutes, section 62D.30;

C. any Medicare risk enrollee contracts authorized by section 1876 of the Social Security Act;

D. any other Medicare contracts; and

E. the health maintenance organization's supplemental benefit operations including a separate schedule H.

Subp. 2. **Other expenses.** Report #2: STATEMENT OF REVENUE AND EXPENSES is amended by adding line 19a, Other Expenses.

Subp. 3. **Additional administrative expenses.** Report #2: STATEMENT OF REVENUE AND EXPENSES is amended by adding line 25a, Additional Administrative Expenses.

Subp. 4. **Uncovered expenses.** Report #2: STATEMENT OF REVENUE AND EXPENSES is amended by requiring a schedule of uncovered expenses.

Statutory Authority: *MS s 62D.05; 62D.08; 62D.182; 62D.20; 62D.21*

History: *10 SR 2159; 14 SR 901; 16 SR 2478*

4685.1950 NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, REPORT #4: ENROLLMENT AND UTILIZATION TABLE.

Subpart 1. **Additional columns.** Report #4: ENROLLMENT AND UTILIZATION TABLE is amended by adding the following columns:

A. 9a, Total Ambulatory Encounters for Period for Mental health; and

B. 9b, Total Ambulatory Encounters for Period for Chemical Dependency.

Subp. 2. **Total members at end of period.** The Report #4: ENROLLMENT AND UTILIZATION TABLE is amended by requiring the itemization of Cumulative Member Months for Period by gender and five-year age increments, and Total Members at End of Period by gender, by five-year age increments, and by county, for the health maintenance organization's Minnesota health maintenance contract enrollment, Medicare risk contract enrollment authorized by section 1876 of the Social Security Act, any other Medicare contract enrollment, and each demonstration project.

Subp. 3. **Type of service.** Report #4: ENROLLMENT AND UTILIZATION TABLE is amended by requiring the itemization of Total Patient Days Incurred, Annualized Hospital Days per 1,000 Enrollees, and Average Length of Stay by five-year age increments and by the following types of service for Minnesota health maintenance contracts, Minnesota health maintenance Medicare risk contracts, authorized by section 1876 of the Social Security Act, any other Medicare contract enrollment, and each demonstration project:

A. medical/surgical, in a hospital;

B. obstetrical/gynecological, in a hospital;

C. mental health, in a hospital or other health care facility;

D. chemical dependency, in a hospital or other health care facility; and

E. other services provided in health care facilities other than hospitals.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20; 62D.21*

History: *10 SR 2159; 14 SR 901*

4685.1955 SUPPLEMENTAL BENEFITS.

Subpart 1. **Definitions.** The terms used in this part have the meanings given them.

A. "Supplemental benefit" means an addition to the comprehensive health maintenance services required to be offered under a health maintenance contract which provides coverage for nonemergency, self-referred medical services which is either a comprehensive supplemental benefit or a limited supplemental benefit according to items B and C.

B. "Comprehensive supplemental benefit" means supplemental benefits for at least 80 percent of the usual and customary charges for all covered supplemental benefits, except emergency care, required for a qualified plan as provided by Minnesota Statutes, section 62E.06, or a qualified Medicare supplement plan as provided by Minnesota Statutes, section 62E.07, if it were offered as a separate health insurance policy.

C. "Limited supplemental benefit" means any supplemental benefit which provides coverage at a lower level of benefits than a comprehensive supplemental benefit as described under item B. A limited supplemental benefit may be for a single service or any combination of services.

Subp. 2. **General requirements on provisions of coverage.**

A. Every contract or evidence of coverage for supplemental benefits must clearly state that supplemental benefits are not used to fulfill comprehensive health maintenance services requirements as defined under part 4685.0700.

B. In any supplemental benefit providing coverage for a medical service, reimbursement for that service must include treatments by all credentialed practitioners providing that service within the lawful scope of their practice, unless the certificate of coverage specifically states the practitioners whose services are not covered. Practitioners described in item C cannot be excluded from coverage. For the purposes of this part, "credentialed practitioners" means any practitioner licensed or registered according to Minnesota Statutes, chapter 214.

C. In any supplemental benefit providing reimbursement for any service which is in the lawful scope of practice of a duly licensed osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of Minnesota Statutes, section 62A.15, subdivision 3a, the person entitled to benefits is entitled to access to that service on an equal basis, whether the service is performed by a physician, osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of Minnesota Statutes, section 62A.15, subdivision 3a, licensed under the laws of Minnesota.

D. A health maintenance organization may not deny supplemental benefit coverage of a service which the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's supplemental benefits contract by the health maintenance organization had prior authorization or second opinion been obtained.

A health maintenance organization may, however, impose a reasonable assessment on coverage for lack of prior authorization or second opinion for supplemental benefit services. The assessment cannot exceed 20 percent of the usual and customary charges for the service received.

Subp. 3. **Disclosure of comprehensive supplemental benefits.** Every contract or evidence of coverage for comprehensive supplemental benefits must include a detailed explanation of the services available, including:

A. that coverage is available for all benefits provided by the health maintenance organization's health maintenance services, except emergency services;

B. the level of coverage available under the supplemental benefits, including any limitations on benefits;

C. all applicable copayments, deductibles, or maximum lifetime benefits;

D. the procedure for any required preauthorization, including any applicable assessment for failure to obtain preauthorization; and

E. the procedure for filing claims under the supplemental benefits, which must comply with Minnesota Statutes, section 72A.201.

Subp. 4. **Disclosure of limited supplemental benefits.** Every contract or evidence of coverage for limited supplemental benefits must include a detailed explanation of the services available including:

A. A listing of all benefits available through the limited supplemental benefits.

B. A listing of any excluded general grouping of services as listed in Minnesota Statutes, section 62D.02, subdivision 7. Those groupings include preventive health services, outpatient health services, and inpatient hospital and physician services. Emergency care is not permitted as a supplemental benefit.

If less than all of the services in a grouping are covered, specific exclusions within that grouping must be clearly stated.

C. The level of coverage available for each benefit.

D. All applicable copayments, deductibles, or maximum lifetime benefits.

E. The procedure for any required preauthorization, including any applicable assessment for failure to obtain preauthorization.

F. The procedure for filing claims under the limited supplemental benefits, which must comply with Minnesota Statutes, section 72A.201.

Subp. 5. **Consumer information.** All supplemental benefits evidences of coverage and contracts must contain a clear and complete statement of enrollees' rights as consumers. The statement must be in bold print and captioned "Important Consumer Information For Supplemental Benefits" and must include the provisions given in this subpart for either comprehensive or limited supplemental benefits, as appropriate.

If the supplemental benefit is presented as a separate section of a contract or evidence of coverage for comprehensive health maintenance services, the supplemental benefit section must begin with the consumer information statement described in this subpart.

If the supplemental benefit is presented as an integrated part of the comprehensive health maintenance services contract or evidence of coverage, the consumer information statement must appear directly after the "Enrollee Bill Of Rights" and "Consumer Information" sections at the beginning of the contract or evidence of coverage. When the supplemental benefits are integrated into the contract or evidence of coverage, the differences between the supplemental benefit and the comprehensive health maintenance services must be clearly set out in the contract or evidence of coverage.

The statement of consumer information must be in the language of item A or B, as appropriate, or in substantially similar language (to accommodate changes based on a prior authorization requirement, for example) approved in advance by the commissioner:

A. CONSUMER INFORMATION FOR COMPREHENSIVE SUPPLEMENTAL BENEFITS

(1) COVERED SERVICES: The comprehensive supplemental benefit of (name of health maintenance organization) covers similar services as the comprehensive health maintenance services, but at a different level of coverage. Copayments, deductibles, and maximum lifetime benefit restrictions may apply. Your contract describes the procedures for receiving coverage through the comprehensive supplemental benefit.

(2) PROVIDERS: To receive services through the comprehensive supplemental benefit, you may go to providers of covered services who are not on the provider list supplied by (name of health maintenance organization) and for whom you did not get a referral.

(3) REFERRALS: A referral from (name of health maintenance organization) for services covered by the comprehensive supplemental benefit is not required to receive coverage. However, if a referral is requested from (name of health maintenance

organization) you may be eligible for the same services, from the same provider at a lower cost to you, as a benefit under your comprehensive health maintenance services. See section (section number) of the evidence of coverage for specific referral details.

(4) PRIOR AUTHORIZATION: You are not required to get prior authorization from (name of health maintenance organization) before using supplemental benefits. However, there may be a reduction in the level of benefits available to you if you do not get prior authorization. See section (section number) of your comprehensive supplemental benefit agreement for specific information about prior authorization.

(5) EXCLUSIONS: Coverage of supplemental benefits is limited to those services specified in your evidence of coverage. Section (specify number) lists related services which are excluded from coverage and clarifies any limitations imposed on coverage of the services.

(6) CONTINUATION: Your comprehensive health maintenance services contract provides for continuation and conversion rights under certain circumstances. If you continue your coverage as an individual under your group contract, the comprehensive supplemental benefits will also continue. If you convert to an individual plan, supplemental benefits may not be available. Your continuation and conversion rights to supplemental benefits are explained fully in your comprehensive supplemental benefits agreement.

(7) DISCONTINUATION: Your comprehensive supplemental benefits are an addition to your comprehensive health maintenance coverage. Changes in your contract may result in the discontinuation of one or more of your supplemental benefits. Please read all amendments to your contract carefully.

B. CONSUMER INFORMATION FOR LIMITED SUPPLEMENTAL BENEFITS

(1) COVERED SERVICES: The limited supplemental benefit of (name of health maintenance organization) covers selected services, at varying levels of coverage. It does not provide coverage from nonparticipating providers for all services which are covered under a qualified health insurance plan under Minnesota law. Copayments, deductibles, and maximum lifetime benefit restrictions may apply. Your certificate of coverage lists the services available and describes the procedures for receiving coverage through the limited supplemental benefit.

(2) PROVIDERS: To receive benefits through the limited supplemental benefit, you may go to providers of covered services who are not on the provider list supplied by (name of health maintenance organization) and for whom you did not get a referral.

(3) REFERRALS: A referral from (name of health maintenance organization) for services covered by the limited supplemental benefit is not required to receive coverage. However, if a referral is requested from (name of health maintenance organization) you may be eligible for the same services, from the same provider at a lower cost to you, as a benefit under your comprehensive health maintenance services. See section (section number) of the evidence of coverage for specific referral details.

(4) PRIOR AUTHORIZATION: You are not required to get prior authorization from (name of health maintenance organization) before using supplemental benefits. However, there may be a reduction in the level of benefits available to you if you do not get prior authorization. See section (section number) of your limited supplemental benefit agreement for specific information about prior authorization.

(5) EXCLUSIONS: Services are not covered by the limited supplemental benefit unless they are listed in the supplemental benefits provisions. Section (specify number) lists related services which are excluded from coverage and clarifies any limitations imposed on coverage of such services.

(6) CONTINUATION: Your comprehensive health maintenance services contract provides for continuation and conversion rights under certain circumstances. If you continue your coverage as an individual under your group contract, the limited supplemental benefits will also continue. If you convert to an individual plan, supplemental benefits may not be available. Your continuation and conversion rights to

supplemental benefits are explained fully in your limited supplemental benefits agreement.

(7) DISCONTINUATION: Your limited supplemental benefits are an addition to your comprehensive health maintenance coverage. Changes in your contract may result in the discontinuation of one or more of your supplemental benefits. Please read all amendments to your contract carefully.

Subp. 6. **Out-of-pocket expenditures.** The out-of-pocket expenses associated with supplemental benefits, including any deductibles, copayments, or assessments shall be included in the total out-of-pocket expenses for the entire package of benefits provided. The total out-of-pocket expenses for a plan, including those associated with supplemental benefits, may not exceed the maximum out-of-pocket expenses allowable for a number three qualified insurance plan as provided by Minnesota Statutes, section 62E.06.

A plan may designate what portion of the maximum out-of-pocket benefits may be used in relation to supplemental benefits, with the remaining amount applicable only to comprehensive health maintenance services. For example, if the maximum out-of-pocket expenses is $3,000, the health maintenance organization may designate in its contract that the maximum out-of-pocket expenses for supplemental benefits is $1,000 and the maximum for comprehensive health maintenance services is $2,000. Every contract and evidence of coverage must include a clear statement describing the maximum out-of-pocket expense limitations and, if applicable, how the maximum expenses are allocated between comprehensive health maintenance services and supplemental benefits. The contract must also include a statement explaining that enrollees must keep track of their own out-of-pocket expenses, provided however, that enrollees may contact the health maintenance organization member services department for assistance in determining the amount paid by the enrollee for specific services received.

Subp. 7. **Annual reports.** A health maintenance organization which offers supplemental benefits shall include in its annual report the following schedules:

A. a schedule analyzing the previous year's estimation of incurred but not reported supplemental benefit claims; and

B. a schedule detailing claim development including historical data.

Subp. 8. **Estimation of incurred but not reported claims.** A health maintenance organization must estimate incurred but not reported supplemental benefit claim liabilities according to generally accepted actuarial methods.

Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but not reported supplemental benefit claims. All such reserves for prior years shall be tested for adequacy and reasonableness by reviewing the health maintenance organization's claim runoff schedules in accordance with generally accepted accounting principles and reported annually in the schedule required under subpart 7, item A.

Subp. 9. **Accrued supplemental benefit claims.** NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, REPORT #1-B: Report#1-B: BALANCE SHEET LIABILITIES AND NET WORTH is amended by adding a line for Accrued Supplemental Benefit Claims, and requiring a separate schedule of such claims detailing direct claims adjusted or in the process of adjustment plus incurred but not reported claims.

Statutory Authority: *MS s 62D.05; 62D.20*

History: *16 SR 2478*

4685.1960 AUDITED REPORT.

The following sections of the NAIC Blank must be audited by a public accountant certified under Minnesota Statutes, section 326.19 and retained by the health maintenance organization for purposes other than performing day to day accounting operations:

A. BALANCE SHEET ASSETS;

B. BALANCE SHEET LIABILITIES AND NET WORTH;

C. STATEMENTS OF REVENUE AND EXPENSES;

D. STATEMENT OF CHANGES IN FINANCIAL POSITION AND NET WORTH; AND

E. SUPPORTING SCHEDULES.

The certified public accountant shall state whether the audit was conducted according to generally accepted auditing standards, and shall express an opinion as to whether the sections audited are in conformity with generally accepted accounting principles applied on a consistent basis.

Statutory Authority: *MS s 62D.08 subd 3; 62D.20; 62D.21*

History: *10 SR 2159*

4685.1970 FINANCIAL DISCLOSURE.

Subpart 1. **Principal officer.** As provided by Minnesota Statutes, section 62D.03, subdivision 4, "principal officer" means an employee whose annual wages, expense reimbursements, and other payments exceed $60,000, if such employee performs the duties of:

A. president;

B. vice-president;

C. secretary;

D. treasurer;

E. executive director;

F. chief executive officer;

G. chief operating officer;

H. chief financial officer;

I. medical director; or

J. general counsel.

Subp. 2. **Disclosure of contractual and financial arrangement.** The disclosure of contractual and financial arrangements under Minnesota Statutes, section 62D.03, subdivision 4, must include a detailed description of the obligations to be met by and compensation to be received by each party to the contract or arrangement.

Subp. 3. **Disclosure of wages, expense reimbursements, and other payments.** The disclosure of wages, expense reimbursements, and other payments under Minnesota Statutes, section 62D.08, subdivision 3, to persons identified in Minnesota Statutes, section 62D.03, subdivision 4, clause (c) must include items taxable as income to such persons under Minnesota Statutes, chapter 290, if the items are received for:

A. direct services rendered in any capacity to the health maintenance organization; or

B. indirect services rendered in any capacity for the health maintenance organization. Indirect services are services essential to the operation of the health maintenance organization, including administration, management, and the provision of medical care, regardless of whether the individual providing the services is compensated by the health maintenance organization or the major participating entity.

Subp. 4. **Allocation.** If the actual compensation for the services listed in subpart 3, items A and B, is unknown, the health maintenance organization shall calculate an allocation of the wages, expense reimbursements, and other payments for the persons identified in Minnesota Statutes, section 62D.03, subdivision 4. The allocation must be based on:

A. time;

B. number of enrollees;

C. gross revenues;

D. dollar volume of claims processed; or

E. number of claims processed.

The health maintenance organization shall indicate in the annual report the allocation basis or bases chosen.

Statutory Authority: *MS s 62D.08 subd 3; 62D.20; 62D.21*

History: *10 SR 2159*

4685.1980 QUARTERLY REPORTS.

The following sections of the NAIC Blank shall be submitted as the health maintenance organization's quarterly reports:

A. NAIC Reports #1, #2, #3; and

B. a description of the enrollment data included in NAIC report #4.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.2000 COMPLAINT REPORTS.

Every health maintenance organization shall submit to the commissioner of health, along with its annual report, a report on the experience of its respective complaint system during the immediately preceding calendar year. Such reports shall include at least the following information:

A. the name and location of the reporting health maintenance organization;

B. the reporting period in question;

C. the name of the individual(s) responsible for the operation of the complaint system;

D. the total number of written complaints received by the health maintenance organization;

E. the total number of written complaints received, classified as to whether they were principally medical care, psychosocial, or coverage-related in nature, or classified according to a classification most suited to the characteristics of the particular health maintenance organization, unless unduly burdensome;

F. the number of enrollees by whom or for whom more than one written complaint was made and the total number of such complaints; and

G. the total number of written complaints resolved to the enrollee's apparent satisfaction.

Statutory Authority: *MS s 62D.20*

4685.2100 ANNUAL REPORTS.

In addition to all other information specified in the act, every health maintenance organization shall include in its annual report to the commissioner of health the following:

A. The results of any and all elections conducted during the preceding calendar year relative to consumer representation on the health maintenance organization's governing body.

B. A copy of the health maintenance organization's most recent information summary provided to its enrollees in accordance with Minnesota Statutes, section 62D.09.

C. A schedule of prepayment charges made to enrollees during the preceding year and any changes which have been implemented or approved up to the reporting date.

D. A listing of participating entities grouped by county, including the name, complete address, and clinic name, if applicable, of each health care provider and a

description of each health care provider's specialty. This listing shall be submitted on forms prescribed by the commissioner.

Statutory Authority: *MS s 62D.03; 62D.04; 62D.08; 62D.11; 62D.182; 62D.20*

History: *14 SR 901; 14 SR 903*

4685.2150 EXTENSION OF REPORTING DEADLINE.

Subpart 1. **Good cause.** An extension of the reporting deadline may be granted if the health maintenance organization demonstrates that its delinquency is due to circumstances which it could not reasonably have anticipated or avoided.

Subp. 2. **Procedure.** In order to be granted an extension, health maintenance organizations shall request an extension of a specific time period in writing at least three working days prior to April 1. If the annual report is not filed by the last day of the extension period, the fine imposed by Minnesota Statutes, section 62D.08, subdivision 4, accrues beginning on the following day.

Subp. 3. **Automatic extension.** If the commissioner fails to have the annual report form available for inspection by December 1 as required by part 4685.1920, item A, good cause shall be deemed to exist for health maintenance organizations to have an automatic extension of time in which to file the annual reports. The extension must equal the number of days the commissioner is overdue in having the annual report form available for inspection.

Statutory Authority: *MS s 62D.08 subd 3; 62D.20; 62D.21*

History: *10 SR 2159*

4685.2200 TERMINATION OF COVERAGE.

Subpart 1. **Definitions.** For the purpose of this part, the following terms have the meanings given them.

A. "Notice date" means the date a written notice of cancellation of coverage is postmarked by the United States Postal Service.

B. "Effective date of notice" means the date that a notice of cancellation of coverage takes effect as stated in the notice.

C. "Cancellation date" means the date coverage ends, as stated in the notice of cancellation.

Subp. 1a. **Justification.** In addition to those reasons specified in Minnesota Statutes, section 62D.12, subdivision 2, a health maintenance organization may, upon 30 days advance notice, cancel or fail to renew the coverage of an enrollee if the enrollee moves out of the geographic service area filed with the commissioner, provided the cancellation or nonrenewal is made within one year following the date the health maintenance organization was provided written notification of the address change. Written notification of the change of address of an enrollee may be from any reliable source, such as the United States Postal Service or providers. If notification is received from a source other than the enrollee, the health maintenance organization must verify that the enrollee has moved out of the service area before sending notice of termination. The verification may be in any form which is separate from the termination notice and which provides an adequate record for the commissioner to audit as required under Minnesota Statutes, section 62D.14.

A health maintenance organization may cancel or fail to renew the coverage of an enrollee if the enrollee knowingly gives false, material information at the time of enrollment relative to the enrollee's health status, provided the cancellation or nonrenewal is made within six months of the date of enrollment. This subpart does not prevent the enrollee from exercising the appeals rights provided by Minnesota Statutes, section 62D.11.

Subp. 2. **Notice.** In any situation where 30 days notice of cancellation or nonrenewal of the coverage of a specified group plan or of the coverage of any individual therein is required, notice given by a health maintenance organization to an authorized

representative of any such group shall be deemed to be notice to all affected enrollees in any such group and satisfy the notice requirement of the act, except as set out in subpart 2a.

The notice requirement of Minnesota Statutes, section 62D.12, subdivision 2a, shall be deemed to be satisfied in the event of voluntary enrollee cancellation or nonrenewal of coverage, including such voluntary cancellation manifested by the nongroup plan enrollee's failure to pay the prescribed prepayment amount.

The notice requirements of Minnesota Statutes, section 62D.12, subdivision 2a, are considered satisfied in the event of voluntary group cancellation or nonrenewal of coverage manifested by the group contract holder's notice to the health maintenance organization of the cancellation or nonrenewal.

Subp. 2a. **Notice of cancellation to group enrollees.** In situations where the health maintenance organization is canceling coverage for all enrollees of a group plan for nonpayment of the premium for coverage under the group plan, the health maintenance organization is required to give all enrollees in the group plan 30 days notice of termination. The effective date of the notice shall not be less than 30 days after the notice date and shall clearly state the cancellation date which shall be no more than 60 days prior to the effective date of the notice. The notice shall include a statement of the enrollees' rights to convert to an individual policy without underwriting restrictions and shall include either an application for conversion coverage or a telephone number which the enrollees can call for further information about conversion to an individual plan.

The health maintenance organization shall not bill a group enrollee for any amount arising before the cancellation date, whether arising from past due premiums or from health services received by the enrollee.

Subp. 3. **Termination of dependents at limiting age.** A health maintenance organization may terminate enrollees who are covered dependents in a family health maintenance contract upon the attainment by the dependent enrollee of a limiting age as specified in the contract. Provided, however, that no health maintenance contract may specify a limiting age of less than 18 years of age. If any health maintenance contract provides for the termination of coverage based on the attainment of a specified age it shall also provide in substance that attainment of that age shall not terminate coverage while the child is incapable of self-sustaining employment by reason of mental disability or physical handicap, and chiefly dependent upon the enrollee for support and maintenance. The enrollee must provide proof of the child's incapacity and dependency within 31 days of attainment of the age, and subsequently as required by the health maintenance organization, but not more frequently than annually after a two-year period following attainment of the age.

Statutory Authority: *MS s 62D.05; 62D.20*

History: *16 SR 2478*

4685.2250 USE OF FILED MATERIAL.

When a health maintenance organization modifies any documents as described in Minnesota Statutes, section 62D.08, subdivision 1, it shall not implement the modifications until notice of the modifications has been filed with the commissioner and the filing is approved, or deemed approved.

Statutory Authority: *MS s 62D.08; 62D.182; 62D.20*

History: *14 SR 901*

4685.2300 INSURANCE TERMINOLOGY.

Except as it relates to the name of any health maintenance organization, Minnesota Statutes, section 62D.12, subdivision 3 shall not be construed to prohibit the use of the words cited or described therein if such usage is incidental to the text of any health

maintenance organization contract or literature, enhances the accuracy or understanding thereof, and is not deceptive or misleading.

Statutory Authority: *MS s 62D.20*

4685.2400 MAXIMUM ENROLLMENT.

The maximum number of enrollees permitted a health maintenance organization shall pertain to current enrollment at any single point in time.

Statutory Authority: *MS s 62D.20*

4685.2500 ENROLLMENT DISCRIMINATION.

A health maintenance organization which refuses to enroll recipients of medical assistance or Medicare because of its good faith inability to qualify for such payments because of state or federal requirements shall not be deemed to be discriminating against any such recipients.

Statutory Authority: *MS s 62D.20*

4685.2600 CERTIFICATE OF NEED.

For the purpose of complying with Minnesota Statutes, section 62D.22, subdivision 6, any health maintenance organization intending to modify the construction of or construct a health care facility as defined in part 4685.1400, subpart 4, item B, shall be deemed to be an "applicant," as such term is defined in section 201(b), Minnesota State Planning Agency Certificate of Need Act Rules and Regulations, 1971.

Statutory Authority: *MS s 62D.20*

4685.2700 USE OF FUNDS.

All income of a health maintenance organization, however derived, including refunds, dividends or rebates on its insurance policies or nonprofit health service plan contracts, shall be considered part of its net earnings and subject to the provisions of Minnesota Statutes, section 62D.12, subdivision 9.

Statutory Authority: *MS s 62D.20*

4685.2800 FEES.

Subpart 1. **Filing fees.** Every filing submitted to the commissioner by a health maintenance organization subject to Minnesota Statutes, sections 62D.01 to 62D.29, shall be accompanied by the following fees:

A. for filing an application for a certificate of authority, $3,000;

B. for filing each annual report, $400;

C. for filing a quarterly report, $200;

D. for filing each amendment to a certificate of authority, including the filings required under Minnesota Statutes, section 62D.08, subdivision 1, $125;

E. for filing a health plan premium, $125 plus $30 per product for which the premium is applicable;

F. for each examination, the costs, including staff salaries and fringe benefits and indirect costs, incurred in preparing for and conducting the examination and preparing the subsequent report. The commissioner shall provide the health maintenance organization an itemized statement at the time of billing.

For the purpose of this item, indirect costs include costs attributable to:

(1) supplies;

(2) professional and technical services;

(3) electronic data processing;

(4) variable telephone usage;

(5) correspondence delivery;

(6) travel and subsistence; and

(7) general overhead, including building rental, telephone systems, executive office services, personnel services, administrative services, and financial management.

The fee charged for the examination must be calculated by totaling staff salaries, fringe benefits, and the costs described in subitems (1) to (6) and adding the percentage of general overhead, described in subitem (7), attributable to the specific examination; and

G. for all other filings, $125. These filings include, but are not limited to:

(1) requests for waiver of open enrollment;

(2) demonstration project applications; and

(3) expense and revenue reports required under Minnesota Statutes, section 62D.03, subdivision 4, clause (g).

Subp. 2. **Renewal fee.** The renewal fee for a certificate of authority is $21,500 for each health maintenance organization plus 70 cents for each person enrolled in the health maintenance organization on December 31 of the preceding year. The fee applies to the calendar year in which the fee is required to be paid.

Statutory Authority: *MS s 62D.08; 62D.20; 62D.21; 62D.211; 144.122*

History: *10 SR 2159; L 1987 c 384 art 2 s 1; 13 SR 2609; 15 SR 2430; 23 SR 1238; 24 SR 1288*

OPEN ENROLLMENT

4685.2900 EFFECTIVE DATE OF OPEN ENROLLMENT.

Open enrollment requirements shall be implemented by an existing health plan within a one-year period commencing July 1, 1975. Health plans formed after the effective date of the act, shall implement such requirements within a one-year period to commence 24 months after beginning operation as a health plan.

Statutory Authority: *MS s 62D.10*

4685.3000 SCOPE.

The requirements of Minnesota Statutes, section 62D.10, subdivision 2, shall apply to those health plans which offer nongroup contracts.

The requirements of Minnesota Statutes, section 62D.10, subdivision 3, shall apply to those health plans which offer group contracts.

Health plans offering nongroup and group contracts shall be subjected to Minnesota Statutes, section 62D.10, subdivision 2, with respect to their nongroup and to Minnesota Statutes, section 62D.10, subdivision 3, with respect to their group contracts.

Statutory Authority: *MS s 62D.10*

4685.3100 NOTICE.

All health plans offering group plans shall provide for reasonable and timely notice of open enrollment provisions to prospective group enrollees or their representatives, including the dates of annual open enrollment and the manner in which to enroll. Such notice shall be given at least 15 days and not more than 45 days prior to the commencement of each annual open enrollment period. All health plans offering individual enrollments shall advertise the dates of their open enrollment and the manner in which to enroll in at least one newspaper of general distribution in the geographical area served by the plan. The advertisement shall run on at least two occasions at least 15 days and at most 45 days before the beginning of the open enrollment period. The advertisement shall be of sufficient size to reasonably apprise readers of the availability of the open enrollment period.

Statutory Authority: *MS s 62D.10*

4685.3200 WAIVER.

Subpart 1. **Application to the commissioner.** The requirements of Minnesota Statutes, section 62D.10 may be waived or the imposition of necessary underwriting restrictions may be authorized upon a written application to the commissioner stating the grounds for the request.

Subp. 2. **Compliance.** The commissioner shall determine whether or not compliance with the requirement for open enrollment would:

A. contravene the maximum enrollment limitation of 500,000 enrollees imposed by the act;

B. prevent a health plan from competing effectively with other health plans or with commercial health insurers for the enrollment of new members or for the retention of current members;

C. result in a health plan incurring unreasonably high expenses in relation to the value of the benefits or services it provides;

D. jeopardize the availability or adequacy of a health plan's working capital and any required surpluses or reserves; or

E. endanger the ability of a health plan to meet its current and future obligations to enrollees.

Subp. 3. **Considerations.** In making this determination the commissioner of health shall:

A. consider information supplied by a health plan in its application for the waiver or underwriting restrictions;

B. be permitted access to all health plan records pertinent to such application;

C. consider prevailing practices and standards relating to the financing and delivery of health care service in the community; and

D. consider any comments submitted by the commissioner of commerce or any interested party.

Statutory Authority: *MS s 62D.10*

History: *L 1983 c 289 s 114 subd 1; L 1984 c 655 art 1 s 92*

4685.3300 PERIODIC FILINGS.

Subpart 1. [Repealed, 14 SR 901]

Subp. 1a. **Final form.** Copies of all contracts, contract forms or documents and their amendments which are required to be filed with the commissioner according to Minnesota Statutes, section 62D.08, subdivision 1, must be submitted in final typewritten form. However, minor legible handwritten changes to the typewritten form may be accepted.

Subp. 2. [Repealed, 14 SR 901]

Subp. 2a. **Insufficient information.** A filing shall be disapproved if supporting information is necessary to determine whether the filed material meets all standards in this chapter or Minnesota Statutes, chapter 62D, and supporting information does not accompany the filing, or the supporting information is not adequate.

In the disapproval letter, the commissioner shall specify the supporting information required, and the health maintenance organization may refile the additional information as an amended filing according to the provisions of subpart 7.

Subp. 3. **Filing of contract.** The filing of any contracts or evidences of coverage under Minnesota Statutes, section 62D.07 or 62D.08, subdivision 1, shall be accompanied by sufficient evidence on cost of services on which copayments are being imposed to allow the commissioner of health to determine the impact and reasonableness of the copayment provisions.

If a health maintenance organization imposes a copayment which is a flat fee based upon the charges for a category of similar services for Medicare, individual, or

group plans according to part 4685.0801, the health maintenance organization must include the information required according to part 4685.0801, subpart 4.

Subp. 4. [Repealed, 14 SR 901]

Subp. 4a. **Form identification.** Each contract, contract form or document and their amendments, filed for approval must contain the health maintenance organization's name, address, and telephone number and must be identified by a unique form number in the lower left hand corner on the first page of the form. If applicable, the health maintenance organization shall identify the filing as either a group or individual contract or evidence of coverage.

Subp. 5. [Repealed, 14 SR 901]

Subp. 5a. **Duplicate copies.** Each contract form or document and its amendments filed with the commissioner must be submitted in duplicate with a cover letter indicating the name and telephone number of the contact person for the health maintenance organization, and the address to which the commissioner's decision shall be mailed.

Subp. 6. **Approval or disapproval.** One copy of each contract form or document and its amendments, filed with the commissioner must be stamped approved or disapproved and returned to the health maintenance organization within 30 days after the commissioner's receipt of the filing. If disapproved, the specific reason for denial shall be stated in writing by the commissioner or authorized representative.

Subp. 7. **Amended filings.** A filing that has been disapproved may be amended and refiled with the commissioner without a filing fee, provided the health maintenance organization submits the amended filing to the commissioner within 30 days after the health maintenance organization receives notice of disapproval. An amended filing shall only address the issues that were the subject of the disapproval. When refiling an amended filing, the health maintenance organization shall use the same identification number that was used on the original filing.

When the health maintenance organization files an amended filing, it shall submit two copies of the amended filing. One copy must be stamped approved or disapproved and returned to the health maintenance organization within 30 days after the commissioner's receipt of the amended filing under subpart 7.

Subp. 8. **Endorsements.** When filing an endorsement, amendment, or rider, the health maintenance organization shall indicate the form number or numbers with which the endorsement, amendment, or rider will be used.

Subp. 9. **Service area expansion.** The filing of a request to expand a service area must be accompanied by sufficient supporting documentation including the following:

A. a detailed map with the proposed service area outlined;

B. provider locations charted on the map;

C. a description of driving distances, using major transportation routes, from the borders of the proposed service area to the participating providers;

D. a description of the providers' hours of operation;

E. evidence that the physicians have admitting privileges at the hospitals that enrollees in the new service area will use;

F. a list of providers in the new service area with the name, address, and specialty of every provider;

G. evidence of contractual arrangements with providers. Acceptable evidence is a copy of the signature page of the provider contract, or a sworn affidavit that states that the providers are under contract with the health maintenance organization; and

H. any other information relating to documentation of service area, facility, and personnel availability and accessibility to allow a determination of compliance with part 4685.1010.

Subp. 10. **Marked up copies.** Any filing that amends or replaces a previously approved filing shall be accompanied by a copy of the previously approved filing with any changes, additions, or deletions noted.

Subp. 11. **Notice of participating entity changes.** Any notice of an addition or deletion of a participating entity must be submitted on forms prescribed by the commissioner, or approved for use by the commissioner.

Statutory Authority: *MS s 62D.05; 62D.08; 62D.182; 62D.20*

History: *14 SR 901; 16 SR 2478; 17 SR 2858*

4685.3400 IMPROPER PRACTICES.

It shall be an improper practice for a health maintenance organization to advertise or market its operation by making qualitative judgment or statements concerning any health professional who provides services for a health maintenance organization.

A health maintenance organization shall not enroll a person who resides outside the health maintenance organization's defined service area, unless the health maintenance organization provides the enrollee with written notice of the consequences of this special enrollment.

Statutory Authority: *MS s 62D.12*

History: *17 SR 1279*

4685.3500 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.3600 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.3700 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.3800 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.3900 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.4000 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.4100 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.4200 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.4300 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.4400 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.4500 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.4600 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.4700 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.4800 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.4900 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.5000 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.5100 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.5200 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.5300 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.5400 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.5500 [Repealed, 1Sp1985 c 14 art 19 s 38]

4685.5600 [Repealed, 1Sp1985 c 14 art 19 s 38]