Department of Health

Adopted Permanent Rules Relating to Health Maintenance Organizations

Rules as Adopted

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

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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 ~~average~~ median provider's charges for similar services or goods received by enrollees. For example, if the ~~average~~ 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 ~~average~~ 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 ~~physician-care~~ 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, ~~chiropractic 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 ~~average~~ median charge.** To determine the ~~average~~ 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

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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.

~~F.--The average charge will be the median charge.~~

Subp. 5. **Required disclosure.** The health maintenance

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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'S CHARGE~~ 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 ~~average~~ 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.

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.

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.

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.

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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. 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

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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

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(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 it 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.

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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.

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:

~~A. 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; or~~

~~B.~~ 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

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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.

4685.3300 PERIODIC FILINGS.

[For text of subps 1a and 2a, see M.R.]

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.

[For text of subps 4a to 11, see M.R.]

REPEALER. Minnesota Rules, part 4685.0800, is repealed.

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