CHAPTER 62D. HEALTH MAINTENANCE ACT OF 1973

62D.10 Provisions applicable to all health plans.

Subdivision 1. The provisions of this section shall be applicable to nonprofit prepaid health care plans regulated under chapter 317, and health maintenance organizations regulated pursuant to sections 62D.01 to 62D.29, both of which for purposes of this section shall be known as "health plans".

[*For text of subds 2 to 4, see M.S.1976*]

[*1977 c 409 s 3*]

62D.101 Conversion privileges for former spouses.

Subdivision 1. No health maintenance contract which in addition to covering an enrollee, also covers the enrollee's spouse shall contain a provision for termination of coverage for a spouse covered under the health maintenance contract solely as a result of a break in the marital relationship except by reason of an entry of a valid decree of dissolution of marriage between the parties.

Subd. 2. Every health maintenance contract, other than a contract whose continuance is contingent upon continued employment or membership, which contains a provision for termination of coverage of the spouse upon dissolution of marriage shall contain a provision to the effect that upon the entry of a valid decree of dissolution of marriage between the covered parties the spouse shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the health maintenance organization within 30 days following the entry of the decree, and upon the payment of the appropriate fee, an individual health maintenance contract. The contract shall provide the coverage then being issued by the organization which is most nearly similar to, but not greater than, the terminated coverage. Any probationary or waiting period set forth in the conversion contract shall be considered as being met to the extent coverage was in force under the prior contract.

Subd. 3. This section applies to every health maintenance contract which is delivered, issued for delivery, renewed or amended on or after the effective date of this section.

[*1977 c 186 s 3*]

CHAPTER 62E. HEALTH CARE

62E.02 Definitions.

[*For text of subd 1, see M.S.1976*]

Subd. 2. "Employer" means any person, partnership, association, trust, estate or corporation, including the state of Minnesota or any agency, instrumentality or

governmental subdivision thereof, which employs ten or more individuals who are residents of this state.

[*For text of subds 3 to 7, see M.S.1976*]

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

[*For text of subds 9 and 10, see M.S.1976*]

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

[*For text of subds 12 to 20, see M.S.1976*]

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

[*For text of subd 22, see M.S.1976*]

[*1977 c 409 s 4-7*]

62E.03 Duties of the employer.

[*For text of subd 1, see M.S.1976*]

Subd. 2. In the event that an employer fails to comply with subdivision 1, none of the employer's costs for health benefits shall qualify as an income tax deduction pursuant to section 290.09, subdivision 2, clause (a)(1). In the case of an employer who meets the requirements of section 297A.25, subdivision 1, clause (j) or clause (p) if the employer fails to make available at least a number two qualified plan to his employees, the employer shall lose his status as an exempt organization under section 297A.25, subdivision 1, clause (j) or clause (p), as appropriate.

[*1977 c 409 s 8*]

62E.04 Duties of insurers.

[*For text of subds 1 to 3, see M.S.1976*]

Subd. 4. **Major medical coverage.** Each insurer and fraternal shall affirma-

tively offer coverage of major medical expenses to every applicant for a new unqualified policy at the time of application and annually to every holder of an unqualified policy of accident and health insurance. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of $250,000.

[*For text of subds 5 to 7, see M.S.1976*]

Subd. 8. **Reduction of benefits because of other services.** No policy of accident and health insurance issued or renewed after August 1, 1977, shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving benefits pursuant to chapters 256B and 256D, or sections 62E.51 to 62E.55.

[*1977 c 409 s 9,10*]

62E.06 Minimum benefits of qualified plan.

Subdivision 1. **Number three plan.** A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A and 62C, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

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

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

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

(1) Hospital services;

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

(3) Drugs requiring a physician's prescription;

(4) Services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under medicare;

(5) Services of a home health agency if the services would qualify as reimbursable services under medicare;

(6) Use of radium or other radioactive materials;

(7) Oxygen;

(8) Anesthetics;

(9) Prostheses other than dental;

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

(11) Diagnostic X-rays and laboratory tests;

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) Services of a physical therapist; and

(14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(c) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) Any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a worker's compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance, medicare or any other governmental program except as otherwise provided by law;

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

(3) Care which is primarily for custodial or domicilliary purposes which would not qualify as eligible services under medicare;

(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semi-private rooms, its most common semi-private room charge shall be considered to be 90 percent of its lowest private room charge;

(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(d) Effective July 1, 1980, the minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (e), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(1) Well baby care;

(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician;

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

(e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in addition to those benefits specified in clause (a), a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory and hospital fees, provided that the coverage need not include the repetition of any diagnostic tests.

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

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

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

[*1977 c 409 s 11*]

62E.08 State plan premium.

Subdivision 1. For the first eighteen months of operation of the comprehensive health insurance plan the association shall establish the following premiums to be charged for membership in the comprehensive health insurance plan:

(a) The premium for the number one qualified plan shall be the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in Minnesota;

(b) The premium for the number two qualified plan shall be the average of rates charged by the five insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in Minnesota;

(c) The premium for a qualified medicare supplement plan shall be the average of rates charged by the five insurers with the largest number of individuals enrolled in a qualified medicare supplement plan; and

(d) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

Subd. 2. For subsequent enrollees or renewals of membership, the schedule of premiums for membership in the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

[*1977 c 409 s 12*]

62E.09 Duties of commissioner.

The commissioner may:

(a) Formulate general policies to advance the purposes of sections 62E.01 to 62E.17;

(b) Supervise the creation of the Minnesota comprehensive health association within the limits described in section 62E.10;

(c) Approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the state plan coverage and premiums to be charged;

(d) Appoint advisory committees;

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

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

(g) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of sections 62E.01 to 62E.17, so that the residents of this state may best avail themselves of the health care benefits provided by these sections;

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

(i) Adopt, amend, suspend and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of sections 62E.01 to 62E.17. The commissioner may until December 31, 1978 adopt emergency rules.

[*1977 c 409 s 13*]

62E.10 Comprehensive health association.

Subdivision 1. **Creation; tax exemption.** There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers, self insurers, fraternals and health maintenance organizations licensed or authorized to do business in this state. The comprehensive health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

[*For text of subd 2, see M.S.1976*]

Subd. 3. **Mandatory membership.** All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, or health maintenance organization business in this state. The association shall submit bylaws and operating rules to the commissioner for approval.

[*For text of subds 4 to 6, see M.S.1976*]

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

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

(b) Sue or be sued;

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

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

(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by sections 62E.04 and 62E.16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:

(1) Individual qualified plans, excluding group conversions;

(2) Group conversions;

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

(4) Major medical coverage.

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

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

[*1977 c 409 s 14-16*]

62E.11 Operation of comprehensive plan.

[*For text of subds 1 to 4, see M.S.1976*]

Subd. 5. Each member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs, pursuant to the terms of the individual reinsurance contracts executed by the association with each member in

accordance with section 62E.10, subdivision 5. Deviations in the claim experience of the state plan from the premium payments allocated to the payment of benefits shall be the liability of the association members. Association members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the member's total cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of Minnesota residents as divided into the total cost of self insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges received by all association members from or on behalf of Minnesota residents, as determined by the commissioner. The reinsurance contract shall provide for an annual determination and assessment of each member's liability, if any. Payment of the assessment shall be due within 30 days after the end of the association's fiscal year. Subject to the approval of the commissioner, the reinsurance contract may provide for interim assessments as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Failure by a member to tender to the association the assessed reinsurance payment within 30 days of notification by the association shall be grounds for termination of the member's membership.

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

[*1977 c 409 s 17*]

62E.13 Administration of plan.

[*For text of subd 1, see M.S.1976*]

Subd. 2. Upon the commissioner's approval of the policy forms and contracts submitted pursuant to chapter 62A, the association may select policies and contracts submitted by a member or members of the association to be the comprehensive health insurance plan. This selection shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified medicare supplement plan, and the health maintenance organization contract.

[*For text of subd 3, see M.S.1976*]

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

[*For text of subds 5 to 9, see M.S.1976*]

[*1977 c 409 s 18,19*]

62E.14 Enrollment by an eligible person.

Subdivision 1. **Certificate, contents.** The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person may enroll by submission of a certificate of eligibility to the writing carrier. The certificate may provide the following:

(a) Name, address, age, and length of time at residence of the applicant;

(b) Name, address, and age of spouse and children if any, if they are to be insured;

(c) Evidence of rejection, or a requirement of restrictive riders, or a preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least two association members within six months of the date of the certificate; and

(d) A designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan.

[*For text of subds 2 and 3, see M.S.1976*]

[*1977 c 409 s 20*]

62E.16 Conversion privileges.

Every program of self insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state, shall include, in addition to the provisions required by section 62A.17, the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions if the individual insured leaves the group regardless of the reason for leaving the group, or upon cancellation or termination of the coverage for the group except where uninterrupted and continuous group coverage is otherwise provided to the group. The person may exercise his right to conversion within 30 days of leaving the group or within 30 days following his receipt of due notice of cancellation or termination of coverage of the group and upon payment of premiums from the date of termination or cancellation. Due notice of cancellation or termination of coverage for a group shall be provided to each employee having coverage in the group by the insurer, self insurer or health maintenance organization cancelling or terminating the coverage except where reasonable evidence indicates that uninterrupted and continuous group coverage is otherwise provided to the group. Every employer having a policy of group accident and health insurance, group subscriber or contract of coverage by a health maintenance organization shall, upon request, provide the insurer or health maintenance organization a list of the names and addresses of covered employees. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue his coverage under the same or a different contract without the addition of underwriting restrictions until he would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived. An individual conversion contract issued by a health maintenance organization shall not be deemed to be an individual enrollment contract for the purposes of section 62D.10.

[*1977 c 335 s 1*]

62E.52 Definitions.

[*For text of subd 1, see M.S.1976*]

Subd. 2. "Eligible person" means any person who is a resident of Minnesota and who, while a resident of Minnesota, has been found by the commissioner to have incurred an obligation to pay:

(1) qualified expenses for himself and any dependents in any 12 consecutive months exceeding:

(a) 40 percent of his household income up to $15,000, plus 50 percent of his household income between $15,000 and $25,000, plus 60 percent of his household income in excess of $25,000; or

(b) $2,500, whichever is greater; or

(2) qualified nursing home expenses for himself and any dependents in any 12 consecutive months exceeding 20 percent of his household income.

[*For text of subd 3, see M.S.1976*]

Subd. 3a. "Qualified nursing home expense" includes any charge incurred for nursing home services after 36 months of continuous care provided to a person 64 years of age or younger in long-term care facilities.

[*For text of subd 4, see M.S.1976*]

Subd. 5. "Household income" means the gross income of an eligible person and all his dependents 23 years of age or older for the calendar year preceding the year in which an application is filed pursuant to section 62E.53.

[*For text of subds 6 to 8, see M.S.1976*]

[*1977 c 448 s 1-3*]

62E.53 Application for assistance.

Subdivision 1. Any person who believes that he is or will become an eligible person may submit an application for state assistance to the commissioner. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the 12 month period for computing expenses began.

Subd. 2. If the commissioner determines that an applicant is an eligible person, he shall pay

(1) 90 percent of all qualified expenses of the eligible person and his dependents in excess of.

(a) 40 percent of his household income under $15,000, plus 50 percent of his household income between $15,000 and $25,000, plus 60 percent of his household income in excess of $25,000; or

(b) $2,500;

whichever is greater for the 12 month period in which the applicant becomes an eligible person and

(2) all qualified nursing home expenses of the eligible person and his dependents in excess of 20 percent of his household income. Provided, however, that the payment of qualified nursing home expenses shall not be made until the end of the fiscal year. If the appropriation for the payment of qualified nursing home expenses is inadequate to pay all qualified nursing home expenses, the commissioner shall prorate the payments among all eligible persons in proportion to their share of the total of the qualified nursing home expenses of all eligible persons.

Subd. 3. The commissioner shall by rule establish procedures for determining whether and to what extent qualified expenses are reasonable charges. Unless otherwise provided for by rule charges shall be reviewed for reasonableness by the same procedures used to review and limit reimbursement under the provisions of chapter 256B. If the commissioner determines that the charge for a health service is excessive, he may limit his payment to the reasonable charge for that service. If the commissioner determines that a health service provided to an eligible person was not medically necessary, he may refuse to pay for the service. The commissioner may contract with a review organization as defined in section 145.61, in making any determinations as to whether or not a charge is excessive and in making any determination as to whether or not a service was medically necessary. If the commissioner in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

[*1977 c 409 s 21; 1977 c 448 s 4*]

62E.531 HEALTH CARE

62E.531 Third party liability.

Subdivision 1. When the commissioner pays for or becomes liable for payments for health services under the provisions of sections 62E.51 to 62E.55, the department of public welfare shall have a lien for payments and liabilities for the services upon any and all causes of action which accrue to the person to whom the services were furnished, or to his legal representatives, as a result of injuries which directly or indirectly led to the incurring of qualified expenses.

The department may perfect and enforce its lien by following the procedures set forth in sections 514.69, 514.70, and 514.71, except that it shall have one year from the date when the last item of health service was furnished in which to file its verified lien statement. The statement shall be filed with the appropriate clerk of court in the county in which the recipient of the services resides or in the county in which the action was filed.

Subd. 2. Where a third party may be liable in whole or in part for payment for health services, the commissioner may consider the charges for the health services to be qualified expenses if the eligible person assigns any rights accruing by virtue of any third party liability to the commissioner to the extent necessary to reimburse the state for any payments made under the provisions of this section.

Subd. 3. Upon furnishing assistance under the provisions of sections 62E.51 to 62E.55, the department of public welfare shall be subrogated, to the extent of its payments for health services, to any rights the eligible person or his dependent may have under the terms of any plan of health coverage as defined in section 62E.02, subdivision 9. The right of subrogation shall not attach prior to written notice of the exercise of subrogation rights to the issuer of the plan of health coverage.

The attorney general, or the appropriate county attorney, acting upon direction from the attorney general, may institute or join a civil action against the issuer of the plan of health coverage to recover under this subdivision.

[*1977 c 409 s 22*]

62E.54 Duties of commissioner.

Subdivision 1. The commissioner shall:

(a) Promulgate reasonable rules, including emergency rules, to implement sections 62E.51 to 62E.55.

(b) Establish application forms and procedures for the use of persons seeking to be declared an eligible person; and

(c) Investigate applications to determine whether or not the applicant is a qualified person and investigate claims from providers of health services to determine whether or not to pay them.

[*For text of subd 2, see M.S.1976*]

[*1977 c 409 s 23*]

CHAPTER 65B. AUTOMOBILE INSURANCE

65B.001 Definitions.

Subdivision 1. Unless a different meaning is expressly made applicable, the