CHAPTER 62D

HEALTH MAINTENANCE ACT OF 1973

62D.01 CITATION AND PURPOSE.

Subdivision 1. Sections 62D.01 to 62D.29 may be cited as the "health maintenance act of 1973".

Subd. 2. (a) Faced with the continuation of mounting costs of health care coupled with its inaccessibility to large segments of the population, the legislature has determined that there is a need to explore alternative methods for the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these services.

(b) It is, therefore, the policy of the state to eliminate the barriers to the organization, promotion, and expansion of health maintenance organizations; to provide for their regulation by the state commissioner of health; and to exempt them from the operation of the insurance and nonprofit health service plan corporation laws of the state except as hereinafter provided.

(c) It is further the intention of the legislature to closely monitor the development of health maintenance organizations in order to assess their impact on the costs of health care to consumers, the accessibility of health care to consumers, and the quality of health care provided to consumers.

History: *1973 c 670 s 1; 1977 c 305 s 45*

62D.02 DEFINITIONS.

Subdivision 1. For the purposes of sections 62D.01 to 62D.29, unless the context clearly indicates otherwise, the terms defined in this section shall have the meaning here given them.

Subd. 2. "Commissioner of commerce" means the commissioner of commerce or a designee.

Subd. 3. "Commissioner of health" means the state commissioner of health or a designee.

Subd. 4. "Health maintenance organization" means a nonprofit corporation organized under chapter 317, or a local governmental unit as defined in subdivision 11, controlled and operated as provided in sections 62D.01 to 62D.29, which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.

Subd. 5. "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee which sets out the coverage to which the enrollee is entitled under the health maintenance contract which covers the enrollee.

Subd. 6. "Enrollee" means any person who has entered into, or is covered by, a health maintenance contract.

Subd. 7. "Comprehensive health maintenance services" means a set of comprehensive health services which the enrollees might reasonably require to be maintained in good health including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, outpatient health services and preventive health services. Elective, induced abortion, except as medically necessary to prevent the death of the mother, whether performed in a hospital, other abortion facility or the office of a physician, shall not be mandatory for any health maintenance organization.

Subd. 8. "Health maintenance contract" means any contract whereby a health maintenance organization agrees to provide comprehensive health maintenance services to enrollees, provided that the contract may contain reasonable enrollee copayment provisions. Copayment provisions in group contracts shall not discriminate on the basis of age, sex, race, length of enrollment in the plan, or economic status; and during every open enrollment period in which all offered health benefit plans, including those subject to the jurisdiction of the commissioners of commerce or health, fully participate without any underwriting restrictions, copayment provisions shall not discriminate on the basis of preexisting health status. In no event shall the annual copayment exceed the maximum out-of-pocket expenses allowable for a number three qualified insurance policy under section 62E.06. Where sections 62D.01 to 62D.30 permit a health maintenance organization to contain reasonable copayment provisions for preexisting health status, these provisions may vary with respect to length of enrollment in the plan. Any contract may provide for health care services in addition to those set forth in subdivision 7.

Subd. 9. "Provider" means any person who furnishes health services and is licensed or otherwise authorized to render such services in the state.

Subd. 10. "Consumer" means any person other than a person (a) whose occupation involves, or before retirement involved, the administration of health activities or the providing of health services; (b) who is, or ever was, employed by a health care facility, as a licensed health professional; or (c) who has, or ever had, a direct, substantial financial or managerial interest in the rendering of health service other than the payment of reasonable expense reimbursement or compensation as a member of the board of a health maintenance organization.

Subd. 11. "Local governmental unit" means any statutory or home rule charter city or county.

Subd. 12. "Participating entity" means any of the following persons, providers, companies, or other organizations with which the health maintenance organization has contracts or other agreements:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.11, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner of health;

(2) a health care professional licensed under health-related licensing boards, as defined in section 214.01, subdivision 2, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner of health;

(3) a group, professional corporation, or other organization which provides the services of individuals or entities identified in (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) any person or organization providing administrative, financial, or management services to the health maintenance organization if the total payment for all services exceeds three percent of the gross revenues of the health maintenance organization.

"Participating entity" does not include (a) another health maintenance organization with which a health maintenance organization has made contractual arrangements or (b) any entity with which a health maintenance organization has contracted primarily in order to purchase or lease equipment or space or (c) employees of the health maintenance organization or (d) employees of any participating entity identified in clause (3).

Subd. 13. "Major participating entity" shall include the following:

(1) a participating entity that receives from the health maintenance organization as compensation for services a sum greater than 30 percent of the health maintenance organization's gross annual revenues;

(2) a participating entity providing administrative, financial, or management services to the health maintenance organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health maintenance organization;

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors of the health maintenance organization.

Subd. 14. "Separate health services contracts" means prepaid dental services contracts and other similar types of prepaid health services agreements in which services are provided by participating entities or employees of the health maintenance organization, but does not include contracts subject to chapter 62A or 62C.

History: *1973 c 670 s 2; 1974 c 284 s 1; 1977 c 305 s 45; 1981 c 122 s 1; 1983 c 205 s 1,2; 1983 c 289 s 114 subd 1; 1984 c 464 s 8-11; 1984 c 655 art 1 s 92; 1986 c 444*

62D.03 ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS.

Subdivision 1. Notwithstanding any law of this state to the contrary, any nonprofit corporation organized to do so or a local governmental unit may apply to the commissioner of health for a certificate of authority to establish and operate a health maintenance organization in compliance with sections 62D.01 to 62D.29. No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization or health maintenance contract unless the organization has a certificate of authority under sections 62D.01 to 62D.29.

Subd. 2. Every person operating a health maintenance organization on July 1, 1973 shall submit an application for a certificate of authority, as provided in subdivision 4, within 90 days of July 1, 1973. Each such applicant may continue to operate until the commissioner of health acts upon the application. In the event that an application is denied, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.

Subd. 3. The commissioner of health may require any person providing physician and hospital services with payments made in the manner set forth in section 62D.02, subdivision 4, to apply for a certificate of authority under sections 62D.01 to 62D.29. Any person directed to apply for a certificate of authority shall be subject to the provisions of subdivision 2.

Subd. 4. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, and shall be in a form prescribed by the commissioner of health. Each application shall include the following:

(a) a copy of the basic organizational document, if any, of the applicant and of each major participating entity; such as the articles of incorporation, or other applicable documents, and all amendments thereto;

(b) a copy of the bylaws, rules and regulations, or similar document, if any, and all amendments thereto which regulate the conduct of the affairs of the applicant and of each major participating entity;

(c) a list of the names, addresses, and official positions of the following:

(1) all members of the board of directors, or governing body of the local govern-

ment unit, and the principal officers and shareholders of the applicant organization; and

(2) all members of the board of directors, or governing body of the local government unit, and the principal officers of the major participating entity and each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

The commissioner may by rule identify persons included in the term "principal officers";

(d) a full disclosure of the extent and nature of any contract or financial arrangements between the following:

(1) the health maintenance organization and the persons listed in clause (c)(1);

(2) the health maintenance organization and the persons listed in clause (c)(2);

(3) each major participating entity and the persons listed in clause (c)(1) concerning any financial relationship with the health maintenance organization; and

(4) each major participating entity and the persons listed in clause (c)(2) concerning any financial relationship with the health maintenance organization;

(e) the name and address of each participating entity and the agreed upon duration of each contract or agreement;

(f) a copy of the form of each contract binding the participating entities and the health maintenance organization. Contractual provisions shall be consistent with the purposes of sections 62D.01 to 62D.29, in regard to the services to be performed under the contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health maintenance organization, the nature and extent of risk sharing permissible, and contractual termination provisions;

(g) a copy of each contract binding major participating entities and the health maintenance organization. Contract information filed with the commissioner shall be confidential and subject to the provisions of section 13.37, subdivision 1, clause (b), upon the request of the health maintenance organization.

Upon initial filing of each contract, the health maintenance organization shall file a separate document detailing the projected annual expenses to the major participating entity in performing the contract and the projected annual revenues received by the entity from the health maintenance organization for such performance. The commissioner shall disapprove any contract with a major participating entity if the contract will result in an unreasonable expense under section 62D.19. The commissioner shall approve or disapprove a contract within 30 days of filing.

Within 120 days of the anniversary of the implementation of each contract, the health maintenance organization shall file a document detailing the actual expenses incurred and reported by the major participating entity in performing the contract in the proceeding year and the actual revenues received from the health maintenance organization by the entity in payment for the performance.

Contracts implemented prior to April 25, 1984, shall be filed within 90 days of April 25, 1984. These contracts are subject to the provisions of section 62D.19, but are not subject to the prospective review prescribed by this clause, unless or until the terms of the contract are modified. Commencing with the next anniversary of the implementation of each of these contracts immediately following filing, the health maintenance organization shall, as otherwise required by this subdivision, file annual actual expenses and revenues.

(h) a statement generally describing the health maintenance organization, its health maintenance contracts and separate health service contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide enrollees with comprehensive health maintenance services and separate health services;

(i) a copy of the form of each evidence of coverage to be issued to the enrollees;

(j) a copy of the form of each individual or group health maintenance contract and

each separate health service contract which is to be issued to enrollees or their representatives;

(k) financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement may be deemed to satisfy this requirement;

(l) a description of the proposed method of marketing the plan, a schedule of proposed charges, and a financial plan which includes a three year projection of the expenses and income and other sources of future capital;

(m) a statement reasonably describing the geographic area or areas to be served and the type or types of enrollees to be served;

(n) a description of the complaint procedures to be utilized as required under section 62D.11;

(o) a description of the procedures and programs to be implemented to meet the requirements of section 62D.04, subdivision 1, clauses (b) and (c) and to monitor the quality of health care provided to enrollees;

(p) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section 62D.06;

(q) a copy of any agreement between the health maintenance organization and an insurer or nonprofit health service corporation regarding reinsurance, stop-loss coverage, or any other type of coverage for potential costs of health services, as authorized in section 62D.04, subdivision 1, clause (f), and section 62D.13; and

(r) other information as the commissioner of health may reasonably require to be provided.

History: *1973 c 670 s 3; 1977 c 305 s 45; 1983 c 205 s 3,4; 1984 c 464 s 12; 1984 c 641 s 2*

62D.04 ISSUANCE OF CERTIFICATE AUTHORITY.

Subdivision 1. Upon receipt of an application for a certificate of authority, the commissioner of health shall determine whether the applicant for a certificate of authority has:

(a) demonstrated the willingness and potential ability to assure that health care services will be provided in such a manner as to enhance and assure both the availability and accessibility of adequate personnel and facilities;

(b) arrangements for an ongoing evaluation of the quality of health care;

(c) a procedure to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the quality, availability and accessibility of its services, and such other matters as may be reasonably required by regulation of the commissioner of health;

(d) reasonable provisions for emergency and out of area health care services;

(e) demonstrated that it is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner of health may consider:

(1) the financial soundness of its arrangements for health care services and the proposed schedule of charges used in connection therewith;

(2) the adequacy of its working capital;

(3) arrangements which will guarantee for a reasonable period of time the continued availability or payment of the cost of health care services in the event of discontinuance of the health maintenance organization;

(4) agreements with providers for the provision of health care services; and

(5) any deposit of cash or securities submitted in accordance with section 62D.041.

(f) demonstrated that it will assume full financial risk on a prospective basis for the provision of comprehensive health maintenance services, including hospital care;

provided, however, that the requirement in this paragraph shall not prohibit a health maintenance organization from obtaining insurance or making other arrangements (i) for the cost of providing to any enrollee comprehensive health maintenance services, the aggregate value of which exceeds $5,000 in any year, (ii) for the cost of providing comprehensive health care services to its members on a nonelective emergency basis, or while they are outside the area served by the organization, or (iii) for not more than 95 percent of the amount by which the health maintenance organization's costs for any of its fiscal years exceed 105 percent of its income for such fiscal years; and

(g) otherwise met the requirements of sections 62D.01 to 62D.29.

Subd. 2. Within 90 days after the receipt of the application for a certificate of authority, the commissioner of health shall determine whether or not the applicant meets the requirements of this section. If the commissioner of health determines that the applicant meets the requirements of sections 62D.01 to 62D.29, the commissioner shall issue a certificate of authority to the applicant. If the commissioner of health determines that the applicant is not qualified, the commissioner shall so notify the applicant and shall specify the reason or reasons for such disqualification.

Subd. 3. Except as provided in section 62D.03, subdivision 2, no person who has not been issued a certificate of authority shall use the words "health maintenance organization" or the initials "HMO" in its name, contracts or literature. Provided, however, that persons who are operating under a contract with, operating in association with, enrolling enrollees for, or otherwise authorized by a health maintenance organization licensed under sections 62D.01 to 62D.29 to act on its behalf may use the terms "health maintenance organization" or "HMO" for the limited purpose of denoting or explaining their association or relationship with the authorized health maintenance organization. No health maintenance organization which has a minority of consumers as members of its board of directors shall use the words "consumer controlled" in its name or in any way represent to the public that it is controlled by consumers.

Subd. 4. Upon being granted a certificate of authority to operate as a health maintenance organization, the organization must continue to operate in compliance with the standards set forth in subdivision 1. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority, in accordance with sections 62D.15 to 62D.17.

History: *1973 c 670 s 4; 1977 c 305 s 45; 1984 c 464 s 13; 1985 c 248 s 23; 1986 c 444*

62D.041 PROTECTION AGAINST INSOLVENCY.

Subdivision 1. **Definition.** For the purposes of this section, the term "uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization for which an enrollee would also be liable in the event of the organization's insolvency, including out-of-area services, referral services, and any other expenditures for health care services for which the health maintenance organization is at risk.

Subd. 2. **Required deposit.** Unless otherwise provided in this section, each health maintenance organization shall deposit with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, freely alienable securities, or any combination of these or other measures that is acceptable to the commissioner in the amount set forth in this section. If a health maintenance organization does not have the required reserves or its reserves are not properly computed, operations shall be adjusted to correct the condition, according to a written plan proposed by the health maintenance organization and approved by the commissioner. If a health maintenance organization does not propose measures to correct its reserves or surplus within a reasonable time, if a corporation violates the plan which has been approved, or if there is evidence that an improper reserve or surplus status cannot be corrected within a reasonable time, the commissioner of commerce may take action against the corporation under chapter 60B.

Subd. 3. **Amount for beginning organizations.** The amount for an organization that is beginning operation shall be the greater of: (a) five percent of its estimated expenditures for health care services for its first year of operation; (b) twice its estimated average monthly uncovered expenditures for its first year of operation; or (c) $100,000.

At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the organization or trustee, cash, freely alienable securities, or any combination of these or other measures acceptable to the commissioner in an amount equal to four percent of its estimated annual uncovered expenditures for that year.

Subd. 4. **Amount for existing organizations.** Unless not applicable, an organization that is in operation on August 1, 1984, shall make a deposit equal to the larger of:

(a) one percent of the preceding 12 months' uncovered expenditures; or

(b) $100,000 on the first day of the fiscal year beginning six months or more after August 1, 1984.

In the second fiscal year, if applicable, the amount of the additional deposit shall be equal to two percent of its estimated annual uncovered expenditures. In the third year, if applicable, the additional deposit shall be equal to three percent of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and subsequent years, if applicable, the additional deposit shall be equal to four percent of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.

Subd. 5. **Waiver.** The commissioner may waive any of the deposit requirements set forth in subdivisions 3 and 4 whenever satisfied that the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year, or its performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income, or the assets of the organization or its contracts with insurers, hospital, or medical service corporations, governments, or other organizations are reasonably sufficient to assure the performance of its obligations.

Subd. 6. **Financial exemptions.** When an organization has achieved a net worth not including land, buildings, and equipment of at least $1,000,000 or has achieved a net worth including organization-related land, buildings, and equipment of at least $5,000,000, the annual deposit requirement does not apply.

The annual deposit requirement does not apply to an organization if the total amount of the accumulated deposit is equal to 25 percent of its estimated annual uncovered expenditures for the next calendar year, or the capital and surplus requirements for the formation for admittance of an accident and health insurer in this state, whichever is less.

If the organization has a guaranteeing organization which has been in operation for at least five years and has a net worth not including land, buildings, and equipment of at least $1,000,000 or which has been in operation for at least ten years and has a net worth including organization-related land, buildings, and equipment of at least $5,000,000, the annual deposit requirement does not apply. If the guaranteeing organization is sponsoring more than one organization, the net worth requirement shall be increased by $400,000 not including organization-related land, buildings, and equipment, for each additional organization, for guaranteeing organizations that have been in operation for at least five years, and by $2,000,000 including organization-related land, buildings, and equipment; for each additional organization, for guaranteeing organizations that have been in operation for at least ten years. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer does not apply during any time that the guaranteeing organization maintains for each organization it sponsors a net worth at least equal to the capital and surplus requirements for an accident and health insurer.

Subd. 7. **Control of over deposits.** All income from deposits shall belong to the

depositing organizations and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, freely alienable securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

Subd. 8. **Reduction by commissioner.** In any year in which an annual deposit is not required of an organization's request the commissioner shall reduce the required, previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the organization not to make the annual deposit. If the amount of net worth no longer supports a reduction of its required deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, provided that its total deposit shall not exceed the maximum required under this section.

History: *1984 c 464 s 14; 1985 c 248 s 24*

62D.05 POWERS OF HEALTH MAINTENANCE ORGANIZATIONS.

Subdivision 1. Any nonprofit corporation or local governmental unit may, upon obtaining a certificate of authority as required in sections 62D.01 to 62D.29, operate as a health maintenance organization.

Subd. 2. A health maintenance organization may enter into health maintenance contracts in this state and engage in any other activities consistent with sections 62D.01 to 62D.29 which are necessary to the performance of its obligations under such contracts or authorize its representatives to do so.

Subd. 3. A health maintenance organization may contract with providers of health care services to render the services the health maintenance organization has promised to provide under the terms of its health maintenance contracts, may, subject to section 62D.12, subdivision 11, enter into separate prepaid dental contracts, or other separate health service contracts, may, subject to the limitations of section 62D.04, subdivision 1, clause (f), contract with insurance companies and nonprofit health service plan corporations for insurance, indemnity or reimbursement of its cost of providing health care services for enrollees or against the risks incurred by the health maintenance organization, and may contract with insurance companies and nonprofit health service plan corporations to insure or cover the enrollees' costs and expenses in the health maintenance organization, including the customary prepayment amount and any copayment obligations.

Subd. 4. A health maintenance organization may contract with other persons for the provision of services, including, but not limited to, managerial and administration, marketing and enrolling, data processing, actuarial analysis, and billing services. If contracts are made with insurance companies or nonprofit health service plan corporations, such companies or corporations must be authorized to transact business in this state.

Subd. 5. Each health maintenance organization authorized to operate under sections 62D.01 to 62D.29, or its representative, may accept from governmental agencies, private agencies, corporations, associations, groups, individuals, or other persons payments covering all or part of the cost of health care services provided to enrollees. Any recipient of medical assistance, pursuant to chapter 256B, may make application to join a health maintenance organization which has been approved for medical assistance by the commissioner of human services.

History: *1973 c 670 s 5; 1983 c 205 s 5; 1984 c 464 s 15; 1984 c 654 art 5 s 58*

62D.06 GOVERNING BODY.

Subdivision 1. The governing body of any health maintenance organization which is a nonprofit corporation may include enrollees, providers, or other individuals; provided, however, that after a health maintenance organization which is a nonprofit corporation has been authorized under sections 62D.01 to 62D.29 for one year, at least

40 percent of the governing body shall be composed of consumers elected by the enrollees from among the enrollees.

After a health maintenance organization which is a local governmental unit has been authorized under sections 62D.01 to 62D.29 for one year, an enrollee advisory body shall be established. The enrollees who make up this advisory body shall be elected by the enrollees from among the enrollees.

Subd. 2. The governing body shall establish a mechanism to afford the enrollees an opportunity to express their opinions in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms as may be prescribed or permitted by the commissioner of health.

History: *1973 c 670 s 6; 1974 c 284 s 10; 1977 c 305 s 45; 1983 c 205 s 6*

62D.07 EVIDENCE OF COVERAGE.

Subdivision 1. Every enrollee residing in this state is entitled to evidence of coverage under a health maintenance contract. The health maintenance organization or its designated representative shall issue the evidence of coverage.

Subd. 2. No evidence of coverage or amendment thereto shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment thereto has been filed with the commissioner of health pursuant to section 62D.03 or 62D.08.

Subd. 3. An evidence of coverage shall contain:

(a) No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which are untrue, misleading or deceptive as defined in section 62D.12, subdivision 1; and

(b) A clear, concise and complete statement of:

(1) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health maintenance contract;

(2) Any exclusions or limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(3) Where and in what manner information is available as to how services, including emergency and out of area services, may be obtained;

(4) The total amount of payment and copayment, if any, for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates; and

(5) A description of the health maintenance organization's method for resolving enrollee complaints and a statement identifying the commissioner as an external source with whom grievances may be registered.

(c) On the cover page of the evidence of coverage, a clear and complete statement of enrollees' rights as consumers, including but not limited to a description of each of the following:

(1) based upon the delivery system of each health maintenance organization, a statement which describes any type of health care professional as defined in section 145.61, whose services may be available only by referral of the health maintenance organization's participating staff;

(2) the right to available and accessible services which can be secured as promptly as appropriate for the symptoms presented, in a manner which assures continuity and, when medically necessary, the right to emergency services available 24 hours a day and seven days a week;

(3) the consumer's right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;

(4) the right to refuse treatment;

(5) the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law;

(6) the right to file a grievance with the health maintenance organization and the commissioner when experiencing a problem with the health maintenance organization or its health care providers;

(7) the right to initiate a legal proceeding when dissatisfied with the health maintenance organization's final determination regarding a grievance;

(8) the right of the enrollee and dependents to continue group coverage in the event the enrollee is terminated or laid off from employment, provided that the cost of such coverage is paid by the enrollee and furthermore, the right of the enrollee to convert to an individual contract at the end of the continuation period;

(9) the right for notification of enrollees regarding the cancellation or termination of contracts with participating primary care professionals, and the right to choose from among remaining participating primary care professionals;

(10) the right to cancel an individual health maintenance contract within ten days of its receipt and to have premiums paid refunded if, after examination of the contract, the individual is not satisfied with it for any reason. The individual is responsible for repaying the health maintenance organization for any services rendered or claims paid by the health maintenance organization during the ten days; and

(11) the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force.

Subd. 4. Any subsequent approved change in an evidence of coverage shall be issued to each enrollee.

Subd. 5. A grace period of 31 days shall be granted for payment of each premium for an individual health maintenance contract falling due after the first premium, during which period the contract shall continue in force.

Subd. 6. Any person entering into an individual health maintenance contract may cancel the contract within ten days of its receipt and to have premium paid refunded if, after examination of the contract, the individual is not satisfied with it for any reason. The individual is responsible for repaying the health maintenance organization for any services rendered or claims paid by the health maintenance organization during the ten days.

History: *1973 c 670 s 7; 1977 c 305 s 45; 1984 c 464 s 16-19; 1986 c 444*

62D.08 ANNUAL REPORT.

Subdivision 1. A health maintenance organization shall, unless otherwise provided for by rules adopted by the commissioner of health, file notice with the commissioner of health prior to any modification of the operations or documents described in the information submitted under clauses (a), (b), (e), (f), (g), (i), (j), (l), (m), (n), (o), (p), (q) and (r) of section 62D.03, subdivision 4. If the commissioner of health does not disapprove of the filing within 30 days, it shall be deemed approved and may be implemented by the health maintenance organization.

Subd. 2. Every health maintenance organization shall annually, on or before April 1, file a verified report with the commissioner of health and to the commissioner of commerce covering the preceding calendar year.

Subd. 3. Such report shall be on forms prescribed by the commissioner of health, and shall include:

(a) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations

engaged to fulfill obligations arising out of the health maintenance contract, and (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment;

(b) The number of new enrollees enrolled during the year, the number of enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) A summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c) in such form as may be required by the commissioner of health;

(d) A report of the names and addresses of all persons set forth in section 62D.03, subdivision 4, clause (c) who were associated with the health maintenance organization or the major participating entity during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization or the major participating entity, as those services relate to the health maintenance organization, including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause (d); and

(e) Such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out the duties under sections 62D.01 to 62D.29.

Subd. 4. Any health maintenance organization which fails to file a verified report with the commissioner on or before April 1 of the year due shall be subject to the levy of a fine up to $500 for each day the report is past due. This failure will serve as a basis for other disciplinary action against the organization, including suspension or revocation, in accordance with sections 62D.15 to 62D.17. The commissioner may grant an extension of the reporting deadline upon good cause shown by the health maintenance organization. Any fine levied or disciplinary action taken against the organization under this subdivision is subject to the contested case and judicial review provisions of sections 14.57 to 14.69.

Subd. 5. Every health maintenance organization shall inform the commissioner of any change in the information described in section 62D.03, subdivision 4, clause (e), including any change in address, any modification of the duration of any contract or agreement, and any addition to the list of participating entities, within ten working days of the notification of the change. Any cancellation or discontinuance of any contract or agreement listed in section 62D.03, subdivision 4, clause (e), or listed subsequently in accordance with this subdivision, shall be reported to the commissioner within seven working days of the date the health maintenance organization sends out or receives the notice of cancellation or discontinuance. Any health maintenance organization which fails to notify the commissioner within the time periods prescribed in this subdivision shall be subject to the levy of a fine up to $100 per contract for each day the notice is past due, accruing up to the date the organization notifies the commissioner of the cancellation or discontinuance. Any fine levied under this subdivision is subject to the contested case and judicial review provisions of chapter 14.

History: *1973 c 670 s 8; 1974 c 284 s 2; 1977 c 305 s 45; 1983 c 289 s 114 subd 1; 1984 c 464 s 20-23; 1984 c 655 art 1 s 92; 1985 c 248 s 70; 1986 c 444*

62D.09 INFORMATION TO ENROLLEES.

Subdivision 1. Any written marketing materials which may be directed toward potential enrollees and which include a detailed description of benefits provided by the health maintenance organization shall include a statement of consumer rights as described in section 62D.07, subdivision 3, paragraph (c).

Subd. 2. The application for coverage by the health maintenance organization shall be accompanied by the statement of consumer rights as described in section 62D.07, subdivision 3, paragraph (c).

Subd. 3. Every health maintenance organization or its representative shall annually, before June 1, provide to its enrollees the following: (1) a summary of its most recent annual financial statement including a balance sheet and statement of receipts

and disbursements; (2) a description of the health maintenance organization, its health care plan or plans, its facilities and personnel, any material changes therein since the last report, (3) the current evidence of coverage; and (4) a statement of consumer rights as described in section 62D.07, subdivision 3, paragraph (c).

History: *1973 c 670 s 9; 1984 c 464 s 24; 1985 c 248 s 25*

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".

Subd. 2. [Repealed, 1984 c 464 s 46]

Subd. 3. A health plan providing health maintenance services or reimbursement for health care costs to a specified group or groups may limit the open enrollment in each group plan to members of such group or groups, but after it has been in operation 24 months shall have an annual open enrollment period of at least 14 days during which it shall accept all otherwise eligible individuals in the order in which they apply for enrollment in a manner which does not discriminate on the basis of age, sex, race, health, or economic status. The health maintenance organization shall notify potential enrollees of any limitations on the number of new enrollees to be accepted. "Specified groups" may include, but shall not be limited to:

(a) Employees of one or more specified employers;

(b) Members of one or more specified labor unions;

(c) Members of one or more specified associations;

(d) Patients of physicians providing services through a health care plan who had previously provided services outside the health care plan; and

(e) Members of an existing group insurance policy.

Subd. 4. A health plan may apply to the commissioner of health for a waiver of the requirements of this section or for authorization to impose such underwriting restrictions upon open enrollment as are necessary (a) to preserve its financial stability, (b) to prevent excessive adverse selection by prospective enrollees, or (c) to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The commissioner of health upon a showing of good cause, shall approve or upon failure to show good cause shall deny such application within 30 days of the receipt thereof from the health plan. The commissioner of health may, in accordance with chapter 14, promulgate rules to implement this section.

Subd. 5. Any fee charged by a health maintenance organization for the process of determining an applicant's eligibility, and any other application fee charged, shall be refunded with interest to the applicant if the applicant is not accepted for enrollment in the health maintenance organization, or credited with interest to the applicant's premiums due if the applicant is accepted for enrollment in the organization.

History: *1973 c 670 s 10; 1974 c 284 s 3,4; 1977 c 305 s 45; 1977 c 409 s 3; 1982 c 424 s 130; 1984 c 464 s 25,26*

62D.101 CONTINUATION AND CONVERSION PRIVILEGES FOR FORMER SPOUSES AND CHILDREN.

Subdivision 1. **Termination of coverage.** 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. **Conversion privilege.** Every health maintenance contract, as described in subdivision 1 shall contain a provision allowing a former spouse and dependent children of an enrollee, without providing evidence of insurability, to obtain from the

health maintenance organization at the expiration of any continuation of coverage required under subdivision 2a or section 62A.146, or upon termination of coverage by reason of an entry of a valid decree of dissolution which does not require the health maintenance organization to provide continued coverage for the former spouse, an individual health maintenance contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the health maintenance organization within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate fee. A contract providing reduced benefits at a reduced fee may be accepted by the former spouse and dependent children in lieu of the optional coverage otherwise required by this subdivision. The individual health maintenance contract shall be renewable at the option of the former spouse as long as the former spouse is not covered under another qualified plan as defined in section 62E.02, subdivision 4, up to age 65 or to the day before the date of eligibility for coverage under title XVIII of the Social Security Act, as amended. Any revisions in the table of rate for the individual contract shall apply to the former spouse's original age at entry, and shall apply equally to all similar contracts issued by the health maintenance organization.

Subd. 2a. **Continuation privilege.** Every health maintenance contract as described in subdivision 1 shall contain a provision which permits continuation of coverage under the contract for the enrollee's former spouse and children upon entry of a valid decree of dissolution of marriage, if the decree requires the enrollee to provide continued coverage for those persons. The coverage may be continued until the earlier of the following dates:

(a) The date of remarriage of either the enrollee or the enrollee's former spouse; or

(b) The date coverage would otherwise terminate under the health maintenance contract.

Subd. 3. **Application.** Subdivision 1 applies to every health maintenance contract which is delivered, issued for delivery, renewed or amended on or after July 19, 1977.

Subdivisions 2 and 2a apply to every health maintenance contract which is delivered, issued for delivery, renewed, or amended on or after March 1, 1983.

History: *1977 c 186 s 3; 1982 c 555 s 10; 1982 c 642 s 16; 1984 c 464 s 27,28*

62D.102 MINIMUM BENEFITS.

In addition to minimum requirements established in other sections, all group health maintenance contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage for at least ten hours of treatment over a 12-month period with a copayment not to exceed the greater of $10 or 20 percent of the applicable usual and customary charge for mental or nervous disorder consultation, diagnosis and treatment services delivered while the enrollee is not a bed patient in a hospital.

History: *1984 c 641 s 3*

62D.103 SECOND OPINION RELATED TO CHEMICAL DEPENDENCY AND MENTAL HEALTH.

A health maintenance organization shall promptly evaluate the treatment needs of any enrollee who is seeking treatment for a problem related to chemical dependency or mental health conditions. In the event that the health maintenance organization or a participating provider determines that no type of structured treatment is necessary, the enrollee shall be immediately entitled to a second opinion paid for by the health maintenance organization, by a health care professional qualified in diagnosis and treatment of the problem and not affiliated with the health maintenance organization. The health maintenance organization or participating provider shall consider the

second opinion but is not obligated to accept the conclusion of the second opinion. The health maintenance organization or participating provider shall document its consideration of the second opinion.

History: *1984 c 641 s 4*

NOTE: This section was also added by Laws 1984, chapter 464, section 29, to read as follows:

"62D.103 **Second opinion related to chemical dependency and mental health.**

A health maintenance organization shall promptly evaluate the treatment needs of any enrollee who is seeking treatment for a problem related to chemical dependency or mental health conditions. In the event that the health maintenance organization or a participating provider determines that no type of treatment, either inpatient or outpatient, is necessary, the enrollee shall immediately be entitled to a second opinion by a health care professional qualified in diagnosis and treatment of the problem. An enrollee who seeks a second opinion from a health care professional not affiliated with the health maintenance organization must do so at his or her own expense. The health maintenance organization or participating provider shall consider the second opinion but is not obligated to accept the conclusion of the second opinion. The health maintenance organization or participating provider shall document its consideration of the second opinion."

62D.11 COMPLAINT SYSTEM.

Subdivision 1. Every health maintenance organization shall establish and maintain a complaint system including an impartial arbitration provision, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning the provision of health care services. Arbitration shall be subject to chapter 572, except (a) in the event that an enrollee elects to litigate a complaint prior to submission to arbitration, and (b) no medical malpractice damage claim shall be subject to arbitration unless agreed to by both parties subsequent to the event giving rise to the claim.

Subd. 2. The health maintenance organization shall maintain a record of each written complaint filed with it for three years and the commissioner of health shall have access to the records.

History: *1973 c 670 s 11; 1974 c 284 s 5; 1977 c 305 s 45; 1986 c 444*

62D.12 PROHIBITED PRACTICES.

Subdivision 1. No health maintenance organization or representative thereof may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Each health maintenance organization shall be subject to sections 72A.17 to 72A.321, relating to the regulation of trade practices, except (a) to the extent that the nature of a health maintenance organization renders such sections clearly inappropriate and (b) that enforcement shall be by the commissioner of health and not by the commissioner of commerce. Every health maintenance organization shall be subject to sections 8.31 and 325F.69.

Subd. 2. No health maintenance organization may cancel or fail to renew the coverage of an enrollee except for (a) failure to pay the charge for health care coverage; (b) termination of the health care plan; (c) termination of the group plan; (d) enrollee moving out of the area served, subject to section 62A.17, subdivisions 1 and 6; (e) enrollee moving out of an eligible group, subject to section 62A.17, subdivisions 1 and 6; (f) failure to make copayments required by the health care plan; or (g) other reasons established in rules promulgated by the commissioner of health. An enrollee shall be given 30 days notice of any cancellation or nonrenewal.

Subd. 3. No health maintenance organization may use in its name, contracts, or literature any of the words "insurance," "casualty," "surety," "mutual," or any other words which are descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state; provided, however, that when a health maintenance organization has contracted with an insurance company for any coverage permitted by sections 62D.01 to 62D.29, it may so state.

Subd. 4. No health maintenance contract or evidence of coverage shall provide for the reimbursement of an enrollee other than through a policy of insurance, except as stated in this subdivision:

(a) the health maintenance organization may refund payments made by or on behalf of an enrollee;

(b) the health maintenance organization may make direct payments to enrollees or providers for obligations incurred for nonelective emergency or out-of-area services received.

Subd. 5. The providers under agreement with a health maintenance organization to provide health care services and the health maintenance organization shall not have recourse against enrollees for amounts above those specified in the evidence of coverage as the periodic prepayment, or copayment, for health care services.

Subd. 6. The rates charged by health maintenance organizations and their representatives shall not discriminate except in accordance with accepted actuarial principles.

Subd. 7. [Repealed, 1984 c 464 s 46]

Subd. 8. No health maintenance organization shall discriminate in enrollment policy against any person solely by virtue of status as a recipient of medical assistance or medicare.

Subd. 9. All net earnings of the health maintenance organization shall be devoted to the nonprofit purposes of the health maintenance organization in providing comprehensive health care. No health maintenance organization shall provide for the payment, whether directly or indirectly, of any part of its net earnings, to any person as a dividend or rebate; provided, however, that health maintenance organizations may make payments to providers or other persons based upon the efficient provision of services or as incentives to provide quality care. The commissioner of health shall, pursuant to sections 62D.01 to 62D.29, revoke the certificate of authority of any health maintenance organization in violation of this subdivision.

Subd. 9a. Authorized expenses of a health maintenance organization shall include:

(1) cash rebates to enrollees, or to persons who have made payments on behalf of enrollees;

(2) direct payments to enrollees or providers as provided in subdivision 4, clause (b);

(3) free or reduced cost health service to enrollees;

(4) payments to any organization or organizations selected by the health maintenance organization which are operated for charitable, educational, or religious or scientific purposes.

Subd. 10. No health maintenance contract or evidence of coverage entered into, issued, amended, renewed or delivered on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit to an enrollee or other beneficiary by the amount of, or in any proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, as amended subsequent to the date of commencement of such benefit, the Railroad Retirement Act, any Veteran's Disability Compensation and Survivor Benefits Act, workers' compensation, or any similar federal or state law, as amended subsequent to the date of commencement of that benefit.

Subd. 11. Any health maintenance organization which includes coverage of comprehensive dental services in its comprehensive health maintenance services shall not include the charge for the dental services in the same rate as the charge for other comprehensive health maintenance services. The rates for dental services shall be computed, stated and bid separately. No employer shall be required to purchase dental services in combination with other comprehensive health services. An employer may purchase dental services separately.

Subd. 12. No health maintenance contract issued or renewed on or after July 1, 1980 shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving medical assistance pursuant to chapter 256B or services pursuant to section 252.27; 260.251, subdivision 1a; 261.27; or 393.07, subdivision 1 or 2.

Subd. 13. No health maintenance organization offering an individual or group health maintenance contract shall refuse to provide or renew the coverage because the applicant or enrollee has an option to elect workers' compensation coverage pursuant to section 176.012.

History: *1973 c 670 s 12; 1974 c 284 s 8,9; 1975 c 323 s 4; 1976 c 296 art 1 s 18; 1977 c 305 s 45; 1980 c 614 s 74; 1983 c 289 s 114 subd 1; 1984 c 464 s 30-36; 1984 c 641 s 5; 1984 c 655 art 1 s 92; 1985 c 248 s 70*

62D.13 POWERS OF INSURERS AND NONPROFIT HEALTH SERVICE PLANS.

Notwithstanding any law to the contrary, an insurer or a hospital or medical service plan corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group for group coverage under the insurance laws and the nonprofit health service plan corporation act. Under such contracts, the insurer or nonprofit health service plan corporation may make benefit payments to health maintenance organizations for health care services rendered, or to be rendered, by providers pursuant to the health care plan. Any insurer, or nonprofit health service plan corporation, licensed to do business in this state, is authorized to provide the types of coverages described in section 62D.05, subdivision 3.

History: *1973 c 670 s 13*

62D.14 EXAMINATIONS.

Subdivision 1. The commissioner of health may make an examination of the affairs of any health maintenance organization and its contracts, agreements, or other arrangements with any participating entity as often as the commissioner of health deems necessary for the protection of the interests of the people of this state, but not less frequently than once every three years, provided that examinations of participating entities pursuant to this subdivision shall be limited to their dealings with the health maintenance organization and its enrollees.

Subd. 2. The commissioner will notify the organization and any involved participating entity in writing when an examination has been initiated. The commissioner will include in this notice a full statement of the pertinent facts and of the matters being examined, and may include a statement that the organization or participating entity must submit to the commissioner within 30 days from the date of the notice a complete written report concerning those matters.

Subd. 3. In order to accomplish the duties under this section with respect to the dealings of the participating entities with the health maintenance organization, the commissioner of health shall have the right to:

(a) inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed;

(b) audit and inspect any books and records of a health maintenance organization and a participating entity which pertain to services performed and determinations of amounts payable under such contract;

(c) require persons or organizations under examination to be deposed and to answer interrogatories, regardless of whether an administrative hearing or other civil proceeding has been or will be initiated; and

(d) employ site visits, public hearings, or any other procedures considered appropriate to obtain the information necessary to determine the issues.

Subd. 4. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee, or any application obtained from any person, shall be private as defined in chapter 13 and shall not be disclosed to any person except (a) to the extent necessary to carry out the purposes of sections 62D.01 to 62D.29, the commissioner and a designee shall have access to the above data or information but the data removed from

the health maintenance organization or participating entity shall not identify any particular patient or client by name or contain any other unique personal identifier; (b) upon the express consent of the enrollee or applicant; (c) pursuant to statute or court order for the production of evidence or the discovery thereof; or (d) in the event of claim or litigation between such person and the provider or health maintenance organization wherein such data or information is pertinent. In any case involving a suspected violation of a law applicable to health maintenance organizations in which access to health data maintained by the health maintenance organization or participating entity is necessary, the commissioner and agents, while maintaining the privacy rights of individuals and families, shall be permitted to obtain data that identifies any particular patient or client by name. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

Subd. 5. The commissioner of health shall have the power to administer oaths to and examine witnesses, and to issue subpoenas.

Subd. 6. Reasonable expenses of examinations under this section shall be assessed by the commissioner of health against the organization being examined, and shall be remitted to the commissioner of health for deposit in the general fund of the state treasury.

Subd. 7. Failure to provide relevant information necessary for conducting examinations pursuant to this section shall be subject to the levy of a fine up to $200 for each day the information is not provided. A fine levied under this subdivision shall be subject to the contested case and judicial review provisions of chapter 14. In the event a timely request for review is made, accrual of a fine levied shall be stayed pending completion of the contested case and judicial review proceeding.

History: *1973 c 670 s 14; 1977 c 305 s 45; 1984 c 464 s 37; 1986 c 444*

62D.15 SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY.

Subdivision 1. The commissioner of health may suspend or revoke any certificate of authority issued to a health maintenance organization under sections 62D.01 to 62D.29 if the commissioner finds that:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health maintenance contract, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62D.03, unless amendments to such submissions have been filed with and approved by the commissioner of health;

(b) The health maintenance organization issues evidences of coverage which do not comply with the requirements of section 62D.07;

(c) The health maintenance organization is unable to fulfill its obligations to furnish comprehensive health maintenance services as required under its health maintenance contract;

(d) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(e) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under section 62D.06;

(f) The health maintenance organization has failed to implement the complaint system required by section 62D.11 in a manner designed to reasonably resolve valid complaints;

(g) The health maintenance organization, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(h) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(i) The health maintenance organization has otherwise failed to substantially comply with sections 62D.01 to 62D.29 or with any other statute or administrative rule applicable to health maintenance organizations, or has submitted false information in any report required hereunder.

Subd. 2. A certificate of authority shall be suspended or revoked only after compliance with the requirements of section 62D.16.

Subd. 3. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

Subd. 4. When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner of health may, by written order, permit further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

History: *1973 c 670 s 15; 1977 c 305 s 45; 1984 c 464 s 38; 1986 c 444*

62D.16 DENIAL, SUSPENSION, AND REVOCATION; ADMINISTRATIVE PROCEDURES.

Subdivision 1. When the commissioner of health has cause to believe that grounds for the denial, suspension or revocation of a certificate of authority exists, the commissioner shall notify the health maintenance organization in writing specifically stating the grounds for denial, suspension or revocation and fixing a time of at least 20 days thereafter for a hearing on the matter, except in summary proceedings as provided in section 62D.18.

Subd. 2. After such hearing, or upon the failure of the health maintenance organization to appear at the hearing, the commissioner of health shall take action as is deemed advisable and shall issue written findings which shall be mailed to the health maintenance organization. The action of the commissioner of health shall be subject to judicial review pursuant to chapter 14.

History: *1973 c 670 s 16; 1977 c 305 s 45; 1982 c 424 s 130; 1986 c 444*

62D.17 PENALTIES AND ENFORCEMENT.

Subdivision 1. The commissioner of health may, for any violation of statute or rule applicable to a health maintenance organization, or in lieu of suspension or revocation of a certificate of authority under section 62D.15, levy an administrative penalty in an amount up to $10,000 for each violation. In the case of contracts or agreements made pursuant to section 62D.05, subdivisions 2 to 4, each contract or agreement entered into or implemented in a manner which violates sections 62D.01 to 62D.29 shall be considered a separate violation. Reasonable notice in writing to the health maintenance organization shall be given of the intent to levy the penalty and the reasons therefor, and the health maintenance organization may have a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation, or have an administrative hearing and review of the commissioner of health's determination. Such administrative hearing shall be subject to judicial review pursuant to chapter 14.

Subd. 2. Any person who violates sections 62D.01 to 62D.29 or knowingly submits false information in any report required hereunder shall be guilty of a misdemeanor.

Subd. 3. (a) If the commissioner of health shall, for any reason, have cause to believe that any violation of sections 62D.01 to 62D.29 has occurred or is threatened, the commissioner of health may, before commencing action under sections 62D.15 and 62D.16, and subdivision 1, give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(b) Proceedings under this subdivision shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner of health may deem appropriate under the circumstances.

Subd. 4. (a) The commissioner of health may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of sections 62D.01 to 62D.29.

(b) Within 20 days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of sections 62D.01 to 62D.29 have occurred. Such hearings shall be subject to judicial review as provided by chapter 14.

If the acts or practices involve violation of the reporting requirements of section 62D.08, or if the commissioner of commerce has ordered the rehabilitation, liquidation, or conservation of the health maintenance organization in accordance with section 62D.18, the health maintenance organization may request an expedited hearing on the matter. The hearing shall be held within 15 days of the request. Within ten days thereafter, an administrative law judge shall issue a recommendation on the matter. The commissioner shall make a final determination on the matter within ten days of receipt of the administrative law judge's recommendation.

When a request for a stay accompanies the hearing request, the matter shall be referred to the office of administrative hearings within three working days of receipt of the request. Within ten days thereafter, an administrative law judge shall issue a recommendation to grant or deny the stay. The commissioner shall grant or deny the stay within five days of receipt of the administrative law judge's recommendation.

To the extent the acts or practices alleged do not involve violations of section 62D.08, if a timely request for a hearing is made, the cease and desist order shall be stayed for a period of 90 days from the date the hearing is requested or until a final determination is made on the order, whichever is earlier. During this stay, the respondent may show cause why the order should not become effective upon the expiration of the stay. Arguments on this issue shall be made through briefs filed with the administrative law judge no later than ten days prior to the expiration of the stay.

Subd. 5. In the event of noncompliance with a cease and desist order issued pursuant to subdivision 4, the commissioner of health may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey county district court.

History: *1973 c 670 s 17; 1977 c 305 s 45; 1982 c 424 s 130; 1984 c 464 s 39; 1984 c 640 s 32; 1984 c 641 s 6*

NOTE: Subdivision 4 was also amended by Laws 1984, chapter 464, section 40, to read as follows:

"Subd. 4. (a) The commissioner of health may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of sections 62D.01 to 62D.29.

(b) Within 20 days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of sections 62D.01 to 62D.29 have occurred. Such hearings shall be subject to judicial review as provided by chapter 14.

If the acts or practices alleged involve violation of the reporting requirements under section 62D.08, or if the commissioner of commerce has ordered the rehabilitation, liquidation, or conservation of the health maintenance organization in accordance with section 62D.18, there shall be no automatic stay of the cease and desist order. If a timely request for a hearing is made, the respondent may show cause why the order should be stayed pending completion of the

administrative contested case process. Written arguments on this issue shall be filed with the commissioner no later than 15 days from the date the hearing is requested. The commissioner has 15 days from the date the written arguments are filed to render a decision regarding the requested stay.

To the extent the acts or practices alleged do not involve violations of section 62D.08, if a timely request for a hearing is made, the cease and desist order shall be stayed for a period of 30 days from the date the hearing is requested. During this stay, the respondent may show cause why the order should not become effective upon the expiration of the stay. Arguments on this issue shall be made through briefs filed with the commissioner no later than ten days prior to the expiration of the stay."

62D.18 REHABILITATION, LIQUIDATION, OR CONSERVATION OF HEALTH MAINTENANCE ORGANIZATION.

The commissioner of commerce may independently, or shall at the request of the commissioner of health, order the rehabilitation, liquidation or conservation of health maintenance organizations. The rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner of commerce and pursuant to chapter 60B, except to the extent that the nature of health maintenance organizations render such law clearly inappropriate.

History: *1973 c 670 s 18; 1977 c 305 s 45; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92*

62D.19 UNREASONABLE EXPENSES.

No health maintenance organization shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner of health shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of sections 62D.01 to 62D.29; in order to safeguard the underlying nonprofit status of health maintenance organizations; and to ensure that the payment of health maintenance organization money to major participating entities results in a corresponding benefit to the health maintenance organization and its enrollees, when determining whether an organization has incurred an unreasonable expense in relation to a major participating entity, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the health maintenance organization have acted with good faith and in the best interests of the health maintenance organization in entering into, and performing under, a contract under which the health maintenance organization has incurred an expense.

History: *1973 c 670 s 19; 1983 c 289 s 114 subd 1; 1984 c 464 s 41; 1984 c 655 art 1 s 92; 1Sp1985 c 10 s 62*

62D.20 RULES.

The commissioner of health may, pursuant to chapter 14, promulgate such reasonable rules as are necessary or proper to carry out the provisions of sections 62D.01 to 62D.29. Included among such rules shall be those which provide minimum requirements for the provision of comprehensive health maintenance services, as defined in section 62D.02, subdivision 7, and reasonable exclusions therefrom. Nothing in such rules shall force or require a health maintenance organization to provide elective, induced abortions, except as medically necessary to prevent the death of the mother, whether performed in a hospital, other abortion facility, or the office of a physician; the rules shall provide every health maintenance organization the option of excluding or including elective, induced abortions, except as medically necessary to prevent the death of the mother, as part of its comprehensive health maintenance services.

History: *1973 c 670 s 20; 1977 c 305 s 45; 1981 c 122 s 2; 1982 c 424 s 130; 1985 c 248 s 70*

62D.21 FEES.

Every health maintenance organization subject to sections 62D.01 to 62D.29 shall pay to the commissioner of health fees as prescribed by the commissioner of health pursuant to section 144.122 for the following:

(a) Filing an application for a certificate of authority,

(b) Filing an amendment to a certificate of authority,

(c) Filing each annual report, and

(d) Other filings, as specified by rule.

History: *1973 c 670 s 21; 1975 c 310 s 1; 1977 c 305 s 45; 1985 c 248 s 70*

62D.22 STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER LAWS.

Subdivision 1. Except as otherwise provided herein, sections 62D.01 to 62D.29 do not apply to an insurer or nonprofit health service plan corporation licensed and regulated pursuant to the laws governing such corporations in this state.

Subd. 2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

Subd. 3. Any health maintenance organization authorized under sections 62D.01 to 62D.29 shall not be deemed to be practicing a healing art.

Subd. 4. To the extent that it furthers the purposes of sections 62D.01 to 62D.29, the commissioner of health shall attempt to coordinate the operations of sections 62D.01 to 62D.29 relating to the quality of health care services with the operations of United States Code, title 42, sections 1320c to 1320c-20.

Subd. 5. Except as otherwise provided in sections 62A.01 to 62A.42 and 62D.01 to 62D.29, and except as they eliminate elective, induced abortions, wherever performed, from health or maternity benefits, provisions of the insurance laws and provisions of nonprofit health service plan corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under sections 62D.01 to 62D.29.

Subd. 6. [Repealed, 1982 c 614 s 12]

Subd. 7. A licensed health maintenance organization shall be deemed to be a prepaid group practice plan for the purposes of chapter 43A and may be allowed to participate as a carrier for state employees subject to any collective bargaining agreement entered into pursuant to chapter 179A and reasonable restrictions applied pursuant to section 43A.23.

Subd. 8. All agents, solicitors, and brokers engaged in soliciting or dealing with enrollees or prospective enrollees of a health maintenance organization, whether employees or under contract to the health maintenance organization, shall be subject to the provisions of section 60A.17, concerning the licensure of health insurance agents, solicitors, and brokers, and lawful rules thereunder. Medical doctors and others who merely explain the operation of health maintenance organizations shall be exempt from the provisions of section 60A.17. Section 60A.17, subdivision 1a, paragraph (b) shall not apply except as to provide for an examination of an applicant in the applicant's knowledge concerning the operations and benefits of health maintenance organizations and related insurance matters.

Subd. 9. [Repealed, 1984 c 464 s 46]

Subd. 10. Any person or committee conducting a review of a health maintenance organization or a participating entity, pursuant to sections 62D.01 to 62D.29, shall have access to any data or information necessary to conduct the review. All data or information is subject to admission into evidence in any civil action initiated by the commissioner of health against the health maintenance organization. The data and information are subject to chapter 13.

History: *1973 c 670 s 22; 1974 c 284 s 6; 1977 c 305 s 45; 1979 c 332 art 1 s 57; 1980 c 617 s 18; 1981 c 122 s 3; 1981 c 210 s 54; 1Sp1981 c 4 art 1 s 50; 1984 c 464 s 42,43; 1985 c 248 s 70; 1Sp1985 c 17 s 10; 1986 c 444; 1Sp1986 c 3 art 1 s 8*

62D.23 FILINGS AND REPORTS AS PUBLIC DOCUMENTS.

All applications, filings and reports required under sections 62D.01 to 62D.29 shall be treated as public documents.

History: *1973 c 670 s 23*

62D.24 STATE COMMISSIONER OF HEALTH'S AUTHORITY TO CONTRACT.

The commissioner of health, in carrying out the obligations under sections 62D.01 to 62D.29, may contract with the commissioner of commerce or other qualified persons to make recommendations concerning the determinations required to be made. Such recommendations may be accepted in full or in part by the commissioner of health.

History: *1973 c 670 s 24; 1977 c 305 s 45; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 444*

62D.25 [Repealed, 1Sp1985 c 9 art 2 s 104]
62D.26 [Repealed, 1Sp1985 c 9 art 2 s 104]
62D.27 [Repealed, 1984 c 464 s 46]
62D.28 [Repealed, 1Sp1985 c 9 art 2 s 104]
62D.29 [Repealed, 1Sp1985 c 9 art 2 s 104]

62D.30 DEMONSTRATION PROJECTS.

Subdivision 1. The commissioner of health may establish demonstration projects to allow health maintenance organizations to extend coverage to:

(a) Individuals enrolled in Part A or Part B, or both, of the medicare program, Title XVIII of the Social Security Act, United States Code, title 42, section 1395 et seq.;

(b) Groups of fewer than 50 employees where each group is covered by a single group health policy;

(c) Individuals who are not eligible for enrollment in any group health maintenance contracts; and

(d) Low income population groups.

For purposes of this section, the commissioner of health may waive compliance with minimum benefits pursuant to sections 62A.151 and 62D.02, subdivision 7, full financial risk pursuant to section 62D.04, subdivision 1, clause (f), open enrollment pursuant to section 62D.10, and to applicable rules if there is reasonable evidence that the rules prohibit the operation of the demonstration project. The commissioner shall provide for public comment before any statute or rule is waived.

Subd. 2. A demonstration project must provide health benefits equal to or exceeding the level of benefits provided in Title XVIII of the Social Security Act and an out of hospital prescription drug benefit. The out of hospital prescription drug benefit may be waived by the commissioner if the health maintenance organization presents evidence satisfactory to the commissioner that the inclusion of the benefit would restrict the operation of the demonstration project.

Subd. 3. A health maintenance organization electing to participate in a demonstration project shall apply to the commissioner for approval on a form developed by the commissioner. The application shall include at least the following:

(a) A statement identifying the population that the project is designed to serve;

(b) A description of the proposed project including a statement projecting a schedule of costs and benefits for the enrollee;

(c) Reference to the sections of Minnesota Statutes and department of health rules for which waiver is requested;

(d) Evidence that application of the requirements of applicable Minnesota Statutes and department of health rules would, unless waived, prohibit the operation of the demonstration project;

(e) Evidence that another arrangement is available for assumption of full financial risk if full financial risk is waived under subdivision 1;

(f) An estimate of the number of years needed to adequately demonstrate the project's effects; and

(g) Other information the commissioner may reasonably require.

Subd. 4. The commissioner shall approve, deny, or refer back to the health maintenance organization for modification, the application for a demonstration project within 60 days of receipt from the health maintenance organization.

Subd. 5. The commissioner may approve an application for a demonstration project for a maximum of six years, with an option to renew.

Subd. 6. Each health maintenance organization for which a demonstration project is approved shall annually file a report with the commissioner summarizing the project's experience at the same time it files its annual report required by section 62D.08. The report shall be on a form developed by the commissioner and shall be separate from the annual report required by section 62D.08.

Subd. 7. The commissioner may rescind approval of a demonstration project if the commissioner makes any of the findings listed in section 62D.15, subdivision 1, with respect to the project for which it has not been granted a specific exemption, or if the commissioner finds that the project's operation is contrary to the information contained in the approved application.

History: *1979 c 268 s 1*