# CHAPTER 62D

# HEALTH MAINTENANCE ACT OF 1973



## 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 the following:

(1) 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

(2) a health maintenance organization from having a provision in a group health maintenance contract allowing an adjustment of premiums paid based upon the actual health services utilization of the enrollees covered under the contract, except that at no time during the life of the contract shall the contract holder fully self-insure the financial risk of health care services delivered under the contract. Risk sharing arrangements shall be subject to the requirements of sections 62D.01 to 62D.30;

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

*[For text of subds 2 to 4, see M.S.1986]*

**History:** *1987 c 130 s 1*

## 62D.05 POWERS OF HEALTH MAINTENANCE ORGANIZATIONS.

*[For text of subds 1 to 5, see M.S.1986]*

Subd. 6. **Supplemental benefits.** A health maintenance organization may, as a supplemental benefit, provide coverage to its enrollees for health care services and supplies received from providers who are not employed by, under contract with, or otherwise affiliated with the health maintenance organization. The commissioner may, pursuant to chapter 14, adopt, enforce, and administer rules relating to this subdivision, including: rules insuring that these benefits are supplementary and not substitutes for comprehensive health maintenance services; rules relating to protection against insolvency, including the establishment of necessary financial reserves; rules relating to appropriate standards for claims processing; rules relating to marketing practices; and other rules necessary for the effective and efficient administration of this subdivision. The commissioner, in adopting rules, shall give consideration to existing laws and rules administered and enforced by the department of commerce relating to health insurance plans. Except as otherwise provided by law, a health maintenance organization may not advertise, offer, or enter into contracts for the coverage described in this subdivision until 30 days after the effective date of rules adopted by the commissioner of health to implement this subdivision.

**History:** *1987 c 337 s 64*

## 62D.08 ANNUAL REPORT.

*[For text of subds 1 and 2, see M.S.1986]*

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, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

(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.

*[For text of subds 4 and 5, see M.S.1986]*

**History:** *1987 c 130 s 2*

## 62D.10 PROVISIONS APPLICABLE TO ALL HEALTH PLANS.

*[For text of subds 1 to 5, see M.S.1986]*

Subd. 6. Health maintenance organization contracts under section 62D.04, subdivision 1, shall include a clear statement of the risk sharing arrangement.

**History:** *1987 c 130 s 3*

## 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 and at least 75 percent of the cost of the usual and customary charges for any additional hours of ambulatory mental health treatment during the same 12-month benefit period for serious and persistent mental or nervous disorders.

Prior authorization may be required for an extension of coverage beyond ten hours of treatment. This prior authorization must be based upon the severity of the disorder, the patient's risk of deterioration without ongoing treatment and maintenance, degree of functional impairment, and a concise treatment plan. Authorization for extended treatment may not exceed a maximum of 30 visit hours during any 12-month benefit period.

For purposes of this section, covered treatment for a minor shall include treatment for the family if family therapy is recommended by a health maintenance organization provider.

**History:** *1987 c 337 s 65*

## 62D.211 RENEWAL FEE.

Each health maintenance organization subject to sections 62D.01 to 62D.29 shall submit to the commissioner of health each year before April 1 a certificate of authority renewal fee in the amount of $10,000 each plus 20 cents per person enrolled in the health maintenance organization on December 31 of the preceding year. The commissioner may adjust the renewal fee in rule under the provisions of chapter 14.

**History:** *1987 c 403 art 2 s 2*