

## CHAPTER 62E

### HEALTH CARE

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#### 62E.02 DEFINITIONS.

*[For text of subds 1 to 22, see M.S.1986]*

Subd. 23. "Contributing member" means those companies operating pursuant to chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance or health maintenance organizations and nonprofit health service plan corporations incorporated under chapter 62C or fraternal benefit society operating under chapter 64B. For the purposes of determining liability of contributing members pursuant to section 62E.11 payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization shall be considered to be accident and health insurance premiums.

**History:** 1987 c 268 art 2 s 17; 1987 c 384 art 3 s 47

#### 62E.06 MINIMUM BENEFITS OF QUALIFIED PLAN.

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

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

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

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

- (1) hospital services;
- (2) professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a physician or at the physician's direction;
- (3) drugs requiring a physician's prescription;
- (4) services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under Medicare;
- (5) services of a home health agency if the services would qualify as reimbursable services under Medicare;
- (6) use of radium or other radioactive materials;
- (7) oxygen;
- (8) anesthetics;
- (9) prostheses other than dental but including scalp hair prostheses worn for hair loss suffered as a result of alopecia areata;
- (10) rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;

(11) diagnostic X-rays and laboratory tests;

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

(13) services of a physical therapist;

(14) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment; and

(15) services of an occupational therapist.

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

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

(2) any charge for treatment for cosmetic purposes other than for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician;

(3) care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under Medicare;

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

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

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

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (e), benefits for well baby care, effective July 1, 1980, subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations.

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

(f) Effective August 1, 1985, the minimum benefits of a qualified plan must include, in addition to the benefits specified in clauses (a), (d), and (e), coverage for special dietary treatment for phenylketonuria when recommended by a physician.

(g) Outpatient mental health coverage is subject to section 62A.152, subdivision 2.

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

**History:** 1987 c 202 s 2; 1987 c 337 s 66

**62E.081** [Repealed, 1987 c 384 art 3 s 34]

**62E.10 COMPREHENSIVE HEALTH ASSOCIATION.**

*[For text of subd 1, see M.S.1986]*

**Subd. 2. Board of directors; organization.** The board of directors of the association shall be made up of nine members as follows: five insurer directors selected by participating members, subject to approval by the commissioner; four public directors selected by the commissioner. Public members may include licensed insurance agents. In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Insurer directors may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

**Subd. 2a. Appeals.** A person may appeal to the commissioner within 30 days after notice of an action, ruling, or decision by the board.

A final action or order of the commissioner under this subdivision is subject to judicial review in the manner provided by chapter 14.

In lieu of the appeal to the commissioner, a person may seek judicial review of the board's action.

*[For text of subds 3 to 8, see M.S.1986]*

**Subd. 9. Experimental delivery method.** The association may petition the commissioner of commerce for a waiver to allow the experimental use of alternative means of health care delivery. The commissioner may approve the use of the alternative means the commissioner considers appropriate. The commissioner may waive any of the requirements of this chapter and chapters 60A, 62A, and 62D in granting the waiver. The commissioner may also grant to the association any additional powers as are necessary to facilitate the specific waiver.

This subdivision is effective until August 1, 1989.

**History:** 1987 c 337 s 67-69

**62E.11 OPERATION OF COMPREHENSIVE PLAN.**

*[For text of subds 1 to 7, see M.S.1986]*

**Subd. 8.** [Repealed, 1987 c 268 art 2 s 38]

**62E.13 ADMINISTRATION OF PLAN.**

*[For text of subds 1 to 8, see M.S.1986]*

**Subd. 9.** [Repealed, 1987 c 268 art 2 s 38]

**62E.14 ENROLLMENT BY AN ELIGIBLE PERSON.**

*[For text of subds 1 to 4, see M.S.1986]*

**Subd. 5. Terminated employees.** An employee who is voluntarily or involuntarily terminated or laid off from employment and unable to exercise the option to continue coverage under section 62A.17 may enroll, within 60 days of termination or layoff, with a waiver of the preexisting condition limitation set forth in subdivision 3 and a waiver of the evidence of rejection set forth in subdivision 1, paragraph (c).

**History:** 1987 c 337 s 70

**62E.18 HEALTH INSURANCE FOR RETIRED EMPLOYEES NOT ELIGIBLE FOR MEDICARE.**

A Minnesota resident who is age 65 or over and is not eligible for the health insurance benefits of the federal Medicare program is entitled to purchase the benefits of a qualified plan, one or two, offered by the Minnesota comprehensive health association without any of the limitations set forth in section 62E.14, subdivision 1, paragraph (c), and subdivision 3.

**History:** 1987 c 337 s 71