CHAPTER 62D

HEALTH MAINTENANCE ACT OF 1973

62D.041 PROTECTION IN THE EVENT OF INSOLVENCY.

Subdivision 1. **Definition.** (a) 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, and that are not guaranteed, insured, or assumed by a person other than the health maintenance organization.

(b) For purposes of this section, if a health maintenance organization offers supplemental benefits as described in section 62D.05, subdivision 6, "uncovered expenditures" excludes any expenditures attributable to the supplemental benefit.

[For text of subds 2 to 9, see M.S.1988]

Subd. 10. **Supplemental deposit.** A health maintenance organization offering supplemental benefits as described in section 62D.05, subdivision 6, must maintain an additional deposit in the first year such benefits are offered equal to $50,000. At the end of the second year such benefits are offered, the health maintenance organization must maintain an additional deposit equal to $150,000. At the end of the third year such benefits are offered and every year thereafter, the health maintenance organization must maintain an additional deposit of $250,000.

History: *1989 c 282 art 2 s 3,4*

62D.042 NET WORTH AND WORKING CAPITAL REQUIREMENTS.

Subdivision 1. **Definitions.** (a) For purposes of this section, "guaranteeing organization" means an organization that has agreed to make necessary contributions or advancements to the health maintenance organization to maintain the health maintenance organization's statutorily required net worth.

(b) For this section, "working capital" means current assets minus current liabilities.

(c) For purposes of this section, if a health maintenance organization offers supplemental benefits as described in section 62D.05, subdivision 6, "expenses" does not include any expenses attributable to the supplemental benefit.

[For text of subds 2 to 7, see M.S.1988]

History: *1989 c 282 art 2 s 5*

62D.05 POWERS OF HEALTH MAINTENANCE ORGANIZATIONS.

[For text of subds 1 to 5, see M.S.1988]

Subd. 6. **Supplemental benefits.** (a) 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. Supplemental benefits may be provided if the following conditions are met:

(1) a health maintenance organization desiring to offer supplemental benefits must at all times comply with the requirements of sections 62D.041 and 62D.042;

(2) a health maintenance organization offering supplemental benefits must maintain an additional surplus in the first year supplemental benefits are offered equal to the lesser of $500,000 or 33 percent of the supplemental benefit expenses. At the end of the second year supplemental benefits are offered, the health maintenance organization must maintain an additional surplus equal to the lesser of $1,000,000 or 33 percent of the supplemental benefit expenses. At the end of the third year benefits are offered and every year after that, the health maintenance organization must maintain an additional surplus equal to the greater of $1,000,000 or 33 percent of the supplemental benefit expenses. When in the judgment of the commissioner the health maintenance organization's surplus is inadequate, the commissioner may require the health maintenance organization to maintain additional surplus;

(3) claims relating to supplemental benefits must be processed in accordance with the requirements of section 72A.201; and

(4) in marketing supplemental benefits, the health maintenance organization shall fully disclose and describe to enrollees and potential enrollees the nature and extent of the supplemental coverage, and any claims filing and other administrative responsibilities in regard to supplemental benefits.

(b) 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 by addressing percentage of out-of-plan coverage; rules relating to the establishment of necessary financial reserves; 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.

History: *1989 c 282 art 2 s 6*

62D.104 REQUIRED OUT-OF-AREA CONVERSION.

Enrollees who have individual health maintenance organization contracts and who have become nonresidents of the health maintenance organization's service area but remain residents of the state of Minnesota shall be given the option, to be arranged by the health maintenance organization if an agreement with an insurer can reasonably be made, of a number three qualified plan, a number two qualified plan, or a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, or, if such enrollees are covered by title XVIII of the Social Security Act (Medicare), they shall be given the option of a Medicare supplement plan as provided by chapter 62A.

This option shall be made available at the enrollee's expense, without further evidence of insurability and without interruption of coverage.

If a health maintenance organization cannot make arrangements for conversion coverage, the health maintenance organization shall notify enrollees of health plans available in other service areas.

History: *1989 c 258 s 9*

62D.12 PROHIBITED PRACTICES.

[For text of subd 1, see M.S.1988]

Subd. 1a. **Swing-out products.** Notwithstanding subdivision 1, nothing in sections 62A.049, 62A.60, and 72A.20, subdivision 4a applies to a commercial health policy issued under this chapter as a companion to a health maintenance contract.

[For text of subds 2 to 16, see M.S.1988]

History: *1989 c 330 s 23*

62D.121 REQUIRED REPLACEMENT COVERAGE.

[For text of subds 1 and 2, see M.S.1988]

Subd. 3. If replacement coverage is not provided by the health maintenance organization, as explained under subdivision 2, the replacement coverage shall provide, for enrollees covered by title XVIII of the Social Security Act, coverage at least equivalent to a basic Medicare supplement plan as defined in section 62A.316, except that the replacement coverage shall also cover the liability for any Medicare part A and part B deductible as defined under title XVIII of the Social Security Act. After satisfaction of the Medicare part B deductible, the replacement coverage shall be based on 120 percent of the Medicare part B eligible expenses less the Medicare part B payment amount. The fee or premium of the replacement coverage shall not exceed the premium charged by the state comprehensive health plan as established under section 62E.08, for a qualified Medicare supplement plan. All enrollees not covered by Medicare shall be given the option of a number three qualified plan or a number two qualified plan as defined in section 62E.06, subdivisions 1 and 2, for replacement coverage. The fee or premium for a number three qualified plan shall not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number three qualified plan of insurance in force in Minnesota. The fee or premium for a number two qualified plan shall not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two qualified plan of insurance in force in Minnesota.

If the replacement coverage is health maintenance organization coverage, the fee shall not exceed 125 percent of the cost of the average fee charged by health maintenance organizations for a similar health plan. The commissioner of health will determine the average cost of the plan on the basis of information provided annually by the health maintenance organizations concerning the rates charged by the health maintenance organizations for the plans offered. Fees or premiums charged under this section must be actuarially justified.

[For text of subds 4 to 7, see M.S.1988]

History: *1989 c 258 s 10*

62D.181 INSOLVENCY; MCHA ALTERNATIVE COVERAGE.

[For text of subds 1 to 3, see M.S.1988]

Subd. 4. **Coverage.** Alternative coverage issued under this section must be at least a number two qualified plan, as described in section 62E.06, subdivision 2, or for individuals over age 65, a basic Medicare supplement plan, as described in section 62A.316.

[For text of subds 5 to 9, see M.S.1988]

History: *1989 c 258 s 11*