CHAPTER 62L

SMALL EMPLOYER INSURANCE REFORM

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62L.01 CITATION.

Subdivision 1. **Popular name.** Sections 62L.01 to 62L.23 may be cited as the Minnesota small employer health benefit act.

Subd. 2. **Jurisdiction.** Sections 62L.01 to 62L.23 apply to any health carrier that offers, issues, delivers, or renews a health benefit plan to a small employer.

Subd. 3. **Legislative findings and purpose.** The legislature finds that underwriting and rating practices in the individual and small employer markets for health coverage create substantial hardship and unfairness, create unnecessary administrative costs, and adversely affect the health of residents of this state. The legislature finds that the premium restrictions provided by this chapter reduce but do not eliminate these harmful effects. Accordingly, the legislature declares its desire to phase out the remaining rating bands as quickly as possible, with the end result of eliminating all rating practices based on risk by July 1, 1997.

History: *1992 c 549 art 2 s 1*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 1, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

62L.02 DEFINITIONS.

Subdivision 1. **Application.** The definitions in this section apply to sections 62L.01 to 62L.23.

Subd. 2. **Actuarial opinion.** "Actuarial opinion" means a written statement by a member of the American Academy of Actuaries that a health carrier is in compliance with this chapter, based on the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the health carrier in establishing premium rates for health benefit plans.

Subd. 3. **Association.** "Association" means the health coverage reinsurance association.

Subd. 4. **Base premium rate.** "Base premium rate" means as to a rating period, the lowest premium rate charged or which could have been charged under the rating system by the health carrier to small employers for health benefit plans with the same or similar coverage.

Subd. 5. **Board of directors.** "Board of directors" means the board of directors of the health coverage reinsurance association.

Subd. 6. **Case characteristics.** "Case characteristics" means the relevant characteristics of a small employer, as determined by a health carrier in accordance with this chapter, which are considered by the carrier in the determination of premium rates for the small employer.

Subd. 7. **Coinsurance.** "Coinsurance" means an established dollar amount or per-

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centage of health care expenses that an eligible employee or dependent is required to pay directly to a provider of medical services or supplies under the terms of a health benefit plan.

Subd. 8. **Commissioner.** "Commissioner" means the commissioner of commerce for health carriers subject to the jurisdiction of the department of commerce or the commissioner of health for health carriers subject to the jurisdiction of the department of health, or the relevant commissioner's designated representative.

Subd. 9. **Continuous coverage.** "Continuous coverage" means the maintenance of continuous and uninterrupted qualifying prior coverage by an eligible employee or dependent. An eligible employee or dependent is considered to have maintained continuous coverage if the individual requests enrollment in a health benefit plan within 30 days of termination of the qualifying prior coverage.

Subd. 10. **Deductible.** "Deductible" means the amount of health care expenses an eligible employee or dependent is required to incur before benefits are payable under a health benefit plan.

Subd. 11. **Dependent.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 19 years, unmarried child who is a full-time student under the age of 25 years as defined in section 62A.301 and financially dependent upon the eligible employee, or dependent child of any age who is handicapped and who meets the eligibility criteria in section 62A.14, subdivision 2. For the purpose of this definition, a child may include a child for whom the employee or the employee's spouse has been appointed legal guardian.

Subd. 12. **Eligible charges.** "Eligible charges" means the actual charges submitted to a health carrier by or on behalf of a provider, eligible employee, or dependent for health services covered by the health carrier's health benefit plan. Eligible charges do not include charges for health services excluded by the health benefit plan or charges for which an alternate health carrier is liable under the coordination of benefit provisions of the health benefit plan.

Subd. 13. **Eligible employee.** "Eligible employee" means an individual employed by a small employer for at least 20 hours per week and who has satisfied all employer participation and eligibility requirements, including, but not limited to, the satisfactory completion of a probationary period of not less than 30 days but no more than 90 days. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include employees who work on a temporary, seasonal, or substitute basis.

Subd. 14. **Financially impaired condition.** "Financially impaired condition" means a situation in which a health carrier is not insolvent, but (1) is considered by the commissioner to be potentially unable to fulfill its contractual obligations, or (2) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

Subd. 15. **Health benefit plan.** "Health benefit plan" means a policy, contract, or certificate issued by a health carrier to a small employer for the coverage of medical and hospital benefits. Health benefit plan includes a small employer plan. Health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense-incurred basis;

(5) credit accident and health insurance issued under chapter 62B;

(6) designed solely to provide dental or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident-only coverage;

(9) long-term care insurance as defined in section 62A.46;

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(10) issued as a supplement to Medicare, as defined in sections 62A.31 to 62A.44, or policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended through December 31, 1991; or

(11) workers' compensation insurance.

For the purpose of this chapter, a health benefit plan issued to employees of a small employer who meets the participation requirements of section 62L.03, subdivision 3, is considered to have been issued to a small employer. A health benefit plan issued on behalf of a health carrier is considered to be issued by the health carrier.

Subd. 16. **Health carrier.** "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; and a multiple employer welfare arrangement, as defined in United States Code, title 29, section 1002(40), as amended through December 31, 1991. For the purpose of this chapter, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that any insurance company or health service plan corporation that is an affiliate of a health maintenance organization located in Minnesota, or any health maintenance organization located in Minnesota that is an affiliate of an insurance company or health service plan corporation, or any health maintenance organization that is an affiliate of another health maintenance organization in Minnesota, may treat the health maintenance organization as a separate carrier.

Subd. 17. **Health plan.** "Health plan" means a health benefit plan issued by a health carrier, except that it may be issued:

(1) to a small employer;

(2) to an employer who does not satisfy the definition of a small employer as defined under subdivision 26; or

(3) to an individual purchasing an individual or conversion policy of health care coverage issued by a health carrier.

Subd. 18. **Index rate.** "Index rate" means as to a rating period for small employers the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

Subd. 19. **Late entrant.** "Late entrant" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period applicable to the employee or dependent under the terms of the health benefit plan, provided that the initial enrollment period must be a period of at least 30 days. However, an eligible employee or dependent must not be considered a late entrant if:

(1) the individual was covered under qualifying existing coverage at the time the individual was eligible to enroll in the health benefit plan, declined enrollment on that basis, and presents to the carrier a certificate of termination of the qualifying prior coverage, provided that the individual maintains continuous coverage;

(2) the individual has lost coverage under another group health plan due to the expiration of benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law Number 99-272, as amended, and any state continuation laws applicable to the employer or carrier, provided that the individual maintains continuous coverage;

(3) the individual is a new spouse of an eligible employee, provided that enrollment is requested within 30 days of becoming legally married;

(4) the individual is a new dependent child of an eligible employee, provided that enrollment is requested within 30 days of becoming a dependent;

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(5) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(6) a court has ordered that coverage be provided for a dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order.

Subd. 20. **MCHA.** "MCHA" means the Minnesota comprehensive health association established under section 62E.10.

Subd. 21. **Medical necessity.** "Medical necessity" means the appropriate and necessary medical and hospital services eligible for payment under a health benefit plan as determined by a health carrier.

Subd. 22. **Members.** "Members" means the health carriers operating in the small employer market who may participate in the association.

Subd. 23. **Preexisting condition.** "Preexisting condition" means a condition manifesting in a manner that causes an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage, or a pregnancy existing as of the effective date of coverage of a health benefit plan.

Subd. 24. **Qualifying prior coverage or qualifying existing coverage.** "Qualifying prior coverage" or "qualifying existing coverage" means health benefits or health coverage provided under:

(1) a health plan, as defined in this section;

(2) Medicare;

(3) medical assistance under chapter 256B;

(4) general assistance medical care under chapter 256D;

(5) MCHA;

(6) a self-insured health plan;

(7) the health right plan established under section 256.9352, when the plan includes inpatient hospital services as provided in section 256.9353;

(8) a plan provided under section 43A.316; or

(9) a plan similar to any of the above plans provided in this state or in another state as determined by the commissioner.

Subd. 25. **Rating period.** "Rating period" means the 12-month period for which premium rates established by a health carrier are assumed to be in effect, as determined by the health carrier. During the rating period, a health carrier may adjust the rate based on the prorated change in the index rate.

Subd. 26. **Small employer.** "Small employer" means a person, firm, corporation, partnership, association, or other entity actively engaged in business who, on at least 50 percent of its working days during the preceding calendar year, employed no fewer than two nor more than 29 eligible employees, the majority of whom were employed in this state. If a small employer has only two eligible employees, one employee must not be the spouse, child, sibling, parent, or grandparent of the other, except that a small employer plan may be offered through a domiciled association to self-employed individuals and small employers who are members of the association, even if the self-employed individual or small employer has fewer than two employees or the employees are family members. Entities that are eligible to file a combined tax return for purposes of state tax laws are considered a single employer for purposes of determining the number of eligible employees. Small employer status must be determined on an annual basis as of the renewal date of the health benefit plan. The provisions of this chapter continue to apply to an employer who no longer meets the requirements of this definition until the annual renewal date of the employer's health benefit plan. Where an association, described in section 62A.10, subdivision 1, comprised of employers contracts with a health carrier to provide coverage to its members who are small employers, the association may elect to be considered to be a small employer, even though the association pro-

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vides coverage to more than 29 employees of its members, so long as each employer that is provided coverage through the association qualifies as a small employer. An association's election to be considered a small employer under this section is not effective unless filed with the commissioner of commerce. The association may revoke its election at any time by filing notice of revocation with the commissioner.

Subd. 27. **Small employer market.** (a) "Small employer market" means the market for health benefit plans for small employers.

(b) A health carrier is considered to be participating in the small employer market if the carrier offers, sells, issues, or renews a health benefit plan to: (1) any small employer; or (2) the eligible employees of a small employer offering a health benefit plan if, with the knowledge of the health carrier, both of the following conditions are met:

(i) any portion of the premium or benefits is paid for or reimbursed by a small employer; and

(ii) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of the Internal Revenue Code, section 106, 125, or 162.

Subd. 28. **Small employer plan.** "Small employer plan" means a health benefit plan issued by a health carrier to a small employer for coverage of the medical and hospital benefits described in section 62L.05.

History: *1992 c 549 art 2 s 2*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 2, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

62L.03 AVAILABILITY OF COVERAGE.

Subdivision 1. **Guaranteed issue and reissue.** Every health carrier shall, as a condition of authority to transact business in this state in the small employer market, affirmatively market, offer, sell, issue, and renew any of its health benefit plans to any small employer as provided in this chapter. Every health carrier participating in the small employer market shall make available both of the plans described in section 62L.05 to small employers and shall fully comply with the underwriting and the rate restrictions specified in this chapter for all health benefit plans issued to small employers. A health carrier may cease to transact business in the small employer market as provided under section 62L.09.

Subd. 2. **Exceptions.** (a) No health maintenance organization is required to offer coverage or accept applications under subdivision 1 in the case of the following:

(1) with respect to a small employer, where the worksite of the employees of the small employer is not physically located in the health maintenance organization's approved service areas; or

(2) with respect to an employee, when the employee does not work or reside within the health maintenance organization's approved service areas.

(b) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subdivision 1 where the commissioner finds that the acceptance of an application or applications would place the small employer carrier in a financially impaired condition, provided, however, that a small employer carrier that has not offered coverage or accepted applications pursuant to this paragraph shall not offer coverage or accept applications for any health benefit plan until 180 days following a determination by the commissioner that the small employer carrier has ceased to be financially impaired.

Subd. 3. **Minimum participation.** (a) A small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan must be guaranteed coverage from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. A health carrier may not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdi-

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vision, waiver of coverage includes only waivers due to coverage under another group health plan.

(b) A health carrier may require that small employers contribute a specified minimum percentage toward the cost of the coverage of eligible employees, so long as the requirement is uniformly applied for all small employers. For the small employer plans, a health carrier must require that small employers contribute at least 50 percent of the cost of the coverage of eligible employees. The health carrier must impose this requirement on a uniform basis for both small employer plans and for all small employers.

(c) Nothing in this section obligates a health carrier to issue coverage to a small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer.

Subd. 4. **Underwriting restrictions.** Health carriers may apply underwriting restrictions to coverage for health benefit plans for small employers, including any preexisting condition limitations, only as expressly permitted under this chapter. Health carriers may collect information relating to the case characteristics and demographic composition of small employers, as well as health status and health history information about employees of small employers. Except as otherwise authorized for late entrants, preexisting conditions may be excluded by a health carrier for a period not to exceed 12 months from the effective date of coverage of an eligible employee or dependent. When calculating a preexisting condition limitation, a health carrier shall credit the time period an eligible employee or dependent was previously covered by qualifying prior coverage, provided that the individual maintains continuous coverage. Late entrants may be subject to a preexisting condition limitation not to exceed 18 months from the effective date of coverage of the late entrant. Late entrants may also be excluded from coverage for a period not to exceed 18 months, provided that if a health carrier imposes an exclusion from coverage and a preexisting condition limitation, the combined time period for both the coverage exclusion and preexisting condition limitation must not exceed 18 months.

Subd. 5. **Cancellations and failures to renew.** No health carrier shall cancel, decline to issue, or fail to renew a health benefit plan as a result of the claim experience or health status of the small employer group. A health carrier may cancel or fail to renew a health benefit plan:

(1) for nonpayment of the required premium;

(2) for fraud or misrepresentation by the small employer, or, with respect to coverage of an individual eligible employee or dependent, fraud or misrepresentation by the eligible employee or dependent, with respect to eligibility for coverage or any other material fact;

(3) if eligible employee participation during the preceding calendar year declines to less than 75 percent, subject to the waiver of coverage provision in subdivision 3;

(4) if the employer fails to comply with the minimum contribution percentage legally required by the health carrier;

(5) if the health carrier ceases to do business in the small employer market; or

(6) for any other reasons or grounds expressly permitted by the respective licensing laws and regulations governing a health carrier, including, but not limited to, service area restrictions imposed on health maintenance organizations under section 62D.03, subdivision 4, paragraph (m), to the extent that these grounds are not expressly inconsistent with this chapter.

Subd. 6. **MCHA enrollees.** Health carriers shall offer coverage to any eligible employee or dependent enrolled in MCHA at the time of the health carrier's issuance or renewal of a health benefit plan to a small employer. The health benefit plan must require that the employer permit MCHA enrollees to enroll in the small employer's health benefit plan as of the first date of renewal of a health benefit plan occurring on or after July 1, 1993, or, in the case of a new group, as of the initial effective date of the health benefit plan. Unless otherwise permitted by this chapter, health carriers must

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not impose any underwriting restrictions, including any preexisting condition limitations or exclusions, on any eligible employee or dependent previously enrolled in MCHA and transferred to a health benefit plan so long as continuous coverage is maintained, provided that the health carrier may impose any unexpired portion of a preexisting condition limitation under the person's MCHA coverage. An MCHA enrollee is not a late entrant, so long as the enrollee has maintained continuous coverage.

History: *1992 c 549 art 2 s 3*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 3, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

62L.04 COMPLIANCE REQUIREMENTS.

Subdivision 1. **Applicability of chapter requirements.** Beginning July 1, 1993, health carriers participating in the small employer market must offer and make available any health benefit plan that they offer, including both of the small employer plans provided in section 62L.05, to all small employers who satisfy the small employer participation requirements specified in this chapter. Compliance with these requirements is required as of the first renewal date of any small employer group occurring after July 1, 1993. For new small employer business, compliance is required as of the first date of offering occurring after July 1, 1993.

Compliance with these requirements is required as of the first renewal date occurring after July 1, 1994, with respect to employees of a small employer who had been issued individual coverage prior to July 1, 1993, administered by the health carrier on a group basis. Notwithstanding any other law to the contrary, the health carrier shall terminate any individual coverage for employees of small employers who satisfy the small employer participation requirements specified in section 62L.03 and offer to replace it with a health benefit plan. If the employer elects not to purchase a health benefit plan, the health carrier must offer all covered employees and dependents the option of maintaining their current coverage, administered on an individual basis, or replacement individual coverage. Small employer and replacement individual coverage provided under this subdivision must be without application of underwriting restrictions, provided continuous coverage is maintained.

Subd. 2. **New carriers.** A health carrier entering the small employer market after July 1, 1993, shall begin complying with the requirements of this chapter as of the first date of offering of a health benefit plan to a small employer. A health carrier entering the small employer market after July 1, 1993, is considered to be a member of the health coverage reinsurance association as of the date of the health carrier's initial offer of a health benefit plan to a small employer.

History: *1992 c 549 art 2 s 4*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 4, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

62L.05 SMALL EMPLOYER PLAN BENEFITS.

Subdivision 1. **Two small employer plans.** Each health carrier in the small employer market must make available to any small employer both of the small employer plans described in subdivisions 2 and 3. Under subdivisions 2 and 3, coinsurance and deductibles do not apply to child health supervision services and prenatal services, as defined by section 62A.047. The maximum out-of-pocket costs for covered services must be $3,000 per individual and $6,000 per family per year. The maximum lifetime benefit must be $500,000. The out-of-pocket cost limits and the deductible amounts provided in subdivision 2 must be adjusted on July 1 every two years, based upon changes in the consumer price index, as of the end of the previous calendar year, as determined by the commissioner of commerce. Adjustments must be in increments of $50 and must not be made unless at least that amount of adjustment is required.

Subd. 2. **Deductible-type small employer plan.** The benefits of the deductible-type small employer plan offered by a health carrier must be equal to 80 percent of the eligible charges for health care services, supplies, or other articles covered under the small

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employer plan, in excess of an annual deductible which must be $500 per individual and $1,000 per family.

Subd. 3. **Copayment-type small employer plan.** The benefits of the copayment-type small employer plan offered by a health carrier must be equal to 80 percent of the eligible charges for health care services, supplies, or other articles covered under the small employer plan, in excess of the following copayments:

(1) $15 per outpatient visit, other than to a hospital outpatient department or emergency room, urgent care center, or similar facility;

(2) $15 per day for the services of a home health agency or private duty registered nurse;

(3) $50 per outpatient visit to a hospital outpatient department or emergency room, urgent care center, or similar facility; and

(4) $300 per inpatient admission to a hospital.

Subd. 4. **Benefits.** The medical services and supplies listed in this subdivision are the benefits that must be covered by the small employer plans described in subdivisions 2 and 3:

(1) inpatient and outpatient hospital services, excluding services provided for the diagnosis, care, or treatment of chemical dependency or a mental illness or condition, other than those conditions specified in clauses (10), (11), and (12);

(2) physician and nurse practitioner services for the diagnosis or treatment of illnesses, injuries, or conditions;

(3) diagnostic X-rays and laboratory tests;

(4) ground transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, or as otherwise required by the health carrier;

(5) services of a home health agency if the services qualify as reimbursable services under Medicare and are directed by a physician or qualify as reimbursable under the health carrier's most commonly sold health plan for insured group coverage;

(6) services of a private duty registered nurse if medically necessary, as determined by the health carrier;

(7) the rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;

(8) child health supervision services up to age 18, as defined in section 62A.047;

(9) maternity and prenatal care services, as defined in sections 62A.041 and 62A.047;

(10) inpatient hospital and outpatient services for the diagnosis and treatment of certain mental illnesses or conditions, as defined by the International Classification of Diseases-Clinical Modification (ICD-9-CM), seventh edition (1990) and as classified as ICD-9 codes 295 to 299;

(11) ten hours per year of outpatient mental health diagnosis or treatment for illnesses or conditions not described in clause (10);

(12) 60 hours per year of outpatient treatment of chemical dependency; and

(13) 50 percent of eligible charges for prescription drugs, up to a separate annual maximum out-of-pocket expense of $1,000 per individual for prescription drugs, and 100 percent of eligible charges thereafter.

Subd. 5. **Plan variations.** (a) No health carrier shall offer to a small employer a health benefit plan that differs from the two small employer plans described in subdivisions 1 to 4, unless the health benefit plan complies with all provisions of chapters 62A, 62C, 62D, 62E, 62H, and 64B that otherwise apply to the health carrier, except as expressly permitted by paragraph (b).

(b) As an exception to paragraph (a), a health benefit plan is deemed to be a small employer plan and to be in compliance with paragraph (a) if it differs from one of the two small employer plans described in subdivisions 1 to 4 only by providing benefits in addition to those described in subdivision 4, provided that the health care benefit

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plan has an actuarial value that exceeds the actuarial value of the benefits described in subdivision 4 by no more than two percent. "Benefits in addition" means additional units of a benefit listed in subdivision 4 or one or more benefits not listed in subdivision 4.

Subd. 6. **Choice products exception.** Nothing in subdivision 1 prohibits a health carrier from offering a small employer plan which provides for different benefit coverages based on whether the benefit is provided through a primary network of providers or through a secondary network of providers so long as the benefits provided in the primary network equal the benefit requirements of the small employer plan as described in this section. For purposes of products issued under this subdivision, out-of-pocket costs in the secondary network may exceed the out-of-pocket limits described in subdivision 1.

Subd. 7. **Benefit exclusions.** No medical, hospital, or other health care benefits, services, supplies, or articles not expressly specified in subdivision 4 are required to be included in a small employer plan. Nothing in subdivision 4 restricts the right of a health carrier to restrict coverage to those services, supplies, or articles which are medically necessary. Health carriers may exclude a benefit, service, supply, or article not expressly specified in subdivision 4 from a small employer plan.

Subd. 8. **Continuation coverage.** Small employer plans must include the continuation of coverage provisions required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law Number 99-272, as amended through December 31, 1991, and by state law.

Subd. 9. **Dependent coverage.** Other state law and rules applicable to health plan coverage of newborn infants, dependent children who do not reside with the eligible employee, handicapped children and dependents, and adopted children apply to a small employer plan. Health benefit plans that provide dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02.

Subd. 10. **Medical expense reimbursement.** Health carriers may reimburse or pay for medical services, supplies, or articles provided under a small employer plan in accordance with the health carrier's provider contract requirements including, but not limited to, salaried arrangements, capitation, the payment of usual and customary charges, fee schedules, discounts from fee-for-service, per diems, diagnostic-related groups (DRGs), and other payment arrangements. Nothing in this chapter requires a health carrier to develop, implement, or change its provider contract requirements for a small employer plan. Coinsurance, deductibles, out-of-pocket maximums, and maximum lifetime benefits must be calculated and determined in accordance with each health carrier's standard business practices.

Subd. 11. **Plan design.** Notwithstanding any other law, regulation, or administrative interpretation to the contrary, health carriers may offer small employer plans through any provider arrangement, including, but not limited to, the use of open, closed, or limited provider networks. A health carrier may only use product and network designs currently allowed under existing statutory requirements. The provider networks offered by any health carrier may be specifically designed for the small employer market and may be modified at the carrier's election so long as all otherwise applicable regulatory requirements are met. Health carriers may use professionally recognized provider standards of practice when they are available, and may use utilization management practices otherwise permitted by law, including, but not limited to, second surgical opinions, prior authorization, concurrent and retrospective review, referral authorizations, case management, and discharge planning. A health carrier may contract with groups of providers with respect to health care services or benefits, and may negotiate with providers regarding the level or method of reimbursement provided for services rendered under a small employer plan.

Subd. 12. **Demonstration projects.** Nothing in this chapter prohibits a health maintenance organization from offering a demonstration project authorized under section 62D.30. The commissioner of health may approve a demonstration project which offers benefits that do not meet the requirements of a small employer plan if the commissioner finds that the requirements of section 62D.30 are otherwise met.

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History: *1992 c 549 art 2 s 5*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 5, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

62L.06 DISCLOSURE OF UNDERWRITING RATING PRACTICES.

When offering or renewing a health benefit plan, health carriers shall disclose in all solicitation and sales materials:

(1) the case characteristics and other rating factors used to determine initial and renewal rates;

(2) the extent to which premium rates for a small employer are established or adjusted based upon actual or expected variation in claim experience;

(3) provisions concerning the health carrier's right to change premium rates and the factors other than claim experience that affect changes in premium rates;

(4) provisions relating to renewability of coverage;

(5) the use and effect of any preexisting condition provisions, if permitted; and

(6) the application of any provider network limitations and their effect on eligibility for benefits.

History: *1992 c 549 art 2 s 6*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 6, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

62L.07 SMALL EMPLOYER REQUIREMENTS.

Subdivision 1. **Verification of eligibility.** Health benefit plans must require that small employers offering a health benefit plan maintain information verifying the continuing eligibility of the employer, its employees, and their dependents, and provide the information to health carriers on a quarterly basis or as reasonably requested by the health carrier.

Subd. 2. **Waivers.** Health benefit plans must require that small employers offering a health benefit plan maintain written documentation of a waiver of coverage by an eligible employee or dependent and provide the documentation to the health carrier upon reasonable request.

History: *1992 c 549 art 2 s 7*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 7, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

62L.08 RESTRICTIONS RELATING TO PREMIUM RATES.

Subdivision 1. **Rate restrictions.** Premium rates for all health benefit plans sold or issued to small employers are subject to the restrictions specified in this section.

Subd. 2. **General premium variations.** Beginning July 1, 1993, each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the index rate charged to small employers for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this subdivision must be based only on health status, claims experience, industry of the employer, and duration of coverage from the date of issue. For purposes of this subdivision, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined to be actuarially valid and approved by the commissioner.

Subd. 3. **Age-based premium variations.** Beginning July 1, 1993, each health carrier may offer premium rates to small employers that vary based upon the ages of the eligible employees and dependents of the small employer only as provided in this subdivision. In addition to the variation permitted by subdivision 2, each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

Subd. 4. **Geographic premium variations.** A health carrier may request approval by

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the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than 20 percent. The commissioner may grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;

(3) if one geographic region is rural, the index rate for the rural region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area;

(4) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

Subd. 5. **Gender-based rates prohibited.** Beginning July 1, 1993, no health carrier may determine premium rates through a method that is in any way based upon the gender of eligible employees or dependents.

Subd. 6. **Rate cells permitted.** Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based on the number of adults and children covered under the policy and may reflect the availability of Medicare coverage.

Subd. 7. **Index and premium rate development.** In developing its index rates and premiums, a health carrier may take into account only the following factors:

(1) actuarially valid differences in benefit designs of health benefit plans;

(2) actuarially valid differences in the rating factors permitted in subdivisions 2 and 3;

(3) actuarially valid geographic variations if approved by the commissioner as provided in subdivision 4.

Subd. 8. **Filing requirement.** No later than July 1, 1993, and each year thereafter, a health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates.

Subd. 9. **Effect of assessments.** Premium rates must comply with the rating requirements of this section, notwithstanding the imposition of any assessments or premiums paid by health carriers as provided under sections 62L.13 to 62L.22.

Subd. 10. **Rating report.** Beginning January 1, 1995, and annually thereafter, the commissioners of health and commerce shall provide a joint report to the legislature on the effect of the rating restrictions required by this section and the appropriateness of proceeding with additional rate reform. Each report must include an analysis of the availability of health care coverage due to the rating reform, the equitable and appropriate distribution of risk and associated costs, the effect on the self-insurance market, and any resulting or anticipated change in health plan design and market share and availability of health carriers.

History: *1992 c 549 art 2 s 8*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 8, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

62L.09 CESSATION OF SMALL EMPLOYER BUSINESS.

Subdivision 1. **Notice to commissioner.** A health carrier electing to cease doing business in the small employer market shall notify the commissioner 180 days prior to the effective date of the cessation. The cessation of business does not include the failure of a health carrier to offer or issue new business in the small employer market or continue an existing product line, provided that a health carrier does not terminate, cancel, or fail to renew its current small employer business or other product lines.

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Subd. 2. **Notice to employers.** A health carrier electing to cease doing business in the small employer market shall provide 120 days' written notice to each small employer covered by a health benefit plan issued by the health carrier. A health carrier that ceases to write new business in the small employer market shall continue to be governed by this chapter with respect to continuing small employer business conducted by the carrier.

Subd. 3. **Reentry prohibition.** A health carrier that ceases to do business in the small employer market after July 1, 1993, is prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the commissioner. This subdivision applies to any health maintenance organization that ceases to do business in the small employer market in one service area with respect to that service area only. Nothing in this subdivision prohibits an affiliated health maintenance organization from continuing to do business in the small employer market in that same service area.

Subd. 4. **Continuing assessment liability.** A health carrier that ceases to do business in the small employer market remains liable for assessments levied by the association as provided in section 62L.22.

History: *1992 c 549 art 2 s 9*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 9, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

62L.10 SUPERVISION BY COMMISSIONER.

Subdivision 1. **Reports.** A health carrier doing business in the small employer market shall file by April 1 of each year an annual actuarial opinion with the commissioner certifying that the health carrier complied with the underwriting and rating requirements of this chapter during the preceding year and that the rating methods used by the health carrier were actuarially sound. A health carrier shall retain a copy of the opinion at its principal place of business.

Subd. 2. **Records.** A health carrier doing business in the small employer market shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

Subd. 3. **Submissions to commissioner.** Subsequent to the annual filing, the commissioner may request information and documentation from a health carrier describing its rating practices and renewal underwriting practices, including information and documentation that demonstrates that a health carrier's rating methods and practices are in accordance with sound actuarial principles and the requirements of this chapter. Except in cases of violations of this chapter or of another chapter, information received by the commissioner as provided under this subdivision is nonpublic.

Subd. 4. **Review of premium rates.** The commissioner shall regulate premium rates charged or proposed to be charged by all health carriers in the small employer market under section 62A.02. The commissioner of health has, with respect to carriers under that commissioner's jurisdiction, all of the powers of the commissioner of commerce under that section.

Subd. 5. **Transitional practices.** The commissioner shall disapprove index rates, premium variations, or other practices of a health carrier if they violate the spirit of this chapter and are the result of practices engaged in by the health carrier between April 23, 1992, and July 1, 1993, where the practices engaged in were carried out for the purpose of evading the spirit of this chapter. Each health carrier shall report to the commissioner, within 30 days and on a form prescribed by the commissioner, each cancellation, nonrenewal, or other termination of coverage of a small employer between April 23, 1992, and June 30, 1993. The health carrier shall provide any related information requested by the commissioner within the time specified in the request. Any health carrier that engages in a practice of terminating or inducing termination of coverage

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of small employers in order to evade the effects of Laws 1992, chapter 549, is guilty of an unfair method of competition and an unfair or deceptive act or practice in the business of insurance and is subject to the remedies provided in sections 72A.17 to 72A.32.

History: *1992 c 549 art 2 s 10*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 10, is effective July 1, 1993, except subdivision 5 is effective April 24, 1992. See Laws 1992, chapter 549, article 2, section 25.

62L.11 PENALTIES AND ENFORCEMENT.

Subdivision 1. **Disciplinary proceedings.** The commissioner may, by order, suspend or revoke a health carrier's license or certificate of authority and impose a monetary penalty not to exceed $25,000 for each violation of this chapter, including the failure to pay an assessment required by section 62L.22. The notice, hearing, and appeal procedures specified in section 60A.051 or 62D.16, as appropriate, apply to the order. The order is subject to judicial review as provided under chapter 14.

Subd. 2. **Enforcement powers.** The commissioners of health and commerce each has for purposes of this chapter all of each commissioner's respective powers under other chapters that are applicable to their respective duties under this chapter.

History: *1992 c 549 art 2 s 11*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 11, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

62L.12 PROHIBITED PRACTICES.

Subdivision 1. **Prohibition on issuance of individual policies.** A health carrier operating in the small employer market shall not knowingly offer, issue, or renew an individual policy, subscriber contract, or certificate to an eligible employee or dependent of a small employer that meets the minimum participation requirements defined in section 62L.03, subdivision 3, except as authorized under subdivision 2.

Subd. 2. **Exceptions.** (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees and dependents otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees and dependents otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees and dependents.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees and dependents as required.

(e) A health carrier may sell, issue, or renew individual coverage if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group coverage or due to the person's need for health care services not covered under the employer's group policy.

(f) A health carrier may sell, issue, or renew an individual policy, with the prior consent of the commissioner, if the individual has elected to buy the individual coverage not as part of a general plan to substitute individual coverage for group coverage nor as a result of any violation of subdivision 3 or 4.

(g) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

Subd. 3. **Agent's licensure.** An agent licensed under chapter 60A or section 62C.17 who knowingly and willfully breaks apart a small group for the purpose of selling individual policies to eligible employees and dependents of a small employer that meets the participation requirements of section 62L.03, subdivision 3, is guilty of an unfair trade practice and subject to the revocation or suspension of license under section 60A.17, subdivision 6c, or 62C.17. The action must be by order and subject to the notice, hear-

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ing, and appeal procedures specified in section 60A.17, subdivision 6d. The action of the commissioner is subject to judicial review as provided under chapter 14.

Subd. 4. **Employer prohibition.** A small employer shall not encourage or direct an employee or applicant to:

(1) refrain from filing an application for health coverage when other similarly situated employees may file an application for health coverage;

(2) file an application for health coverage during initial eligibility for coverage, the acceptance of which is contingent on health status, when other similarly situated employees may apply for health coverage, the acceptance of which is not contingent on health status;

(3) seek coverage from another carrier, including, but not limited to, MCHA; or

(4) cause coverage to be issued on different terms because of the health status or claims experience of that person or the person's dependents.

Subd. 5. **Sale of other products.** A health carrier shall not condition the offer, sale, issuance, or renewal of a health benefit plan on the purchase by a small employer of other insurance products offered by the health carrier or a subsidiary or affiliate of the health carrier, including, but not limited to, life, disability, property, and general liability insurance. This prohibition does not apply to insurance products offered as a supplement to a health maintenance organization plan, including, but not limited to, supplemental benefit plans under section 62D.05, subdivision 6.

History: *1992 c 549 art 2 s 12*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 12, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

62L.13 REINSURANCE ASSOCIATION.

Subdivision 1. **Creation.** The health coverage reinsurance association is established as a nonprofit corporation. All health carriers in the small employer market shall be and remain members of the association as a condition of their authority to transact business.

Subd. 2. **Purpose.** The association is established to provide for the fair and equitable transfer of risk associated with participation by a health carrier in the small employer market to a private reinsurance pool established and maintained by the association.

Subd. 3. **Exemptions.** The association, its transactions, and all property owned by it are exempt from taxation under the laws of this state or any of its subdivisions, including, but not limited to, income tax, sales tax, use tax, and property tax. The association may seek exemption from payment of all fees and taxes levied by the federal government. Except as otherwise provided in this chapter, the association is not subject to the provisions of chapters 13, 14, 60A, 62A to 62H, and section 471.705. The association is not a public employer and is not subject to the provisions of chapters 179A and 353. Health carriers who are members of the association are exempt from the provisions of sections 325D.49 to 325D.66 in the performance of their duties as members of the association.

Subd. 4. **Powers of association.** The association may exercise all of the powers of a corporation formed under chapter 317A, including, but not limited to, the authority to:

(1) establish operating rules, conditions, and procedures relating to the reinsurance of members' risks;

(2) assess members in accordance with the provisions of this section and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses;

(3) sue and be sued, including taking any legal action necessary to recover any assessments;

(4) enter into contracts necessary to carry out the provisions of this chapter;

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(5) establish operating, administrative, and accounting procedures for the operation of the association; and

(6) borrow money against the future receipt of premiums and assessments up to the amount of the previous year's assessment, with the prior approval of the commissioner.

The provisions of this chapter govern if the provisions of chapter 317A conflict with this chapter. The association shall adopt bylaws and shall be governed in accordance with this chapter and chapter 317A.

Subd. 5. **Supervision by commissioner.** The commissioner of commerce shall supervise the association in accordance with this chapter. The commissioner of commerce may examine the association. The association's reinsurance policy forms, its contracts, its premium rates, and its assessments are subject to the approval of the commissioner of commerce. The association's policy forms, contracts, and premium rates are deemed approved if not disapproved by the commissioner of commerce within 60 days after the date of filing them with the commissioner of commerce. The association's assessments are deemed approved if not disapproved by the commissioner of commerce within 15 business days after filing them with the commissioner of commerce. The association shall notify the commissioner of all association or board meetings, and the commissioner or the commissioner's designee may attend all association or board meetings. The association shall file an annual report with the commissioner on or before July 1 of each year, beginning July 1, 1994, describing its activities during the preceding calendar year. The report must include a financial report and a summary of claims paid by the association. The annual report must be available for public inspection.

History: *1992 c 549 art 2 s 13*

62L.14 BOARD OF DIRECTORS.

Subdivision 1. **Composition of board.** The association shall exercise its powers through a board of 13 directors. Four members must be public members appointed by the commissioner. The public members must not be employees of or otherwise affiliated with any member of the association. The nonpublic members of the board must be representative of the membership of the association and must be officers, employees, or directors of the members during their term of office. No member of the association may have more than three members of the board. Directors are automatically removed if they fail to satisfy this qualification.

Subd. 2. **Election of board.** On or before July 1, 1992, the commissioner shall appoint an interim board of directors of the association who shall serve through the first annual meeting of the members and for the next two years. Except for the public members, the commissioner's initial appointments must be equally apportioned among the following three categories: accident and health insurance companies, nonprofit health service plan corporations, and health maintenance organizations. Thereafter, members of the association shall elect the board of directors in accordance with this chapter and the bylaws of the association, subject to approval by the commissioner. Members of the association may vote in person or by proxy. The public members shall continue to be appointed by the commissioner.

Subd 3. **Term of office.** The first annual meeting must be held by December 1, 1992. After the initial two-year period, each director shall serve a three-year term, except that the board shall make appropriate arrangements to stagger the terms of the board members so that approximately one-third of the terms expire each year. Each director shall hold office until expiration of the director's term or until the director's successor is duly elected or appointed and qualified, or until the director's death, resignation, or removal.

Subd. 4. **Resignation and removal.** A director may resign at any time by giving written notice to the commissioner. The resignation takes effect at the time the resignation is received unless the resignation specifies a later date. A nonpublic director may be removed at any time, with cause, by the members.

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Subd. 5. **Quorum.** A majority of the members of the board of directors constitutes a quorum for the transaction of business. If a vacancy exists by reason of death, resignation, or otherwise, a majority of the remaining directors constitutes a quorum.

Subd. 6. **Duties of directors.** The board of directors shall adopt or amend the association's bylaws. The bylaws may contain any provision for the purpose of administering the association that is not inconsistent with this chapter. The board shall manage the association in furtherance of its purposes and as provided in its bylaws. On or before January 1, 1993, the board or the interim board shall develop a plan of operation and reasonable operating rules to assure the fair, reasonable, and equitable administration of the association. The plan of operation must include the development of procedures for selecting an administering carrier, establishment of the powers and duties of the administering carrier, and establishment of procedures for collecting assessments from members, including the imposition of interest penalties for late payments of assessments. The plan of operation must be submitted to the commissioner for review and approval and must be submitted to the members for approval at the first meeting of the members. The board of directors may subsequently amend, change, or revise the plan of operation without approval by the members.

Subd. 7. **Compensation.** Members of the board may be reimbursed by the association for reasonable and necessary expenses incurred by them in performing their duties as directors, but shall not otherwise be compensated by the association for their services.

Subd. 8. **Officers.** The board may elect officers and establish committees as provided in the bylaws of the association. Officers have the authority and duties in the management of the association as prescribed by the bylaws and determined by the board of directors.

Subd. 9. **Majority vote.** Approval by a majority of the board members present is required for any action of the board. The majority vote must include one vote from a board member representing an accident and health insurance company, one vote from a board member representing a health service plan corporation, one vote from a board member representing a health maintenance organization, and one vote from a public member.

History: *1992 c 549 art 2 s 14*

62L.15 MEMBERS.

Subdivision 1. **Annual meeting.** The association shall conduct an annual meeting of the members of the association for the purpose of electing directors and transacting any other appropriate business of the membership of the association. The board shall determine the date, time, and place of the annual meeting. The association shall conduct its first annual member meeting on or before December 1, 1992.

Subd. 2. **Special meetings.** Special meetings of the members must be held whenever called by any three of the directors. At least two categories must be represented among the directors calling a special meeting of the members. The categories are accident and health insurance companies, nonprofit health service plan corporations, and health maintenance organizations. Special meetings of the members must be held at a time and place designated in the notice of the meeting.

Subd. 3. **Member voting.** Each member's vote is a weighted vote and is based on each member's total insurance premiums, subscriber contract charges, health maintenance contract payments, or other health benefit plan revenue derived from, or on behalf of, small employers during the preceding calendar year, as determined by the board and approved by the commissioner, based on annual statements and other reports considered necessary by the board of directors.

Subd. 4. **Initial member meeting.** At least 60 days before the first annual meeting of the members, the commissioner shall give written notice to all members of the time and place of the member meeting. The members shall elect directors representing the members, approve the initial plan of operation of the association, and transact any other appropriate business of the membership of the association.

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Subd. 5. **Member compliance.** All members shall comply with the provisions of this chapter, the association's bylaws, the plan of operation developed by the board of directors, and any other operating, administrative, or other procedures established by the board of directors for the operation of the association. The board may request the commissioner to secure compliance with this chapter through the use of any enforcement action otherwise available to the commissioner.

History: *1992 c 549 art 2 s 15*

62L.16 ADMINISTRATION OF ASSOCIATION.

Subdivision 1. **Administrator.** The association shall contract with a qualified entity to operate and administer the association. If there is no available qualified entity, or in the event of a termination under subdivision 2, the association may directly operate and administer the reinsurance program. The administrator shall perform all administrative functions required by this chapter. The board of directors shall develop administrative functions required by this chapter and written criteria for the selection of an administrator. The administrator must be selected by the board of directors, subject to approval by the commissioner.

Subd. 2. **Term.** The administrator shall serve for a period of three years, unless the administrator requests the termination of its contract and the termination is approved by the board of directors. The board of directors shall approve or deny a request to terminate within 90 days of its receipt after consultation with the commissioner. A failure to make a final decision on a request to terminate within 90 days is considered an approval.

Subd. 3. **Duties of administrator.** The association shall enter into a written contract with the administrator to carry out its duties and responsibilities. The administrator shall perform all administrative functions required by this chapter including the:

(1) preparation and submission of an annual report to the commissioner;

(2) preparation and submission of monthly reports to the board of directors;

(3) calculation of all assessments and the notification thereof of members;

(4) payment of claims to health carriers following the submission by health carriers of acceptable claim documentation; and

(5) provision of claim reports to health carriers as determined by the board of directors.

Subd. 4. **Bid process.** The association shall issue a request for proposal for administration of the reinsurance association and shall solicit responses from health carriers participating in the small employer market and from other qualified entities. Methods of compensation of the administrator must be a part of the bid process. The administrator shall substantiate its cost reports consistent with generally accepted accounting principles.

Subd. 5. **Audits.** The board of directors may conduct periodic audits to verify the accuracy of financial data and reports submitted by the administrator.

Subd. 6. **Records of association.** The association shall maintain appropriate records and documentation relating to the activities of the association. All individual patient-identifying claims data and information are confidential and not subject to disclosure of any kind, except that a health carrier shall have access upon request to individual claims data relating to eligible employees and dependents covered by a health benefit plan issued by the health carrier. All records, documents, and work product prepared by the association or by the administrator for the association are the property of the association. The commissioner shall have access to the data for the purposes of carrying out the supervisory functions provided for in this chapter.

History: *1992 c 549 art 2 s 16*

62L.17 PARTICIPATION IN THE REINSURANCE ASSOCIATION.

Subdivision 1. **Minimum standards.** The board of directors or the interim board

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shall establish minimum claim processing and managed care standards which must be met by a health carrier in order to reinsure business.

Subd. 2. **Participation.** A health carrier may elect to not participate in the reinsurance association through transferring risk only after filing an application with the commissioner of commerce. The commissioner may approve the application after consultation with the board of directors. In determining whether to approve an application, the commissioner shall consider whether the health carrier meets the following standards:

(1) demonstration by the health carrier of a substantial and established market presence;

(2) demonstrated experience in the small group market and history of rating and underwriting small employer groups;

(3) commitment to comply with the requirements of this chapter for small employers in the state or its service area; and

(4) financial ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance.

Initial application for nonparticipation must be filed with the commissioner no later than February 1993. The commissioner shall make the determination and notify the carrier no later than April 15, 1993.

Subd. 3. **Length of participation.** A health carrier's initial election is for a period of two years. Subsequent elections of participation are for five-year periods.

Subd. 4. **Appeal.** A health carrier whose application for nonparticipation has been rejected by the commissioner may appeal the decision. The association may also appeal a decision of the commissioner, if approved by a two-thirds majority of the board. Chapter 14 applies to all appeals.

Subd. 5. **Annual certification.** A health carrier that has received approval to not participate in the reinsurance association shall annually certify to the commissioner on or before December 1 that it continues to meet the standards described in subdivision 2.

Subd. 6. **Subsequent election.** Election to participate in the reinsurance association must occur on or before December 31 of each year. If after a period of nonparticipation, the nonparticipating health carrier subsequently elects to participate in the reinsurance association, the health carrier retains the risk it assumed when not participating in the association.

If a participating health carrier subsequently elects to not participate in the reinsurance association, the health carrier shall cease reinsuring through the association all of its small employer business and is liable for any assessment described in section 62L.22 which has been prorated based on the business covered by the reinsurance mechanism during the year of the assessment.

Subd. 7. **Election modification.** The commissioner, after consultation with the board, may authorize a health carrier to modify its election to not participate in the association at any time, if the risk from the carrier's existing small employer business jeopardizes the financial condition of the health carrier. If the commissioner authorizes a health carrier to participate in the association, the health carrier shall retain the risk it assumed while not participating in the association. This election option may not be exercised if the health carrier is in rehabilitation.

History: *1992 c 549 art 2 s 17*

62L.18 CEDING OF RISK.

Subdivision 1. **Prospective ceding.** For health benefit plans issued on or after July 1, 1993, all health carriers participating in the association may prospectively reinsure an employee or dependent within a small employer group and entire employer groups of seven or fewer eligible employees. A health carrier must determine whether to reinsure an employee or dependent or entire group within 60 days of the commencement

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of the coverage of the small employer and must notify the association during that time period.

Subd. 2. **Eligibility for reinsurance.** A health carrier may not reinsure existing small employer business through the association. A health carrier may reinsure an employee or dependent who previously had coverage from MCHA who is now eligible for coverage through the small employer group at the time of enrollment as defined in section 62L.03, subdivision 6. A health carrier may not reinsure individuals who have existing individual health care coverage with that health carrier upon replacement of the individual coverage with group coverage as provided in section 62L.04, subdivision 1.

Subd. 3. **Reinsurance termination.** A health carrier may terminate reinsurance through the association for an employee or dependent or entire group on the anniversary date of coverage for the small employer. If the health carrier terminates the reinsurance, the health carrier may not subsequently reinsure the individual or entire group.

Subd. 4. **Continuing carrier responsibility.** A health carrier transferring risk to the association is completely responsible for administering its health benefit plans. A health carrier shall apply its case management and claim processing techniques consistently between reinsured and nonreinsured business. Small employers, eligible employees, and dependents shall not be notified that the health carrier has reinsured their coverage through the association.

History: *1992 c 549 art 2 s 18*

62L.19 ALLOWED REINSURANCE BENEFITS.

A health carrier may reinsure through the association only those benefits described in section 62L.05.

History: *1992 c 549 art 2 s 19*

62L.20 TRANSFER OF RISK.

Subdivision 1. **Reinsurance threshold.** A health carrier participating in the association may transfer up to 90 percent of the risk above a reinsurance threshold of $5,000 of eligible charges resulting from issuance of a health benefit plan to an eligible employee or dependent of a small employer group whose risk has been prospectively ceded to the association. If the eligible charges exceed $50,000, a health carrier participating in the association may transfer 100 percent of the risk each policy year not to exceed 12 months.

Satisfaction of the reinsurance threshold must be determined by the board of directors based on eligible charges. The board may establish an audit process to assure consistency in the submission of charge calculations by health carriers to the association.

Subd. 2. **Conversion factors.** The board shall establish a standardized conversion table for determining equivalent charges for health carriers that use alternative provider reimbursement methods. If a health carrier establishes to the board that the carrier's conversion factor is equivalent to the association's standardized conversion table, the association shall accept the health carrier's conversion factor.

Subd. 3. **Board authority.** The board shall establish criteria for changing the threshold amount or retention percentage. The board shall review the criteria on an annual basis. The board shall provide the members with an opportunity to comment on the criteria at the time of the annual review.

Subd. 4. **Notification of transfer of risk.** A participating health carrier must notify the association, within 90 days of receipt of proof of loss, of satisfaction of a reinsurance threshold. After satisfaction of the reinsurance threshold, a health carrier continues to be liable to its providers, eligible employees, and dependents for payment of claims in accordance with the health carrier's health benefit plan. Health carriers shall not pend or delay payment of otherwise valid claims due to the transfer of risk to the association.

Subd. 5. **Periodic studies.** The board shall, on a biennial basis, prepare and submit a report to the commissioner of commerce on the effect of the reinsurance association

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on the small employer market. The first study must be presented to the commissioner no later than January 1, 1995, and must specifically address whether there has been disruption in the small employer market due to unnecessary churning of groups for the purpose of obtaining reinsurance and whether it is appropriate for health carriers to transfer the risk of their existing small group business to the reinsurance association. After two years of operation, the board shall study both the effect of ceding both individuals and entire small groups of seven or fewer eligible employees to the reinsurance association and the composition of the board and determine whether the initial appointments reflect the types of health carriers participating in the reinsurance association and whether the voting power of members of the association should be weighted and recommend any necessary changes.

History: *1992 c 549 art 2 s 20*

62L.21 REINSURANCE PREMIUMS.

Subdivision 1. **Monthly premium.** A health carrier ceding an individual to the reinsurance association shall be assessed a monthly reinsurance coverage premium that is 5.0 times the adjusted average market price. A health carrier ceding an entire group to the reinsurance association shall be assessed a monthly reinsurance coverage premium that is 1.5 times the adjusted average market price. The adjusted average market premium price must be established by the board of directors in accordance with its plan of operation. The board may consider benefit levels in establishing the reinsurance coverage premium.

Subd. 2. **Adjustment of premium rates.** The board of directors shall establish operating rules to allocate adjustments to the reinsurance premium charge of no more than minus 25 percent of the monthly reinsurance premium for health carriers that can demonstrate administrative efficiencies and cost-effective handling of equivalent risks. The adjustment must be made annually on a retrospective basis. The operating rules must establish objective and measurable criteria which must be met by a health carrier in order to be eligible for an adjustment. These criteria must include consideration of efficiency attributable to case management, but not consideration of such factors as provider discounts.

Subd. 3. **Liability for premium.** A health carrier is liable for the cost of the reinsurance premium and may not directly charge the small employer for the costs. The reinsurance premium may be reflected only in the rating factors permitted in section 62L.08, as provided in section 62L.08, subdivision 10.

History: *1992 c 549 art 2 s 21*

62L.22 ASSESSMENTS.

Subdivision 1. **Assessment by board.** For the purpose of providing the funds necessary to carry out the purposes of the association, the board of directors shall assess members as provided in subdivisions 2, 3, and 4 at the times and for the amounts the board of directors finds necessary. Assessments are due and payable on the date specified by the board of directors, but not less than 30 days after written notice to the member. Assessments accrue interest at the rate of six percent per year on or after the due date.

Subd. 2. **Initial capitalization.** The interim board of directors shall determine the initial capital operating requirements for the association. The board shall assess each licensed health carrier $100 for the initial capital requirements of the association. The assessment is due and payable no later than January 1, 1993.

Subd. 3. **Retrospective assessment.** On or before July 1 of each year, the administering carrier shall determine the association's net loss, if any, for the previous calendar year, the program expenses of administration, and other appropriate gains and losses. If reinsurance premium charges are not sufficient to satisfy the operating and administrative expenses incurred or estimated to be incurred by the association, the board of directors shall assess each member participating in the association in proportion to

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each member's respective share of the total insurance premiums, subscriber contract payments, health maintenance organization payments, and other health benefit plan revenue derived from or on behalf of small employers during the preceding calendar year. The assessments must be calculated by the board of directors based on annual statements and other reports considered necessary by the board of directors and filed by members with the association. The amount of the assessment shall not exceed four percent of the member's small group market premium. In establishing this assessment, the board shall consider a formula based on total small employer premiums earned and premiums earned from newly issued small employer plans. A member's assessment may not be reduced or increased by more than 50 percent as a result of using that formula, which includes a reasonable cap on assessments on any premium category or premium classification. The board of directors may provide for interim assessments as it considers necessary to appropriately carry out the association's responsibilities. The board of directors may establish operating rules to provide for changes in the assessment calculation.

Subd. 4. **Additional assessments.** If the board of directors determines that the retrospective assessment formula described in subdivision 3 is insufficient to meet the obligations of the association, the board of directors shall assess each member not participating in the reinsurance association, but which is providing health plan coverage in the small employer market, in proportion to each member's respective share of the total insurance premiums, subscriber contract payments, health maintenance organization payments, and other health benefit plan revenue derived from or on behalf of small employers during the preceding calendar year. The assessment must be calculated by the board of directors based on annual statements and other reports considered necessary by the board of directors and filed by members with the association. The amount of the assessment may not exceed one percent of the member's small group market premium. Members who paid the retrospective assessment described in subdivision 3 are not subject to the additional assessment.

If the additional assessment is insufficient to meet the obligations of the association, the board of directors may assess members participating in the association who paid the retrospective assessment described in subdivision 3 up to an additional one percent of the member's small group market premium.

Subd. 5. **Abatement or deferment.** The association may abate or defer, in whole or in part, the retrospective assessment of a member if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations or the member is placed under an order of rehabilitation, liquidation, receivership, or conservation by a court of competent jurisdiction. In the event that a retrospective assessment against a member is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred may be assessed against other members in accordance with the methodology specified in subdivisions 3 and 4.

Subd. 6. **Refund.** The board of directors may refund to members, in proportion to their contributions, the amount by which the assets of the association exceed the amount the board of directors finds necessary to carry out its responsibilities during the next calendar year. A reasonable amount may be retained to provide funds for the continuing expenses of the association and for future losses.

Subd. 7. **Appeals.** A health carrier may appeal to the commissioner of commerce within 30 days of notice of an assessment by the board of directors. A final action or order of the commissioner is subject to judicial review in the manner provided in chapter 14.

Subd. 8. **Liability for assessment.** Employer liability for other costs of a health carrier resulting from assessments made by the association under this section are limited by the rate spread restrictions specified in section 62L.08.

History: *1992 c 549 art 2 s 22*

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62L.23 LOSS RATIO STANDARDS.

Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, each policy or contract form used with respect to a health benefit plan offered, or issued in the small employer market, is subject, beginning July 1, 1993, to section 62A.021. The commissioner of health has, with respect to carriers under that commissioner's jurisdiction, all of the powers of the commissioner of commerce under that section.

History: *1992 c 549 art 2 s 23*

NOTE: This section, as added by Laws 1992, chapter 549, article 2, section 23, is effective July 1, 1993. See Laws 1992, chapter 549, article 2, section 25.

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