CHAPTER 62L

SMALL EMPLOYER INSURANCE REFORM

62L.02 DEFINITIONS.

[For text of subds 1 to 7, see M.S.1992]

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. For purposes of sections 62L.13 to 62L.22, "commissioner" means the commissioner of commerce.

[For text of subds 9 and 10, see M.S.1992]

Subd. 11. **Dependent.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 19 years, unmarried child under the age of 25 years who is a full-time student 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. 11a. **Discounted eligible charges.** "Discounted eligible charges" means, as determined by the board of directors, eligible charges reduced by the average difference between eligible charges and the expected liability of the health carrier for services performed. The board of directors, in its discretion, may determine additional different discounts, based upon geographic area and type of delivery system.

[For text of subds 12 to 14, see M.S.1992]

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 as defined in section 62B.02;

(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) a long-term care policy as defined in section 62A.46;

(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;

(11) workers' compensation insurance; or

(12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health benefit plan.

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 health 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 health carrier.

[For text of subds 17 and 18, see M.S.1992]

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, due to loss of eligibility for that coverage, provided that the individual maintains continuous coverage. For purposes of this clause, eligibility for prior coverage does not include eligibility for continuation coverage required under state or federal law;

(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;

(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.

[For text of subds 20 to 25, see M.S.1992]

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 an employer has only two eligible employees and one is the spouse, child, sibling, parent, or grandparent of the other, the employer must be a Minnesota domiciled employer and have paid social security or self-employment tax on behalf of both eligible employees. 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. 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 shall be considered to be a small employer, with respect to those employers in the association that employ no fewer than two nor more than 29 eligible employees, even though the association provides coverage to its members that do not qualify as small employers. An association in existence prior to July 1, 1993, is exempt from this chapter with respect to small employers that are members as of that date. However, in providing coverage to new groups after July 1, 1993, the existing association must comply with all requirements of this chapter. Existing associations must register with the commissioner of commerce prior to July 1, 1993. If an employer has employees covered under a trust established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq., as amended, those employees are excluded in determining whether the employer qualifies as a small employer.

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, either of the following conditions is met:

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

(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.

[For text of subd 28, see M.S.1992]

History: *1993 c 247 art 2 s 1-5; 1993 c 345 art 7 s 1-3*

NOTE: Subdivision 11a was also amended by Laws 1993, chapter 47, section 1, to read as follows:

"Subd. 11a. **Discounted eligible charges.** "Discounted eligible charges" means the amount paid to a health carrier for claims submitted to the association."

62L.03 AVAILABILITY OF COVERAGE.

[For text of subd 1, see M.S.1992]

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 health carrier participating in the small employer market 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 health carrier participating in the small employer market in a financially impaired condition, provided, however, that a health carrier participating in the small employer market 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 health carrier is not financially impaired and that offering coverage or accepting applications under subdivision 1 would not cause the health carrier to become financially impaired.

Subd. 3. **Minimum participation and contribution.** (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 and that contributes at least 50 percent toward the cost of coverage of eligible employees 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 subdivision, waiver of coverage includes only waivers due to coverage under another group health plan.

(b) If a small employer does not satisfy the contribution or participation requirements under this subdivision, a health carrier may voluntarily issue or renew individual coverage or a health benefit plan which, except for guaranteed issue, must fully comply with this chapter. A health carrier that provides group coverage to a small employer that does not meet the contribution or participation requirements of this subdivision must maintain this information in its files for audit by the commissioner. A health carrier may not offer individual coverage, purchased through an arrangement between the employer and the health carrier, to any employee unless the health carrier also offers coverage, on a guaranteed issue basis, to all other employees of the same employer.

(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. For purposes of this subdivision, "underwriting restrictions" means any refusal of the health carrier to issue or renew coverage, any premium rate higher than the lowest rate charged by the health carrier for the same coverage, or any preexisting condition limitation or exclusion. 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. A health carrier shall, at the time of first issuance or renewal of a health benefit plan on or after July 1, 1993, credit against any

preexisting condition limitation or exclusion permitted under this section, the time period prior to July 1, 1993, during which an eligible employee or dependent was covered by qualifying existing coverage or qualifying prior coverage, if the person has maintained continuous coverage.

Subd. 5. **Cancellations and failures to renew.** (a) 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 persons covered or to be covered by the health benefit plan. 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 under section 62L.09; 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.

(b) A health carrier need not renew a health benefit plan, and shall not renew a small employer plan, if an employer ceases to qualify as a small employer as defined in section 62L.02. If a health benefit plan, other than a small employer plan, provides terms of renewal that do not exclude an employer that is no longer a small employer, the health benefit plan may be renewed according to its own terms. If a health carrier issues or renews a health plan to an employer that is no longer a small employer, without interruption of coverage, the health plan is subject to section 60A.082.

[For text of subd 6, see M.S.1992]

History: *1993 c 247 art 2 s 6,7; 1993 c 345 art 7 s 4,5*

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 and contribution 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 offer to 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.

[For text of subd 2, see M.S.1992]

History: *1993 c 345 art 7 s 6*

62L.05 SMALL EMPLOYER PLAN BENEFITS.

[For text of subd 1, see M.S.1992]

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 charges, as specified in subdivision 10, for health care services, supplies, or other articles covered under the small 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 charges, as specified in subdivision 10, 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, including visits to an urgent care center but not including visits to a hospital outpatient department or emergency room, or similar facility;

(2) $15 per visit 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, 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. Benefits under this subdivision may be provided through the managed care procedures practiced by health carriers.

(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). The health care services required to be covered under this clause must also be covered if rendered in a nonhospital environment, on the same basis as coverage provided for those same treatments or services if rendered in a hospital, provided, however, that this sentence must not be interpreted as expanding the types or extent of services covered;

(2) physician, chiropractor, 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;

(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.

[For text of subd 5, see M.S.1992]

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. A secondary network must not be used to provide "benefits in addition" as defined in subdivision 5, except in compliance with that subdivision.

[For text of subds 7 to 9, see M.S.1992]

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, diagnosis-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.

[For text of subds 11 and 12, see M.S.1992]

History: *1993 c 247 art 2 s 8; 1993 c 345 art 7 s 7-10*

62L.08 RESTRICTIONS RELATING TO PREMIUM RATES.

[For text of subds 1 to 3, see M.S.1992]

Subd. 4. **Geographic premium variations.** A health carrier may request approval by 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. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. A health carrier may also request approval to establish one additional geographic region and a separate index rate for premiums for employees residing outside of Minnesota, and that index rate must not be more than 30 percent higher than the next highest index rate. 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.

[For text of subds 5 to 7, see M.S.1992]

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. The rates shall not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549. For premium rates proposed to go into effect between July 1, 1993 and December 31, 1993, the pertinent growth rate is the growth rate applied under section 62J.04, subdivision 1, paragraph (b), to calendar year 1994. As provided in section 62A.65, subdivision 3, this subdivision applies to the individual market, as well as to the small employer market.

[For text of subds 9 and 10, see M.S.1992]

History: *1993 c 345 art 7 s 11,12*

62L.081 PHASE-IN.

Subdivision 1. **Compliance.** No health carrier, as defined in section 62L.02, shall renew any health benefit plan, as defined in section 62L.02, except in compliance with this section.

Subd. 2. **Premium adjustments.** (a) Any increase or decrease in premiums by a health carrier that is caused by section 62L.08, and that is greater than 30 percent, is subject to this subdivision. A health carrier shall determine renewal premiums only as follows:

(1) one-half of that premium increase or decrease may be charged upon the first renewal of the coverage on or after July 1, 1993; and

(2) the remaining one-half of that premium increase or decrease may be charged upon the renewal of the coverage one year after the date of the renewal under clause (1).

(b) For purposes of this subdivision, the premium increase or decrease is the total premium increase or decrease caused by section 62L.08 and not just the portion that exceeds 30 percent. This subdivision does not apply to any portion of a premium increase or decrease that is not caused by section 62L.08.

History: *1993 c 345 art 7 s 15*

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 health carrier shall simultaneously provide a copy of the notice to each small employer covered by a health benefit plan issued by the health carrier.

Upon making the notification, the health carrier shall not offer or issue new business in the small employer market. The health carrier shall renew its current small employer business due for renewal within 120 days after the date of the notification but shall not renew any small employer business more than 120 days after the date of the notification.

A health carrier that elects to cease doing business in the small employer market shall continue to be governed by this chapter with respect to any continuing small employer business conducted by the health carrier.

Subd. 2. [Repealed, 1993 c 345 art 7 s 16]

[For text of subds 3 and 4, see M.S.1992]

History: *1993 c 345 art 7 s 13*

NOTE: Subdivision 2 was also amended by Laws 1993, chapter 247, article 2, section 9, to read as follows:

"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 health carrier."

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. Violations include the failure to pay an assessment required by section 62L.22, and knowingly and willfully encouraging a small employer to not meet the contribution or participation requirements of section 62L.03, subdivision 3, in order to avoid the requirements of this chapter. 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.

[For text of subd 2, see M.S.1992]

History: *1993 c 345 art 7 s 14*

62L.13 REINSURANCE ASSOCIATION.

Subdivision 1. **Creation.** The health coverage reinsurance association may operate as a nonprofit unincorporated association, but is authorized to incorporate under chapter 317A. 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.

[For text of subd 2, see M.S.1992]

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. The board of directors and health carriers who are members of the association are exempt from sections 325D.49 to 325D.66 in the performance of their duties as directors and 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;

(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 may operate under the plan of operation approved by the board and shall be governed in accordance with this chapter and may operate

in accordance with chapter 317A. If the association incorporates as a nonprofit corporation under chapter 317A, the filing of the plan of operation meets the requirements of filing articles.

[For text of subd 5, see M.S.1992]

History: *1993 c 47 s 2,3; 1993 c 247 art 2 s 10-12*

NOTE: Subdivision 4 was also amended by Laws 1993, chapter 47, section 4, to read as follows:

"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;

(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 may operate under the plan of operation approved by the board and shall be governed in accordance with this chapter and may operate in accordance with chapter 317A. If the association incorporates as a nonprofit corporation under chapter 317A, the filing of the plan of operation must meet the requirements of filing articles."

62L.14 BOARD OF DIRECTORS.

Subdivision 1. **Composition of board.** The association shall exercise its powers through a board of 13 directors. Four directors must be public members appointed by the commissioner. The public directors must not be employees of or otherwise affiliated with any member of the association. The nonpublic directors 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 directors. 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 until the annual meeting in 1994. Except for the public directors, 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 plan of operation, subject to approval by the commissioner. Members of the association may vote in person or by proxy. The public directors shall continue to be appointed by the commissioner to terms meeting the requirements of subdivision 3.

Subd 3. **Term of office.** After the annual meeting in 1994, each director shall serve a three-year term, except that the board shall make appropriate arrangements to stagger the terms of the directors 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. If a vacancy occurs for a public director, the commissioner shall appoint a new public director for the duration of the unexpired term.

Subd. 5. **Quorum.** A majority of the 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.** 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.** Public directors 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.

[For text of subd 8, see M.S.1992]

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

History: *1993 c 47 s 5,7,8; 1993 c 247 art 2 s 13-20*

NOTE: Subdivision 4 was also amended by Laws 1993, chapter 47, section 6, to read as follows:

"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. If a vacancy occurs for a public member board position, the commissioner shall appoint a new public member for the duration of the unexpired term."

62L.15 MEMBERS.

[For text of subd 1, see M.S.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 public directors, 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.

[For text of subds 3 to 5, see M.S.1992]

History: *1993 c 247 art 2 s 21*

NOTE: Subdivision 2 was also amended by Laws 1993, chapter 47, section 9, to read as follows:

"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 public members, 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."

62L.16 ADMINISTRATION OF ASSOCIATION.

[For text of subds 1 to 4, see M.S.1992]

Subd. 5. **Audits.** The board of directors may conduct periodic audits to verify the accuracy of financial data and reports submitted by the administrator. The board may establish in the plan of operation a uniform audit program. All costs of the uniform audit program and any additional audits conducted by the board to verify the accuracy of claims submissions are the responsibility of the health carrier. Failure of a health carrier to comply with the requirements of the audit program, including the failure to pay the costs of an audit, may subject the health carrier to the penalties described in section 62L.11.

[For text of subd 6, see M.S.1992]

Subd. 7. **Indemnification.** The association shall indemnify members, directors, officers, employees, and agents to the same extent that persons may be indemnified by corporations under section 317A.521.

History: *1993 c 47 s 10,11; 1993 c 247 art 2 s 22,23*

62L.17 PARTICIPATION IN THE REINSURANCE ASSOCIATION.

Subdivision 1. **Minimum standards.** The board of directors or the interim board shall establish minimum claim processing and managed care standards which must be met by a health carrier in order to have its business reinsured by the association.

[For text of subds 2 and 3, see M.S.1992]

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 under this subdivision.

[For text of subds 5 to 7, see M.S.1992]

History: *1993 c 247 art 2 s 24,25*

62L.19 ALLOWED REINSURANCE BENEFITS.

A health carrier may reinsure through the association only those benefits described in section 62L.05. The board may establish guidelines to clarify what coverage is included within the benefits described in this chapter. If a health plan conforms to those benefits as clarified by the board, the benefits are considered to be in accordance with this chapter for purposes of the association's obligations.

History: *1993 c 47 s 12; 1993 c 247 art 2 s 26*

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 $55,000, 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 discounted eligible charges. The board may establish an audit process to assure consistency in the submission of charge calculations by health carriers to the association. The association shall determine the amount to be paid to the health carrier for claims submitted based on discounted eligible charges. The board may also establish upper limits on the amount paid by the association based on a usual and customary determination. The board shall establish in the plan of operation a procedure for determining the discounted eligible charge.

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 health carrier's conversion factor is equivalent to the association's standardized conversion table, the association shall accept the health carrier's conversion factor.

[For text of subds 3 to 5, see M.S.1992]

History: *1993 c 47 s 13; 1993 c 247 art 2 s 27,28*