

STATE

HEALTH

INSURE.

4

SECTION BY SECTION COMPARISON OF HB 977 AND SIMILAR LEGISLATION FROM OTHER JURISDICTIONS

<u>SECTION 1</u>	
18.12.010: requires employers to provide 2 qualified coverage for regular employees and their dependents.	Based on Hawaii law except that minimum standard of coverage is based on prevailing coverage and dependents are not covered.
18.12.020: allows employers to select type of plan and contractor.	Based on Hawaii law.
large employers must provide employees with a "dual option" or choice of plan type to enroll in.	Based on Minnesota law.
18.12.030 - 18.12.130: details of employer coverage.	Same as Hawaii law.
18.12.140: premium supplementation.	Based on Hawaii law except that Hawaii sets up a separate fund.
18.12.150 - 18.12.200: existing plans, termination of chapter, and definitions.	Same as Hawaii law.
<u>SECTION 2</u>	
21.50.010: duties of insurers.	Same as Minnesota law.
21.50.020: certification of qualified plans.	Same as Minnesota law.
21.50.030: minimum benefits of qualified plan.	Based on Minnesota law except that Alaska law covers medically necessary transportation and alcoholism treatment, and Minnesota law delays the effective date of coverage for preventative care services.
21.50.040 - 21.50.150: details of state plan and administration.	Same as Minnesota law.
<u>SECTION 3</u>	
47.05.070 - 47.05.100: medical assistance by insurance or service contracts.	Same as Oregon law.

47.05.110: cash advances.

No model.

47.05.120: interest on late payments.

No model.

SECTION 4

Extends Medicaid to all optional eligible groups.

No model.

SECTION 5

Expands Medicaid coverage to optional services.

No model.

SECTION 6

General Relief-Medically Needy program.

No model.

SECTION 7

Expands AFDC and Medicaid coverage to unborn children.

No model.

SECTION 8

Repeals AS 47.07.020(d).

Companion to SECTION 4.

SECTION 9

Adjustment of Employer sponsored plans.

Same as Hawaii law.

GEORGE P. ARIYOSHI
GOVERNOR



STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF REGULATORY AGENCIES
1010 RICHARDS STREET
P. O. BOX 541
HONOLULU, HAWAII 96809

TANY S. HONG
DIRECTOR
BANK EXAMINER
COMMISSIONER OF SECURITIES
INSURANCE COMMISSIONER
DONALD D. H. CHING
DEPUTY DIRECTOR

March 24, 1980

Representative Thelma Buchholdt
State Representative
District 9 (Spenard)
Chair, House HFSS Committee
Alaska State Legislature
Pouch V, State Capitol
Juneau, Alaska 99811

Dear Representative Buchholdt:

This is to acknowledge receipt of your letter of March 18, 1980, inviting me to testify on proposed legislation similar to Hawaii's "Prepaid Health Care Act." Because the subject matter is not related at all with the state department which I am presently serving, I originally could not justify my going to Juneau as official State of Hawaii business. However, my Director and the Governor both feel that if my presence would assist Alaska in enacting progressive health care legislation, I would be given leave to go to Juneau with Hawaii's experience in this field.

I have spoken with Ms. Sorice of your office and am making plans to arrive in Juneau on Sunday, March 30, 1980, and will be available to testify on March 31 and April 1, 1980, if necessary.

I am looking forward to being of any assistance that I can possibly render in your efforts to enact such a bill. I think it has been of much benefit to the people of the State of Hawaii.

May I give you a short biographical sketch so that you may use this in further evaluation of my testimony next week:

1. Member of the Hawaii Legislature from 1953-1978
(8 years-House of Representatives; 12 years-Senate).

Representative Thelma Buchholdt

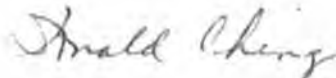
TWO

March 24, 1980

2. Attorney-at-Law.
3. Former Vice-President of the Bank of Hawaii (1963-1979).
4. Presently Deputy Director of the Department of Regulatory Agencies, State of Hawaii.
5. Member of the Board of Directors-Hawaii Medical Service Association (Blue Shield and Blue Cross Plan) (1965 to present), presently serving as its President.

I have never been to the great State of Alaska, and I am looking forward to my first visit.

Very truly yours,



Donald D. Ching
Deputy Director

cc: Ms. Jan Sorice

STATE OF MINNESOTA

Commissioner of Banks
(612) 296-2715

Commissioner of Insurance
(612) 296-2488



Commissioner of Securities
(612) 296-6848

Executive Secretary
(612) 296-2283

DEPARTMENT OF COMMERCE

500 Metro Square Building
St. Paul, Minnesota 55101

March 24, 1980

Ms. Jan Sorice
Health, Education & Social Services
State of Alaska
Room 108 State Capitol
Juneau, Alaska 99801

Dear Ms. Sorice:

This will confirm our telephone conversation today. You advised you are sending a copy of the proposed health legislation for my review prior to presenting testimony relative to Minnesota's experience with similar legislation known as the Minnesota Comprehensive Health Act of 1976.

My testimony will be heard between 1:30 p.m. and 3:30 p.m. on Monday, March 31. I shall report to your office at 10 a.m. for a final briefing prior to my testimony.

Enclosed is a copy of travel plans from Minneapolis to Juneau. You have graciously arranged for lodging March 29 through March 31 at the Baranof Hotel.

I look forward to meeting you, the interested members of your legislature, and visiting your capital city.

Sincerely,

A handwritten signature in cursive script that reads "John T. Ingrassia".

John T. Ingrassia
Supervisor
Life and Health Section
Insurance Division

mw
enclosure





Travel Service

Travel Plans

Mr. John T. Ingrassia

FOR:

REMARKS:

DEPART AND ARRIVE	CARRIER	FLIGHT	DATE	TIME DEPART	TIME ARRIVE	STATUS
FROM: MPLS/St. Paul						
TO: Seattle	Northwest	125	March 29	2:40PM	5:06PM	ok
TO: Juneau	Alaska	69	March 29	7:05PM	9:20PM	ok
TO: Seattle	Alaska	60	April 1	7:00AM	9:55AM	ok
TO: MPLS/St. Paul	Northwest	50	April 1	11:30AM	4:22PM	ok
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March 26, 1980


Honorable Thelma Bucholdt
Alaska State House of Representatives
Pouch V
Juneau, AK 99811

Dear Thelma:

I have enclosed a copy of Women for Political
Action's position on health issues before your committee.

We furnished a statement to Susan Johnson at
AKPIRG for use as a teleconference hearing on April 1, 1980
in Anchorage.

Very truly yours,


Linda O'Bannon
Chair, WPA Legislative
Committee
3281 Montpelier Ct.
Anchorage, AK 99503

LO/vlm

March 26, 1980

Women for Political Action, an Anchorage based organization, affiliated with the National Women's Political Caucus recognizes the difficulty that many low income persons in Alaska have in locating and procuring adequate medical care and services. Many of the Alaskans who are not receiving adequate medical care are women and children, who traditionally in our society have been without political power and who are often at the lower end of the economic scale.

Women for Political Action endorses the efforts of those legislators who are attempting to find the solution to the problem of inadequate medical care for low income Alaskans. In a State fortunate enough to be able to consider repeal of state income taxes and payments to its citizens from the permanent fund, it seems reasonable for that state to establish aid and support programs designed to promote adequate medical care of all of its citizens.

AMENDMENTS

p.5 line 3:(2) protected by health insurance or a prepaid health care plan established under a law of the United States other than as a beneficiary of a residual health care plan:

This amendment is mainly for clarification for the Native groups of the state; it ensures that they are eligible for the benefits of the legislation and that they are not excluded because of Indian Health Services.

p. 15, line 11: (O) substance abuse

This includes drug and alcohol abuse

p. 34 line 12: Sec. 8. AS 47.07.020 (d) is repealed

p. 30, line 7: Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE

OR SERVICE CONTRACTS. (a) A person eligible for medical assistance may elect to obtain policies of insurance or health care service contracts in lieu of receiving medical assistance by direct payments to providers and upon such election, the commissioner shall use available medical assistance funds to purchase and pay premiums on policies of insurance or pay the expenses on health care service contracts or medical or hospital service contracts that provide one or more of the medical and remedial care and services available under state medical assistance programs.

This amendment lets the client choose between a health insurance policy or health care service contract and medical assistance by direct payments.

GEORGE R. ARIYOSHI
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March 24, 1980

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I have never been to the great State of Alaska, and I am looking forward to my first visit.

Very truly yours,



Donald D. H. Ching
Deputy Director

cc: ✓ Ms. Jan Sorice

**HEALTH CARE
FINANCING OPTIONS
FOR COLORADO**

CONFERENCE SPONSORED BY

Colorado Department of Health

and

National Center For Health Services Research

September 24-25, 1979

HAWAII'S PREPAID HEALTH CARE ACT

George Yuen

Director of Health, State of Hawaii

HAWAII'S PREPAID HEALTH CARE ACT

George Yuen

Director of Health, State of Hawaii

September 24, 1979

First of all, let me say that I am very happy to be in the backyard of the Denver Broncos and the Nuggets. As you know, Hawaii does not have a professional football team and neither do we have a professional basketball team so that, as a matter of practice, we adopt certain professional teams on the mainland and consider them as our "home team," so to speak. So I can say that we have a lot of Bronco and Nugget fans in Hawaii. By the way, most of the games are televised live in Hawaii so we are in pretty close touch with what is going on.

Secondly, whenever I speak away from home, I really can't resist the urge to extend greetings to you from Hawaii, the youngest and healthiest state in the country. I say "healthiest" because, according to the latest U.S. census, the average citizen in Hawaii lives three years longer than the average resident on the mainland. Also we show the lowest incidence of killer diseases such as heart disease, cancer and stroke, and also the lowest rate per unit population of death due to accidents. Environmentally, we take pride in having the cleanest air and the cleanest water in the country, although some of you from the other states may dispute that, especially those of you from Colorado.

Coming back to the Hawaii plan—five years ago, Hawaii became the first state in the country to mandate employers to provide comprehensive health insurance for every full-time employee. Although our law is not perfect, we in Hawaii are very proud of this innovative legislation which is being reviewed by a number of states and by the federal government as possible model legislation. We view this law as yet another milestone in a very impressive record of progressive legislation enacted since Hawaii became a state in 1959. In this respect Hawaii is, in reality, a very unique laboratory for the nation.

Normally, in a presentation of this kind, one begins with a historical review and gradually leads up to the description of the plan itself. What I am going to do today is to give you a description of the plan first, followed by a little history, a discussion of our experience, and a listing of our recommendations after we have observed the plan in operation for five years. The plan became effective January 1, 1975.

I. WHAT ARE SOME OF THE BASIC PRINCIPLES OF HAWAII'S PREPAID HEALTH CARE ACT OF 1974?

1. Every regular full-time employee in private employment is protected by a prepaid plan providing for hospital, surgical, and medical coverage. Coverage for dependents of employees is not mandatory under the law. However, most employers in Hawaii do provide full or partial coverage for dependents. Normally, the employer chooses the health plan, unless collective bargaining is involved. We have found that benefits established under collective bargaining are usually equal to or superior to those specified in the Act.

2. The level of benefits provided must be equal to those of the most prevalent plan in Hawaii and must include certain benefits specified in the Act. Therefore, coverage of outpatient care as well as surgery and hospitalization

plus catastrophic coverage provided by the most prevalent plan is required of all carriers.

As a result, at least the following benefits are mandated:

- a. hospitalization (full service, 120 days per year);
- b. surgery and anesthesia;
- c. medical services (home, office, and hospital);
- d. diagnostic laboratory and X-ray services and radiotherapy;
- e. maternity services; and
- f. substance abuse services (including outpatient and inpatient services), mandated by a 1976 amendment to the Act.

In summary, a basic benefit package covering outpatient care as well as surgery and hospitalization plus catastrophic coverage (\$50,000 - \$250,000) is now required of all insurance carriers. In addition, I am proud and happy to point out that, entirely on a voluntary basis, and this is not required in the law, most of the carriers in Hawaii now provide for abortions and some coverage for mental health conditions.

3. Costs are shared by the employer and the employee. The employer pays at least half the cost of the coverage. The employee's share, in any event, is limited to 1.5% of his wages; we have calculated for employees receiving a minimum wage, this represents about \$7 a month. The employee's share, in any event, is limited to 1.5% of his wages. We have found that many employers pay the entire cost of the premium as a fringe benefit.

4. Coverage can be arranged with any existing carrier who offers an approved plan. This includes Kaiser Health Maintenance Organization, Hawaii

Medical Services Association (HMSA), a nonprofit association offering both fee-for-service and health maintenance programs, and also commercial insurance companies like Aetna and Travelers and so forth, that may also participate in this plan.

5. Generally, the free choice of a physician by the employee is protected. At the same time the employer or often the employee can choose a health maintenance plan which will probably mean less out-of-pocket expenses for the employee.

6. Finally, an employer who fails to provide the required health coverage is liable for any costs incurred by his employees during the period when he failed to provide coverage and, in addition to that, fines are also assessed for noncompliance.

II. HOW IS THE ACT ADMINISTERED?

The Hawaii Prepaid Health Care Act is administered by the Disability Compensation Division of the Hawaii Department of Labor and Industrial Relations, with the assistance and support of an appointed citizen group. The name of this group is the Prepaid Health Care Advisory Council. The function of this council is to review all plans submitted by carriers for medical equivalency of benefits. All plans meeting the standards of our Act are approved.

Because this division already monitors temporary disability insurance, worker's compensation and unemployment compensation, only about a dozen employees were needed to monitor compliance with the new Act. The major carriers remain the primary fiscal agents.

III. HOW HAS THE LAW WORKED OVER THE FIRST FIVE YEARS?

A recent federally funded study of the impact of the law concluded that:

1. The law has not resulted in any identifiable strains on the health care system.
2. It has not caused recognizable economic problems for employers.
3. It has not resulted in major dislocations among employers.
4. It has expanded health insurance coverage both in terms of the number of persons covered and the type of benefits received.
5. It has guaranteed an open competitive environment between the traditional fee-for-service system and prepaid health maintenance plan or the HMO.
6. It has made it possible for about 98% of the people to receive insurance coverage.

Good as it is, Hawaii's Prepaid Health Care Plan is not without shortcomings. I will go into that later, but I would first like to discuss the major factors which enabled Hawaii to pass and successfully implement the first mandatory comprehensive health insurance plan in the nation.

IV. WHY WAS HAWAII ABLE TO PASS THIS INNOVATIVE LEGISLATION?

1. Historically, plantation medicine played a major role in defining employer responsibility. At the same time, it supported the development of group or individual practice. Subsequently, large multi-specialty clinics were established stressing ambulatory care over hospitalization. About one-third of physicians in Hawaii are associated with these multi-specialty clinics. By comparison, about 12% of the physicians in the other states throughout the country are so associated. So that's a comparison of 33% to 12%.

2. Since attaining statehood in 1959, Hawaii has consistently shown a willingness to enact relatively liberal social legislation -- e.g. minimum wages, wage and hour requirements, worker's compensation, unemployment insurance, and temporary disability income. All of these were generously defined in terms of coverage, benefits, or requirements to protect workers.

3. In addition, the first years of Hawaii's statehood coincided with a period of economic growth and prosperity. As a result, costs of social benefits had not been of primary or overriding concern.

4. When the idea of a Prepaid Health Care Law was aggressively proposed, the Hawaii legislature in 1968 requested that its legislative reference bureau research the subject and prepare a comprehensive report on the subject. The report, prepared between 1969-1971, reviewed the various current approaches to compulsory or universal health insurance and noted the extent and scope of existing prepaid health care coverage. The study found that, of the total resident population, 88% of the people of Hawaii had hospital insurance, 12% did not, and 83% had medical insurance either under an insurance plan or a government-sponsored program, or 17% did not.

5. Perhaps most important, however, to the passage of the Act was the fact that the Prepaid Health Care Act only required what most employers--and virtually all of the major employers--were already doing. With close to 90% of the population covered, no major interest-group saw the proposed legislation as a significant threat.

Support for the proposal came from various health-related organizations such as the Hawaii Tuberculosis and Respiratory Disease Association, the State Advisory Council for Comprehensive Health Planning, and the Regional Medical Program. No labor unions opposed it and, in fact, one labor union, the IILWU, actually supported it.

The strongest objections, mentioned many times in opposing testimony during the period of legislative debate in 1971-74, was the idea that it would be inappropriate or unnecessary for Hawaii to enact such a plan because federal action on the subject of national health insurance was imminent. Events have since shown that fear to have been unfounded.

The Hawaii Medical Association recommended that "any action on the Hawaii Prepayment Act be deferred until such time as this national program comes into being." That's a medical profession. This objection was met by adding a provision in the Hawaii law mandating its termination on "the effective date of federal legislation that provides for mandatory prepaid health care for the people of Hawaii." So we have that proviso in the law.

The Health Insurance Association of America also opposed the bill, feeling that it was not necessary and that it would impose a financial burden on the people.

In general, opposition was regarded as being more a matter of preference, a matter of philosophy, or approach, than a matter of vital interest.

Other factors which, to account for the successful implementation of the Act, include:

1. The statutory requirements were based on a well developed existing administrative structure. The law is administered by the State Department of Labor and Industrial Relations in tandem with Worker's Compensation and Temporary Disability Insurance requirements. In turn, the benefit requirements are met through health insurance carriers.

2. Premium supplements from the state are available to employers who can show economic hardship as a result of the requirements for health insurance coverage. In other words, if an employer can show that his costs of coverage exceed 1.5% of his employees' salaries and that it exceeds 5% of his own income, he may apply for supplemental assistance from a fund which was appropriated by the legislature. I might say at this time that our data has shown that the number of applications for supplemental assistance has been very, very low. The legislature appropriated over \$300,000 for that purpose and, during the first year of the application of the law, we spent less than \$25,000 out of that amount for supplemental assistance. So the need for employers for help has been practically nil.

3. Hawaii's health care delivery financing systems have effective incentives and controls limiting hospitalization. This, in turn, helps keep costs down. Hawaii's hospital-use rate, adjusted for population differences, is about 45% of the rate throughout continental U.S. This does not appear to be due to significant differences in disease patterns (except possibly for terminal diseases among the elderly) but more to what doctors do in treating disease. Because of the high incidence of group practice, doctors in Hawaii tend to restrict hospital use to just serious illnesses. They tend to avoid hospitalization for conditions which can otherwise be handled on an ambulatory basis. Many of these doctors who participated in group practice have established very

well-equipped clinics. By group practice we mean 6 or more doctors being associated and practicing in a clinic. We have many of these well-equipped clinics and they have the benefit of peer consultation and so forth. This practice is further supported by reimbursement by all health insurance carriers for out-of-hospital treatment as well as in-hospital care.

The net result is comparatively comprehensive and economical care for the residents of our state.

As I mentioned previously, Hawaii's Prepaid Health Care Act is not perfect.

V. WHAT ARE SOME OF ITS SHORTCOMINGS?

1. Coverage is not truly universal. In 1977, only 72% of the civilian population was covered by employer-subsidized premiums. A liberal Medicaid policy covers another 11%, about 7% are covered by Medicare and 8% by CEAMPUS. In short, an estimated 2% of the state's civilian population, or about 15,000 individuals, do not have adequate health insurance coverage. Among these are unpaid family workers (people who work in a family business), seasonal or part-time employees (these are employees who work less than 20 hours a week), temporarily unemployed persons, new employees (the law provides that you must be on the job for at least 4 weeks before you can qualify for coverage--some of these new employees are not covered), some immigrants are not covered, persons with marginal incomes but with assets too great to qualify for Medicaid, and some dependents of some employees are not covered. Naturally we are concerned about this so-called "gap group."

2. There are some gaps in coverage, especially dental care and mental health services which are not mandated, although limited mental health coverage became part of the package for certain of the large carriers.

3. The law lacks an implicit requirement for coverage of workers' dependents.

4. The uniform cost of the premium for all employees results in a regressive burden of costs, as the percentage of wages paid to health care decreases as wages increase. The co-payment aspect (about 20% of cost) of the fee-for-service often becomes burdensome for the working poor.

A major problem Hawaii faces is not with the implementation of the law itself, but rather a threat at the national level.

Through District Court action, Standard Oil Company of California successfully challenged the right of Hawaii to enact and enforce such a law, contending that through the Employee Retirement Security Act of 1974, Congress had pre-empted all state initiatives regarding employee benefits. Hawaii contends that this was not the intention of Congress, and that such legislation will deny states the right to try novel social and economic experiments without risk to the rest of the country. As the plaintiff's contention was confirmed by a Supreme Court ruling rendered in November 1977, Hawaii is seeking remedial legislation through Congress.

This year marks the 10th anniversary of Hawaii's first steps toward a mandatory Prepaid Health Care Act, and the fifth year of its actual operation. We have found that this law, which formalized a health care delivery and financing system characterized by effective incentives and controls limiting hospitalization, works to provide about 98% of Hawaii's residents with comprehensive health care coverage. Hawaii has a health insurance system that is affordable, comprehensive, and virtually universal.

The relatively simple and cost-effective administration of the law by the Department of Labor, and the full cooperation of the insurance carriers to keep costs to a minimum, further contribute to its successful implementation.

Our present concerns are to extend this coverage to 100% of our residents and to assure that the high quality of health care in our state is not lowered or pre-empted by national legislation.

Looking into the future, we would like to see coverage extended to dental health, possibly the provision of hearing and visual aids and prosthetics, and definitely to a broad spectrum of mental health care. Cost of these services, together with catastrophic coverage and coverage for "gap" groups (especially immigrants), should be borne by the federal government within the framework of a national health insurance plan.

It is my belief that Hawaii's Prepaid Health Care Plan can serve as a model for a national health insurance plan, as we have testified in Washington several times, and we feel that it is also applicable to individual state plans. Today, mandatory health care is an integral part of life in Hawaii. It has been accomplished with a minimum of effort and cost to the taxpayers. It is our hope that we can convey to you a balanced accounting so that Hawaii's Prepaid Health Care Act and its operation can be readily understood and realistically assessed.

In closing, I would like to quote from a recent study on the matter:

"Whether the experience of Hawaii should inspire emulation -- by other states of the United States -- is a policy matter. It is not our intention

or appropriate function to advocate one form of legislation or another. But, we believe, it is clear that wider recognition of Hawaii's achievements in health care organization and financing is appropriate. Hawaii's experience gives some dimension as to what can be done."

It has been a pleasure for me to be here today to share our experience with you. I hope I have given you some idea as to what we are doing in Hawaii. Most importantly, I hope the State of Colorado will move forward vigorously and with vision to adopt a plan which will provide high quality health care for all the people, a plan that would entail minimum cost, and a plan which would be accepted by all. And in your move to achieve this, I hope we can be of some help to you. Thank you.

MINNESOTA HEALTH INSURANCE ACT

Brian Osberg

Administrative Assistant to the Minnesota House and Welfare Committee

September 24, 1979

Good afternoon. I have been asked to brief you on the workings of the 1976 Minnesota Law which has improved the availability and quality of health insurance coverage that has established a financial assistance program for families who incur high medical expenses. Respective articles of this law are referred to as the Comprehensive Health Insurance Act and the Catastrophic Health Defense Protection Act.

It is my understanding that the State of Colorado is currently evaluating alternative methods of financing medical expenses incurred by its indigent population. As I describe the Minnesota program, I will note its viability in terms of being a suitable alternative. It must be kept in mind, however, that the Minnesota Law was not enacted with the intent of providing medical assistance to the poor. Minnesota has a very extensive medical care system for the indigent. The State's Medicaid program covers the medical care system for the indigent. The State's Medicaid program covers the medically needy as well as categorical program recipients. Plus, we have a medical care program for the indigents who are not otherwise eligible for medical assistance. It is what we call the General Systems Medical Care Program, financed by the State and local counties. What the Minnesota Legislature recognized and sought to correct was the poor standard of existing health insurance policies, the unavailability of coverage for the high risk population and the exhaustion of resources of families who were unfortunate enough to incur high medical expenses. Our programs are primarily geared to middle class and working populations; however, I believe that they could be adapted to serve the poor and the near-poor.

The 1976 law consists of three articles:

- . Article I establishes minimal standards for health insurance policies and creates an insurance pool for persons unable to buy coverage, because of an existing health condition.
- . Article III provides for financial relief to households which incur high medical expenses; i.e. our catastrophic program.

Concerning Article I, I plan to concentrate my remarks on the insurance pool; however, I do want to briefly review the changes in our health insurance laws, as well. The objective of this article is to:

1. upgrade health insurance policies, and
2. increase the availability of insurance coverage.

Concerning the first objective, we established minimal insurance standards and in establishing those standards, the article outlines the duties of the insurers and the employers. All health insurance companies doing business in the State of Minnesota are required to offer what the law defines as a qualified health insurance plan. The qualified plan must pay at least 80% of the cost of covered services in excess of an annual deductible. These covered services, or minimal benefits as it is sometimes called, are itemized in the statute. This does not prohibit insurers from developing and selling an unqualified plan; however, they must offer a qualified plan so that the enrollee has the opportunity to purchase a comprehensive policy. Employers who make available to their employees the health insurance plan, must offer a qualified plan to those employees. This does not necessarily mean they have to finance the plan, however; it can be financed from funds contributed solely by the employer or solely by the employees, or a combination thereof. Again, I do not want to dwell on that portion of the law. If you have any questions concerning the health insurance statute, I will be glad to answer them.

The second aspect of Article I is the creation of a Comprehensive Health Association, for purposes of operating a Health Insurance Plan, or what we call a State Pool, to those who are uninsurable. This association, which is made up of all health insurers doing business in our State, is responsible for selecting a writing carrier to administer this Plan. The writing carrier is Northwestern National Life at the present time. In accordance to administrative rules, any person who has been turned down by two private insurers, or who has a presumptive condition, such as kidney disease, is eligible for enrollment in the Plan.

The Insurance Plan was intended to be self-supporting. The premium for the first 18 months of the Plan's operation was set equal to the average premium charged for equivalent policies offered by the five largest insurers in each planned category. In other words, for a group plan, we took the five largest insurers in Minnesota doing group plans and averaged their premium. This average then became the charge for the premium during the first 18 months of the operation of the pool. After that time, it was to be based on actuarial experience, to be self-supporting, but that did not work out as well as planned. The rate of claim expense was so high that the Association feared an increase of 100% in the premium rate would be necessary. With the possibility of a forbidding premium increase staring the Legislature in the face, they placed a cap of 125% on the average premiums charged in order to make the plan affordable. We replaced that cap in a rider in an appropriations bill. We have now put it in statute; however, this has caused some problems, which I will explain later. With that, in 1978 the Legislature appropriated \$200,000 to the Association to pay for any claims over the premiums generated. In other words, we are going to subsidize them to a point, realizing that if we are going to put a cap on, we certainly could not allow the Association to bear all the losses of the plan. However, a long-term solution on the financial stability of the Plan was necessary. During the last Legislative

session, the Legislature decided that the State should assume the financial responsibility of the Plan. The 125% cap on those premiums remained intact, and any losses incurred due to the operation of the plan would now be assumed by the State.

At the present time, we have only 1,500 policies in force in this un-insurable pool, a figure much lower than what we projected. It is either a problem of marketing or we simply overestimated the number of people who needed such protection. I think we overestimated the number of uninsurable or high-risk people in need of this kind of protection. We also have trouble marketing the plan but I don't believe that is the major problem at this point.

The question at hand, however, is whether or not the State should expand the population of this pool to include low-income individuals. This would probably involve a premium subsidy program, based on the ability to pay. The advantages would be twofold:

1. We could improve the experience of the plan due to the inclusion of a healthier population. This would especially be true if we included other poor-risk groups, such as small contracts, self-employers, and others who have difficulty in getting access to health insurance coverage.
2. We would provide protection to a population that has fallen through the assistance crack. I am referring to families who make between \$5,000 and \$10,000 a year, for example; too rich to receive public assistance in our State, too poor to afford health insurance coverage.

In our incremental approach to protect Minnesotans from high medical costs, the low-income or working poor as we call them, will be the next group to receive consideration. Thus, I believe that medical expense protection

can be provided to the near-poor through an insurance pool with an appropriate premium subsidy program. I do not believe that it is the answer for the indigent who are categorized as medically needy, though it may be feasible. It would depend on the nature of the subsidy program and the extent of the use of deductibles and co-payments of the Plan. I will be happy to share my thoughts on the effectiveness of the creating of a health insurance plan for uninsurables, or the working poor. For a closer look at this section of the law I would refer you to a publication by John Stone, entitled appropriately, THE MINNESOTA COMPREHENSIVE HEALTH INSURANCE ACT OF 1976.

Some final thoughts on the first Article of this Law. We received some resistance from the insurance industry, as expected, though most of the Minnesota-based companies are now in support, or at least not in opposition. There has been litigation initiated by some foreign insurers, challenging certain portions of the Act. I expect that the State will win that lawsuit; however, a separate challenge involving self-insurers seeking preemption from ORISA does not look as hopeful. That lawsuit should be decided soon. It will be very interesting, not only for the State of Minnesota, but across the country, in terms of establishing such plans.

If the State of Colorado decides to develop an insurance plan to increase access to coverage, it should include all poor-risk population groups; the near-poor, high-risk, self-employed and possibly small contract groups. You should not do what we did in terms of financial responsibility; i.e., do not make insurance companies—in other words, the members of the Association or whatever group you establish--responsible for losses of the pool; the State should take on that burden. The reasons for this approach are:

1. to keep the premium rate affordable,
2. the State can change or adapt that program to meet other population groups,

3. to avoid constitutional questions which have been raised in Minnesota.

I want to touch briefly on Article II of the law which is called the Hospital Rate Review Program. When you talk about increasing the access to insurance protection and mandating certain benefits, you have to talk about cost, which is the purpose of this Article. Article II establishes a system of reviewing hospital acute care rates, by a non-profit rate review organization, with direction and supervision given by the State Health Department. We have been quite encouraged by the results of this process. If the hospitals comply to their approved budgets, acute care rates will rise only 9 to 10%, compared to 14% a few years ago. I understand that the State of Colorado has considered abandoning their rate review or rate setting system. I'm not advocating rate setting, but I do want to press the need for some kind of cost containment efforts, particularly when you talk about increasing your programs to include the medically indigent.

Cost containment is essential as a State begins to commit its natural resources to the payment of medical services for the poor. We have begun to look at ways of instituting market forces into the health care system as a way of creating competition on a price basis. For example, the development and promotion of HMOs and other alternative health care plans have begun. Many believe that this is preferable to governmental regulation when addressing the cost problem. Minnesota has Interstudy which has been supporting HMOs, and other market forces in the health system in lieu of governmental regulation. We are looking at these options very seriously this year.

Moving on to Article III, or the Catastrophic Program. As I indicated earlier, this Act provides financial relief to individuals who incur catastrophic medical expenses. Under the program as initially enacted, in 1976, the State pays 90% of qualified expenses for which no third-party is liable

in excess of a threshold figure, which is calculated by an income-related formula. These qualified expenses are those minimal benefits listed in Article I, of our law. Let me give you an example of how this works. If the household income of a particular family is \$20,000, the State will pay 90% of out-of-pocket medical expenses exceeding \$8,500 (that \$8,500 is calculated in our income-related formula). If the family has incurred out-of-pocket expenses of \$100,000, the State will pay \$82,350, with the remainder being the responsibility of the family. That is how the program worked when the law was passed in 1976. The income-related formula, for purposes of calculating the threshold figure, was as small as 40% of the first \$15,000 of household income, 50% of the next \$10,000, and 60% of any income over \$25,000, with a minimum of \$2,500; in other words, a family had to incur, not necessarily pay, but incur \$2,500 before the State comes in. Due to the low rate of the utilization of the program, those percentage figures have been reduced, and the \$2,500 minimum has been removed.

What is important to note and remember here is that our program has two criteria:

1. the household income of the family, and
2. the amount of out-of-pocket medical expenses incurred by the family.

This income formula can be adjusted depending on the level of financial commitment that the State is going to make. Unlike other states' catastrophic programs, specifically Rhode Island, we do not include the amount of health insurance carried by the family, as a criterion. We considered this, however, it appeared to us to be discriminatory.

The catastrophic program has unlimited success, to say the least. The Legislature appropriated \$8,000,000 for fiscal year 1978, of which only \$252,000 was expended. In my opinion, there are four reasons for the low utilization.

First, the threshold figures in the formula were simply too high. As I said, they are being adjusted down; for example, instead of 40% of the first \$15,000, next year they will be 30% of the first \$15,000 of income, and the year after, it will be 20%. This was put into one of our riders in the appropriations bill, but it was not codified, so in another two years, we could revert back, but I doubt that. I expect that in the next two years, we will codify those percentage reductions.

Second, we have mandated a limitation of \$3,000 on out-of-pocket expenses for qualified health insurance policies issued in Minnesota, thus, diminishing the need for catastrophic coverage. We do not even allow for an actuarial equivalency to our catastrophic coverage that we require in our health insurance policies provided in Minnesota. Thus, it is very important; if nobody has to pay more than \$3,000 out-of-pocket during a one-year period, they are not going to reach the threshold figure in our catastrophic program. So, the people who have access to qualified health plans, which is a great majority in Minnesota, will simply not benefit from the catastrophic program, due to the high-threshold figures, and due to the structure of the formula itself.

Third, the program is administered by a county welfare agency which is probably not the preferable office, since the people seeking assistance are not on welfare, and a stigma seems to exist that catastrophic insurance is then a welfare program.

Fourth, the Minnesota Department of Public Welfare restrictively interpreted the array of services covered in the catastrophic program. This has not been resolved, but I expect some alterations to the State Department rule on the services covered.

In spite of the changes in threshold figures and services covered, I

do not expect a major increase in the program's expenditures. Though the Legislature appropriated \$6,000,000 for the current fiscal year, again I do not think we are going to spend that much money. We are closely watching Rhode Island's program and watching our experience and maybe in our third and fourth year we may indeed see the kinds of increases that Rhode Island has had in their program.

In an analysis prepared by our Department of Public Welfare, it was found that during the first 14 months of the program, there were only 149 eligible cases. Two-thirds of those cases were between the ages of 45 and 65, and one-half of the patients were suffering from either cancer or heart disease. We also found that almost one-half of the patients had no health insurance coverage of any type. It was feared that this program would be relied upon as an alternative to health insurance. We see no evidence at all of that occurring; that is, we do not see people abandoning their insurance policy in order to take the risk and then rely on catastrophic as a last resort. It is also interesting to note that 75% of the cases involved families of household incomes of less than \$10,000. In other words, this program, without our intention necessarily, is being utilized primarily by the working poor or near-poor. This is explained by the fact that most of the cases were chronic in nature and these people may be limited in generating the high income.

Before I get into some final comments in this program, as a viable approach to providing medical assistance to the poor, I want to review another section of the Catastrophic Law which I suggest you do not consider. This section is the payment of nursing-home expenses for persons under the age of 65, who have resided in a nursing home for more than 24 months. This was a provision tailored for a very, very persistent lobbyist or citizen in the State Legislature. Initially, it was for anybody under the age of 65 who has been in a nursing home for more than three years, then the program would come in. This program is known as CHEP II, and is a separate

program from our other Catastrophic Program. It covers all nursing-home expenses in excess of 20% of household income, for a person who has resided in a nursing home for more than two years. The inclusion of nursing-home care under the regular Catastrophic Program was heavily debated; senior citizen groups lobbied hard for this provision; however, the cost of such inclusion was prohibitive. I would strongly urge any State considering the Catastrophic Program, to have only one system. It should be up to the State to determine whether or not they have the resources and priority to include long-term care in a Catastrophic Program. Avoid the separate system.

Let me conclude my remarks by commenting on the Catastrophic Program as a viable alternative. I would highly suggest that if the State of Colorado chooses to go this route, that you determine in advance the population group you want to assist and then develop the income formula, accordingly. We did not necessarily do that. The advantage of this system is that it can be adapted to serve the population you want to serve.

The nature of a Catastrophic Program suggests that it is a plan of last resort. It does not apply until all other insurance coverage is exhausted and, further, it requires the payment of a deductible. For that reason, a Catastrophic Health Expense Program would fall short of meeting the medical needs of the indigent. This type of program is designed to prevent a family from spending down to welfare or from going bankrupt due to high medical expenses. One of the disadvantages of instituting such a system for the medically indigent is the fact that it is 100% State-financed. There is no federal participation, such as we have in the Medical Assistance Program. However, I would encourage you to negotiate at the federal level, with the possibility of receiving some medical assistance monies since it can be argued that a Catastrophic Program assists the family before they spend down their assets to become eligible for MA (Medical Assistance) thus

saving federal funds. We made that argument and had a very good reception from the Federal Government. Our Department of Public Welfare did not follow up on that and at the present time I do not know the status of trying to ascertain some federal monies, due to keeping some people off the medical assistance role.

In our Catastrophic Program we have put in some requirements allowing the Commission of the Department of Public Welfare to question the necessity of some medical services. It is also to question the reason for the charge being made, or a reasonable charge of the provider. We gave the Department the option to have a contract with the PSRO to determine medical necessity if they so wish, and I believe they are doing that. I believe that is important in the Catastrophic Program, since it assures some safeguards, similar to our medical assistance program, of making sure that the charges are reasonable and that services are indeed necessary.

In conclusion, I would submit that the need for a Catastrophic Program is dependent in large part on two factors:

1. The prevalence of catastrophic coverage in available health insurance policies and
2. The comprehensiveness of government medical assistance programs.

I offer the assistance of my office to the State of Colorado, if they so choose, to develop a similar program. I will be happy to answer any questions.

Thank you.

"AN OVERVIEW OF
THE MINNESOTA COMPREHENSIVE HEALTH ACT OF 1976, AS AMENDED"

Presentation Prepared
for
North Dakota Legislative Council
Health Care Committee

John T. Ingrassia
Supervisor
Life and Health Section
Insurance Division
State of Minnesota

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Bismarck, North Dakota

"AN OVERVIEW OF

THE MINNESOTA COMPREHENSIVE HEALTH ACT OF 1976, AS AMENDED"

It has been my privilege to be deeply involved in a health and welfare plan which has demonstrated that a state has the foresight and ability to provide benefits from such a plan to the residents within its jurisdiction.

It is further a privilege for me to represent the State of Minnesota and its Commissioner of Insurance, Michael D. Markman, as your guest at this meeting.

I am pleased that the Health Care Committee has shown an interest in the Minnesota experience and state honestly that it is flattering to our legislature and to the hundreds of people both from State Government and industry who have cooperated to bring the purposes of the Act to fruition.

As a result of the mandate, the Minnesota Comprehensive Health Association was established, the primary purpose for which was to make comprehensive health coverage available to those Minnesota residents who cannot obtain such coverage from the private health insurance market at standard rates. Such persons who do not have access to comprehensive health coverage face the possible harms of:

- 1) forgoing necessary medical attention in order to meet everyday living expenses;
- 2) losing opportunities for gainful employment because of an inability to pay for necessary medical care; and
- 3) living with the anxiety of lacking means to pay for medical care in the event of serious illness or accident.

The Minnesota Legislature was made aware of these problems and reacted accordingly.

The health coverage made available by the Association is known as the State Plan.

It is comprehensive major medical coverage with a choice of deductibles \$500 or \$1,000, 80% co-insurance feature and a \$3,000 annual out-of-pocket limitation.

State plan eligibility standards require that an applicant demonstrate Minnesota residency and a denial of coverage or coverage subject to a restrictive rider from two insurers within the previous six months. An experiment to provide coverage to individuals suffering from one or more conditions included in a list of "presumptive conditions" was supported by the industry generally and proved popular with agents in particular because of convenience. The conditions are of such a serious nature that, without doubt, an applicant with such a condition would be rejected for coverage. Unfortunately, the mandatory eligibility requirements were reestablished by amendment pending promulgation of rules pertaining to eligibility.

The Association is managed by a Board of seven directors, representative of the membership. The current Board is composed of five representatives of commercial insurance companies, one representative of a non-profit health service plan corporation, and one representative of a health maintenance organization. The directors are elected by the members of the Association based on a weighted vote, in proportion to their volume of accident and health insurance business, HMO business, or self-insurance business in the State of Minnesota.

The day-to-day administration of the State Plan is performed by Northwestern National Life Insurance Company as the writing carrier acting as agent of the Association and the Commissioner. The Association operates under close supervision of the Commissioner, pursuant to the Act and Rules promulgated by the Commissioner.

Claims expenses exceeding premiums collected, operating and administrative expenses of the Association were until May 31, 1979, shared by members of the Association in an amount equal to the ratio of each member's total accident and health insurance premiums (or subscriber contract charges or plan costs) received from Minnesota residents divided by the total accident and health insurance premium received by all insurers, HMO's and self-insurers from Minnesota residents. Assessments are levied by the Board of Directors of the Association subject to approval by the Commissioner.

Currently only "contributing members" are responsible for Association assessments attributable to losses on and after May 31, 1979. A contributing member is one which pays premium tax. Such members may offset any assessments against all premium and income taxes payable to the State of Minnesota. This most recent example of our legislature providing public funding for the Association was preceded by an appropriation for the biennium ended June 30, 1979, in the amount of \$200,000.00 for reimbursement to the Association for claims expenses incurred after June 30, 1978 in excess of State Plan premium collected.

The present public funding is subject to a "sunset" provision which ends July 1, 1981. During this time, the effect of the offset is to be reported to several committees of the legislature. Considering the past support demonstrated by the legislature, including a large state subsidy to reduce losses in 1978 and 1979, proponents of the State Plan predict that the offset provision will be renewed or another form of public funding will be enacted.

It has been recommended by the magistrate who presided at the trial in U. S. District Court, Insurers' Action Council Et Al Vs. Berton W. Heaton Et Al, that the Court enter judgment and adjudicating and declaring the Minnesota Comprehensive Health Act unconstitutional. The magistrate found that the assessments violate the Equal Protection Clause of the Fourteenth Amendment to the U. S. Constitution.

The Association not only denies that classification of "contributing members" constitutes invidious discrimination but maintains the classification is rationally related to a legitimate state interest.

The magistrate found that the eligibility requirements of the Act, including the discretion granted the Commissioner to determine additional, consistent requirements for coverage under the State Plan, constitute an unlawful delegation of legislative authority and are vague.

The Association has requested the Court to reject the magistrate's recommendations and find that the Act is not in violation of the Equal Protection Clause nor in violation of proscriptions against vagueness or unlawful delegation of legislative authority on the basis of the record and the law. The magistrate is charged with committing innumerable errors of fact and law as well as many irrelevant and immaterial references. It is the conclusion of the Association that the magistrate has failed completely to understand the basic issues of the lawsuit.

United Cerebral Palsy, Minnesota Epilepsy League and Minnesota Association of Retarded Citizens intervened as defendants in support of the Act. Appearing as amici curiae are Minnesota Public Interest Research Group; the Minnesota Catholic Conference; Senior Citizens Coalition of Greater St. Paul, Inc.; Metropolitan Senior Federation, Inc.; and Senior Citizens Legislative Council of St. Paul.

The Health Insurance Association of America participated as amicus curiae in opposition to the Act.

In addition to the creation of the Minnesota Comprehensive Health Association, the Act provided for establishment and administration of certain plans of health insurance to make minimum benefits available to all persons in Minnesota. The objective is to improve health care by making comprehensive accident and health insurance easily available to all persons in Minnesota willing to pay the premium. The Act mandated that every company offering or providing hospital, surgical, and medical care coverage in Minnesota must offer a plan that contains certain minimum levels of coverage and to discourage sale of coverages which are so limited as to be of little value to most consumers.

The Act requires that all insurers and fraternalists who sell broad coverage individual hospital, surgical, and medical care policies in Minnesota, in addition to other policies, offer their customers a so-called "qualified" plan containing the list of

comprehensive hospital, surgical and medical care benefits set forth in the Act or the actuarial equivalent of those benefits. To be eligible to purchase a qualified plan, a person must meet the insurer's underwriting requirements and, of course, pay the premium established by the insurer for such a plan. Insurers selling group plans must offer "qualified" group plans.

Insurers are not prohibited in any way from selling or even recommending unqualified policies. However, it is required that persons applying for or renewing an unqualified plan be offered a major medical rider or policy at a premium established by the insurer. Again, underwriting standards may apply.

The Act further requires that insurers which sell Medicare Supplement policies to persons over age 65 offer, as an alternative to unqualified Medicare Supplement policies, a qualified Medicare Supplement Plan.

The Act further requires that every group health care policy issued to employers include the right of an individual leaving the group, or the dependents of a deceased group member, to convert to an individual qualified plan without the imposition of meeting insurability requirements. However, the premium is payable by the insured and not by the group policyholder.

These requirements are, in the opinion of the magistrate, unconstitutional. The magistrate believes that the mandatory offer provisions violate due process, that the major medical offer provision violates the Contract Clause, and that the extra-territorial application to conversion requirement violates the Commerce Clause.

Oral arguments are to be heard by Judge Edward Devitt on February 29. It is anticipated that the decision will be appealed by the aggrieved party.

changed to 4/25/80

The Association is still breathing and appears to be serving its intended purpose. As of December 31, 1979, 1,608 policies were in force. Approximately 60 applica-

tions are processed monthly. For each dollar of premium received the plan is paying two dollars in benefits. This steady but unspectacular growth contrasts sharply with the testimony of the plaintiffs who projected that the State Plan enrollees would number 4,000 by the end of its first year of operation. The State Plan opened for business on January 2, 1977. Opening day was the culmination of a cooperative effort among members of the legislature, its staff, the unselfish participation by dozens of industry people, consumers and State personnel.

In May of 1976 call was made for volunteers to serve on proposed advisory committees which would review and study the Act in order to recommend positive programs for consideration by the Commissioner as to implementation and administration of the requirements contained in the Act. The response to the call for help resulted in the formation of five advisory committees in the area of legal, forms, administration, actuarial and public information.

Prototype forms were developed which could be immediately certified by the Commissioner as qualified plans. Included in the prototypes are group, individual, major medical and Medicare Supplement. The plans were available to any interested company for use as their own with the company's own rate structure.

The actuarial committee developed rate schedules for the State Plan and developed an actuarial equivalence table which was subsequently incorporated into the rules.

The public information committee prepared and distributed informational brochures and conducted seminars throughout the state to advise the public and the industry agency force of the State Plan.

To the volunteers who staffed the committees and who continue to serve unselfishly to sustain the Association and the State Plan, the people of Minnesota are grateful. All of us in Minnesota benefit from the operation of the Act. The fruits of the

program vary but certainly they contribute meaningfully to the way we live in Minnesota and to the concern we have for each other.

I shall be happy to respond to any question or to comment further on the implementation of the Act.

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III. An Analysis of the Social Impact of the Proposed Legislation

With hospital care averaging \$369 per patient day for acute inpatient care, plus an array of high priced medical technology and drugs for out patient care, and physicians fees on top of that, any accident or illness requiring more than nominal medical attention can mean serious financial hardship or catastrophe for the average family. As the cost of medical care continues to rise faster than any component of the consumer price index, some form of health insurance, pre-paid health care, or other third-party health coverage becomes more and more essential to people's health, welfare, and economic security.

The 56 to 71 thousand Alaskans who currently lack health coverage are likely to be unemployed, marginally employed, self-employed, or those employed by a small business, plus their dependents. The proposed legislation would automatically extend coverage to all those in regular employment and their dependents. The expansion of Medicaid coverage and the General Relief - medically needy program in the bill would fill another coverage gap.

The income threshold for the medically needy program is set at 150% of the poverty guidelines for Alaska. For 1979, the poverty guidelines were as follows:

Non-farm poverty income guidelines

<u>Family size</u>	<u>Annual</u>	<u>Monthly</u>	<u>150%</u>
1	\$4,270	356	534
2	5,640	470	705
3	7,010	584	876
4	8,380	698	1047
5	9,750	813	1219
6	11,120	927	1390

A person or family which is over income becomes eligible for medical assistance under this program if their income in excess of the threshold is spent on medical bills. Essentially, this provides a form of catastrophic coverage for all families, as well as a form of basic coverage for low-income families. The program would probably cover a large proportion of Alaska's unemployed and marginally employed people who lack health coverage from other sources.

The bill also would make coverage available to approximately 200 people who are presently denied private insurance due to high-risk health conditions. Thus, the most significant group of people who would still lack health coverage are likely to be middle-income self-employed people who do not choose to purchase health insurance, new employees who are not covered for their first month, and some seasonal employees who do not qualify for the medically needy program during their off-season because their assets (other than income) exceed the assets limits set in regulation. These groups are not likely to be large, however. Under the

proposed legislation, probably fewer than five percent of the population would be without coverage.

Impact of the Mandatory Health Benefits on Employers and Employees

Most large employers provide health insurance for their employees anyway, so the largest impact will probably be on small employers and low-budget non-profit organizations. Mandating employer-sponsored health benefits would have essentially the same economic impact as raising the minimum wage -- it would make it more expensive for employers to hire people, so fewer people would be hired. Though the resulting unemployment would not be significant among skilled and experienced workers, unskilled and teenage workers would be hardest hit. On the other hand, teenagers will often be covered as dependents under their parent's policy and therefore exempt from coverage by their own employer. Similarly, spouses, welfare recipients, and moonlighters may have coverage from another source and therefore be exempt. The fact that employers are not required to provide coverage to people such as these who have coverage from another source may offer a small financial incentive to the employer to hire them. If the employee group is enrolled in a plan which charges a higher premium rate for employees with dependents than for single employees, the employer may have some financial incentive to discriminate against people with dependents.

A number two qualified plan would cost about \$30 to \$50 per month for a single employee, and \$75 to \$110 per month for

an employee with dependents. The bill requires that the employer pay at least half the premium cost. A small employer whose liability would exceed 1.5 percent of their total payroll plus five percent of the employer's gross income from the business would be entitled to premium supplementation from the State. The employee's share is also limited to 1.5%* of his or her wages, or about \$8.85 per month for a minimum wage employee; the employer is liable for the difference.

From the employees' point of view, the share they must pay toward the premium cost of the mandatory coverage, however small, will lower their take-home pay. Although it would insure them against financial catastrophe due to medical expenses, in most cases it would provide no tangible benefits. With a deductible as high as \$500 per person, most people won't incur any claims.

Impact on Insurance Carriers

The impact on carriers of the minimum benefits regulation will depend on two factors: how closely the bill tracks with current practice, and how large the volume of business is that the carrier conducts in Alaska. Smaller carriers may find that the required changes in their policies and practices would

* This limit may not be appropriate for Alaska. It is taken from Hawaii where health insurance costs are about two-thirds of what they are in Alaska.

be more trouble and expense than they are worth for the small volume of business the carrier does in Alaska, and they may choose to stop writing health and accident insurance in Alaska rather than comply with the law.

Addendum Concerning High Risk "Uninsurables"

A number of insurance carriers in Minnesota who were opposed to the joint underwriting of high risk coverage in that state testified to a projection of 4,000 enrollees in the State Plan, which provides health coverage for "uninsurable" individuals, within the first year of operation. This incidence would be one per thousand population. In fact, actual enrollment over the first three years of operation has been less than half of that projection, though it is still growing.

Alaska has a young, healthy population compared to most other states, and therefore might expect a lower incidence of high-risk health conditions than Minnesota. Therefore, one high-risk "uninsurable" individual per two thousand population, or 200 people statewide, is a high estimate of what State Plan enrollment in Alaska might be.

In Minnesota, the ratio of claims to premiums under the State Plan has been running two to one, with an estimated loss of \$800,000 for 1979. As Alaska has approximately one-tenth the population of Minnesota, a rough estimate of the loss Alaska might incur from the State Plan would be \$80,000 per year.

HEALTH CARE 62E.04

Subd. 7. The commissioner may rescind approval of a demonstration project if the commissioner makes any of the findings listed in section 62D.15, subdivision 1, with respect to the project for which it has not been granted a specific exemption, or if the commissioner finds that the project's operation is contrary to the information contained in the approved application.

[1979 c 268 s 1]

CHAPTER 62E. HEALTH CARE

Sec.		Sec.	
62E.02	Definitions	62E.10	Comprehensive health association
62E.035	Self insurer identification and reporting	62E.11	Operation of comprehensive plan
62E.04	Duties of insurers	62E.13	Administration of plan
62E.06	Minimum benefits of qualified plan	62E.14	Enrollment by an eligible person
62E.08	State plan premium		

62E.02 Definitions.

[For text of subs 1 to 9, see M.S.1978]

Subd. 10. "Insurer" means those companies operating pursuant to chapters 62A or 62C and offering, selling, issuing, or renewing policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations.

[For text of subs 11 to 22, see M.S.1978]

Subd. 23. "Contributing member" means those companies operating pursuant to chapter 62A, paying premium taxes pursuant to section 60A.15, and offering, selling, issuing, or renewing policies or contracts of accident and health insurance.

[1979 c 272 s 1,2]

62E.035 Self insurer identification and reporting.

The commissioner shall require self insurers to report annually that they are engaged in self insurance business. These reports shall be for the previous calendar year and shall include the self insurer's total cost of self insurance and other information the commissioner may by rule require relating to the self insurer's plan of health coverage. Upon request of the commissioner, the commissioner of revenue shall cooperate with the commissioner in the identification of self insurers, and shall modify forms and promulgate rules as may be necessary to identify self insurers. In adopting the forms and rules promulgated pursuant to this section the commissioner of revenue shall consult with the commissioner.

[1979 c 272 s 3]

62E.04 Duties of insurers.

[For text of subs 1 to 3, see M.S.1978]

Subd. 4. Major medical coverage. Each insurer and fraternal shall affirmatively offer coverage of major medical expenses to every applicant who applies to the insurer or fraternal for a new unqualified policy at the time of application and annually to every holder of an unqualified policy of accident and health insurance renewed by the insurer or fraternal. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of \$5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of \$250,000. The offer of coverage of major medical expenses may consist of the offer of a rider on an existing unqualified policy or a new policy which is a qualified plan.

62E.04 HEALTH CARE

[For text of subs 5 to 7, see M.S.1978]

Subd. 8. Reduction of benefits because of other services. No policy of accident and health insurance shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving benefits pursuant to chapters 256B and 256D, or sections 62E.51 to 62E.55 or 252.27; 260.251, subdivision 1a; 261.27; 393.07, subdivision 1 or 2.

[1979 c 174 s 3; 1979 c 272 s 4]

62E.06 Minimum benefits of qualified plan.

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

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

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

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

- (1) Hospital services;
- (2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;
- (3) Drugs requiring a physician's prescription;
- (4) Services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under medicare;
- (5) Services of a home health agency if the services would qualify as reimbursable services under medicare;
- (6) Use of radium or other radioactive materials;
- (7) Oxygen;
- (8) Anesthetics;
- (9) Prostheses other than dental;
- (10) Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;
- (11) Diagnostic X-rays and laboratory tests;
- (12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;
- (13) Services of a physical therapist; and
- (14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.

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

(1) Any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-

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HEALTH CARE 62E.08

insurance, or (iii) for which benefits are payable under another policy of accident and health insurance, medicare or any other governmental program except as otherwise provided by law;

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

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

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

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

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

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (e), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(1) Well baby care, effective July 1, 1980;

(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician, effective July 1, 1982;

(3) Multiphasic screening and other diagnostic testing, effective July 1, 1982. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for services listed in this clause.

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

[For text of subs 2 to 4, see M.S. 1978]

[1979 c 272 s 3]

62E.08 State plan premium.

Subdivision 1. The association shall establish the following maximum premiums to be charged for membership in the comprehensive health insurance plan:

(a) The premium for the number one qualified plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in Minnesota;

(b) The premium for the number two qualified plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in Minnesota;

(c) The premium for a qualified medicare supplement plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals enrolled in a qualified medicare supplement plan; and

(d) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

The five insurers whose rates are used to establish the premium for each type of coverage offered by the association shall be determined by the commissioner on the ba-

62E.08 HEALTH CARE

sis of information provided by all insurers annually at the commissioner's request, concerning the number of individual qualified plans and qualified medicare supplement plans or actuarially equivalent plans offered by the insurer and rates charged by the insurer for each type of plan offered by the insurer. In determining the insurers whose rates shall be used in establishing the premium, the commissioner shall utilize generally accepted actuarial principles and structurally compatible rates. Subject to this subdivision, the commissioner shall include any insurer operating pursuant to chapter 62C in establishing the premium. In establishing premiums pursuant to this section, the association shall utilize generally accepted actuarial principles.

Subd. 2. Subject to subdivision 1, the schedule of premiums for coverage under the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

[1979 c 272 s 6]

62E.10 Comprehensive health association.

Subdivision 1. **Creation; tax exemption.** There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers, self insurers, fraternal and health maintenance organizations licensed or authorized to do business in this state. The comprehensive health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

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

Subd. 3. **Mandatory membership.** All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, or health maintenance organization business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 15.041 to 15.052.

Subd. 4. **Open meetings.** All meetings of the association, its board, and any committees of the association shall comply with the provisions of section 471.705.

Subd. 5. [Repealed, 1979 c 272 s 11]

Subd. 6. **Antitrust exemption.** In the performance of their duties as members of the association, the members shall be exempt from the provisions of sections 325.8011 to 325.8028.

Subd. 7. **General powers.** The association may:

- (a) Exercise the powers granted to insurers under the laws of this state;
- (b) Sue or be sued;
- (c) Enter into contracts with insurers, similar associations in other states or with other persons for the performance of administrative functions including the functions provided for in clauses (e) and (f);
- (d) Establish administrative and accounting procedures for the operation of the association;

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HEALTH CARE 62E.11

(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by sections 62E.04 and 62E.16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:

- (1) Individual qualified plans, excluding group conversions;
- (2) Group conversions;
- (3) Group qualified plans with fewer than 50 employees or members; and
- (4) Major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance; and

(f) Provide for the administration by the association of policies which are reinsured pursuant to clause (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.

Subd. 8. **Department of state exemption.** The association shall be exempt from the provisions of chapter 15.

[1979 c 272 s 7]

62E.11 Operation of comprehensive plan.

Subdivision 1. Upon certification as an eligible person in the manner provided by section 62E.14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

Subd. 2. Any employer which has in its employ one or more eligible persons enrolled in the comprehensive health insurance plan may make all or any portion of the state plan premium payment to the state plan directly to the writing carrier.

Subd. 3. Not less than 87-1/2 percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than 12-1/2 percent shall be used for the payment of agent referral fees as authorized in section 62E.15, subdivision 3 and for payment of the writing carrier's direct and indirect expenses, as specified in section 62E.13, subdivision 7.

Subd. 4. Any income in excess of the costs incurred by the association in providing reinsurance or administrative services pursuant to section 62E.07, clauses (e) and (f) shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 5. Each contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the contrib-

62E.11 HEALTH CARE

uting member's total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium, received by all contributing members from or on behalf of Minnesota residents, as determined by the commissioner.

Subd. 6. The association shall make an annual determination of each contributing member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the contributing members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment shall be due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days shall be grounds for termination of the contributing member's membership. A contributing member which ceases to do accident and health insurance business within the state shall remain liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment, as determined herein, would not exceed ten dollars.

Subd. 7. Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 8. Any annual fiscal year end or interim assessment levied against a contributing member may be offset, in an amount equal to the assessment paid to the association, against the income tax or the premium tax payable by that contributing member pursuant to section 60A.15 for the year in which the annual fiscal year end or interim assessment is levied. The commissioner of revenue shall annually, on or before January 15, report to the chairmen of the senate finance, house appropriations, senate commerce and house financial institutions and insurance committees as to the total amount of income tax or premium tax offset claimed by contributing members during the preceding calendar year.

{ 1979 c 272 s 8 }

NOTE: The provisions of subdivision 8 shall expire July 1, 1981. See Laws 1979, Chapter 272, Section 12.

62E.13 Administration of plan.

[For text of subd 1, see M.S.1978]

Subd. 2. The association may select policies and contracts, or parts thereof, submitted by a member or members of the association, or by the association or others, to develop specifications for bids from any members which wish to be selected as a writing carrier to administer the state plan. The selection of the writing carrier shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified medicare supplement plan, and the health maintenance organization contract.

[For text of subs 3 to 9, see M.S.1978]

{ 1979 c 272 s 9 }

62E.14 Enrollment by an eligible person.

Subdivision 1. **Certificate, contents.** The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person shall enroll by submission of a certificate of eligibility to the writing carrier. The certificate shall provide the following:

FIRE AND RELATED INSURANCE 65A.08

(a) Name, address, age, and length of time at residence of the applicant;

(b) Name, address, and age of spouse and children if any, if they are to be insured;

(c) Evidence of rejection, a requirement of restrictive riders, a rate up, or a pre-existing conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least two association members within six months of the date of the certificate, or other eligibility requirements adopted by rule by the commissioner which are not inconsistent with this chapter and which evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk; and

(d) A designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan. Upon ceasing to be a resident of Minnesota a person is no longer eligible to purchase or renew coverage under the state plan.

[For text of subs 2 and 3, see M.S. 1978]

[1979 c 272 s 10]

CHAPTER 64A. FRATERNAL BENEFICIARY ASSOCIATIONS

Sec.
64A.221 Payment to welfare recipients

64A.221 Payment to welfare recipients.

No association authorized to do business in this state which provides or pays for any health care benefits shall issue any certificate which contains any provision denying or reducing benefits because services are rendered to a certificate holder or beneficiary who is eligible for or receiving medical assistance pursuant to chapter 256B or services pursuant to sections 252.27; 260.251, subdivision 1a; 261.27; or 393.07, subdivision 1 or 2.

[1979 c 174 s 4]

CHAPTER 65A. FIRE AND RELATED INSURANCE

Sec.		Sec.	
65A.01	Minnesota standard fire insurance policy	65A.29	Cancellation, nonrenewal, refusal to write
65A.08	Special provisions	65A.35	Fair plan business, distribution and placement
65A.27	Definitions		
65A.28	Disclosure and filing requirements		

65A.01 Minnesota standard fire insurance policy.

[For text of subs 1 and 2, see M.S. 1978]

Subd. 2a. Facsimile signatures authorized. On any policy of insurance regulated under this chapter, the signature of an officer or agent of the insurer may be a facsimile signature.

[For text of subs 3 to 6, see M.S. 1978]

[1979 c 115 s 2]

65A.08 Special provisions.

Subdivision 1 [Repealed, 1979 c 175 s 1]

[For text of subs 2 to 6, see M.S. 1978]

1979
Amendments to
MINNESOTA

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1978, Section 176.521, Subdivision 2, is amended to read:

Subd. 2. APPROVAL. Settlements shall be approved only where the terms conform with this chapter.

The division and the workers' compensation court of appeals shall exercise discretion in approving or disapproving a proposed settlement.

The parties to the agreement of settlement have the burden of proving that the settlement is reasonable, fair, and in conformity with this chapter. A settlement agreement where both the employee or his dependent and the employer or insurer and intervenors in the matter are represented by an attorney shall be presumed to be reasonable, fair, and in conformity with chapter 176.

Sec. 2. Minnesota Statutes 1978, Section 79.21, is amended to read:

79.21 RATES TO BE UNIFORM; EXCEPTIONS. No insurer shall write insurance at a rate other than that made and put into force by the bureau and approved as adequate and reasonable by the commissioner. The bureau may reduce or increase a rate by the application to individual risks of the system of merit or experience rating which has been approved by the commissioner. This reduction or increase shall be set forth in the policy or by indorsement thereon. Upon written request an insurer shall furnish a written explanation to the insured of how and why the individual rate was adjusted by application of a system of merit or experience rating. This explanation shall be mailed to the insured within 30 days of the request.

Approved May 30, 1979.

CHAPTER 272—S.F.No.1191

An act relating to insurance; providing for changes in the operation and funding of the comprehensive health association, requiring identification of certain insurers, setting premium standards, changing the effective dates of certain mandated benefits, amending Minnesota Statutes 1978, Sections 62E.02, Subdivision 10, and by adding a subdivision, 62E.04, Subdivision 4, 62E.06, Subdivision 1; 62E.08, 62E.10, 62E.11, 62E.13, Subdivision 2, 62E.14, Subdivision 1, and Chapter 62E, by adding a section, repealing Minnesota Statutes 1978, Section 62E.10, Subdivision 5.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA

Section 1. Minnesota Statutes 1978, Section 62E.02, Subdivision 10, is amended to read:

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Subd. 10. "Insurer" and offering of health insurance. "Insur

Sec. 2. Minnes division to read:

Subd. 23. "Contr" 62A, paying pr of renewing poli

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Subd. 10. "Insurer" means those companies operating pursuant to chapters 62A or ~~62C~~ and offering or ~~selling~~, issuing, or renewing policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations.

Sec. 2. Minnesota Statutes 1978, Section 62E.02. is amended by adding a subdivision to read:

Subd. 23. "Contributing member" means those companies operating pursuant to ~~chapter 62A~~, paying premium taxes pursuant to section 60A.15, and offering, selling, ~~issuing~~, or renewing policies or contracts of accident and health insurance.

Sec. 3. Minnesota Statutes 1978, Chapter 62E, is amended by adding a section to read:

[62E.03] SELF INSURER IDENTIFICATION AND REPORTING. The commissioner shall require self insurers to report annually that they are engaged in self insurance business. These reports shall be for the previous calendar year and shall include the self insurer's total cost of self insurance and other information the commissioner may by rule require relating to the self insurer's plan of health coverage. Upon request of the commissioner, the commissioner of revenue shall cooperate with the commissioner in the identification of self insurers and shall modify forms and promulgate rules as may be necessary to identify self insurers. In adopting the forms and rules promulgated pursuant to this section the commissioner of revenue shall consult with the commissioner.

Sec. 4. Minnesota Statutes 1978, Section 62E.04, Subdivision 4. is amended to read:

Subd. 4. **MAJOR MEDICAL COVERAGE.** Each insurer and fraternal shall ~~alternatively~~ offer coverage of major medical expenses to every applicant who applies to ~~the insurer or fraternal~~ for a new unqualified policy at the time of application and annually to every holder of an unqualified policy of accident and health insurance ~~insured by the insurer or fraternal~~. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of \$5,000 or more within a calendar year for ~~services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any payment authorized by the commissioner up to a maximum lifetime limit of \$250,000. The offer of coverage of major medical expenses may consist of the offer of a rider on an existing unqualified policy or a new policy which is a qualified plan.~~

Sec. 5. Minnesota Statutes 1978, Section 62E.06, Subdivision 1. is amended to read:

62E.06 MINIMUM BENEFITS OF QUALIFIED PLAN. Subdivision 1. **NUMBER THREE PLAN.** A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A and 62C, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

- (a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed \$150 per person. The changes or additions indicated by underline deletions by strikeout

coverage shall include a limitation of \$3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall be subject to a maximum lifetime benefit of not less than \$250,000.

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

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

- (1) Hospital services;
- (2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;
- (3) Drugs requiring a physician's prescription;
- (4) Services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under medicare;
- (5) Services of a home health agency if the services would qualify as reimbursable services under medicare;
- (6) Use of radium or other radioactive materials;
- (7) Oxygen;
- (8) Anesthetics;
- (9) Prostheses other than dental;
- (10) Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;
- (11) Diagnostic X-rays and laboratory tests;
- (12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when performed in connection with the extraction or repair of teeth;
- (13) Services of a physical therapist; and
- (14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.

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

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

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

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

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

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

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

(d) Effective July 1, 1980, The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (c), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(1) Well baby care, effective July 1, 1980;

(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician, effective July 1, 1982;

(3) Multiphasic screening and other diagnostic testing, effective July 1, 1982. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for services listed in this clause.

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

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tests.

Sec. 6. Minnesota Statutes 1978, Section 62E.08, is amended to read:

62E.08 STATE PLAN PREMIUM. Subdivision 1. For the first eighteen months of operation of the comprehensive health insurance plan The association shall establish the following maximum premiums to be charged for membership in the comprehensive health insurance plan:

(a) The premium for the number one qualified plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in Minnesota;

(b) The premium for the number two qualified plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in Minnesota;

(c) The premium for a qualified medicare supplement plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals enrolled in a qualified medicare supplement plan; and

(d) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

The five insurers whose rates are used to establish the premium for each type of coverage offered by the association shall be determined by the commissioner on the basis of information provided by all insurers annually at the commissioner's request, concerning the number of individual qualified plans and qualified medicare supplement plans or actuarially equivalent plans offered by the insurer and rates charged by the insurer for each type of plan offered by the insurer. In determining the insurers whose rates shall be used in establishing the premium, the commissioner shall utilize generally accepted actuarial principles and structurally compatible rates. Subject to this subdivision, the commissioner shall include any insurer operating pursuant to chapter 62C in establishing the premium. In establishing premiums pursuant to this section, the association shall utilize generally accepted actuarial principles.

Subd. 2. For subsequent enrollees or renewals of membership Subject to subdivision 1 of this section, the schedule of premiums for membership in coverage under the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

Sec. 7. Minnesota Statutes 1978, Section 62E.10, is amended to read:

62E.10 COMPREHENSIVE HEALTH ASSOCIATION. Subdivision 1. CREATION; TAX EXEMPTION. There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers, self insurers, fraternal and health maintenance organizations licensed or authorized to do business in this state. The comprehensive Changes or additions indicated by underline deletions by strikeout

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health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

Subd. 2. **BOARD OF DIRECTORS; ORGANIZATION.** The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the commissioner. ~~To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting.~~ In determining voting rights at the ~~organizational meeting members' meetings,~~ each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. ~~If the board of directors is not selected within 60 days after notice of the organizational meeting, the commissioner may appoint the initial board.~~ In approving ~~or selecting~~ members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Subd. 3. **MANDATORY MEMBERSHIP.** All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, or health maintenance organization business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 15.041 to 15.052

Subd. 4. **OPEN MEETINGS.** All meetings of the association, its board, and any committees of the association shall comply with the provisions of section 471.705.

Subd. 5. All members shall enter into a contract with the association according to terms specified in section 11. The contract of reinsurance shall be executed on or before January 1, 1977, for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year.

Subd. 6. **ANTITRUST EXEMPTION.** In the performance of their duties as members of the association, the members shall be exempt from the provisions of sections 325.8011 to 325.8028.

Subd. 7. **GENERAL POWERS.** The association may:

- (a) Exercise the powers granted to insurers under the laws of this state;
- (b) Sue or be sued;

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(c) Enter into contracts with insurers, similar associations in other states or with other persons for the performance of administrative functions including the functions provided for in clauses (e) and (f);

(d) Establish administrative and accounting procedures for the operation of the association:

(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by sections 62E.04 and 62E.16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:

(1) Individual qualified plans, excluding group conversions;

(2) Group conversions;

(3) Group qualified plans with fewer than 50 employees or members; and

(4) Major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance, and

(f) Provide for the administration by the association of policies which are reinsured pursuant to clause (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.

Subd. 8. DEPARTMENT OF STATE EXEMPTION. The association shall be exempt from the provisions of chapter 15.

Sec. 8 Minnesota Statutes 1978, Section 62E.11, is amended to read

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62E.11 OPERATION OF COMPREHENSIVE PLAN. Subdivision 1. Upon certification as an eligible person in the manner provided by section 62E.14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

Subd. 2. Any employer which has in its employ one or more eligible persons enrolled in the comprehensive health insurance plan may make all or any portion of the state plan premium payment to the state plan directly to the writing carrier.

Subd. 3. Not less than 87-1/2 percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than 12-1/2 percent shall be used for the payment of agent referral fees as authorized in section 62E.15, subdivision 3 and for payment of the writing carrier's direct and indirect expenses, as specified in section 62E.13, subdivision 7.

Subd. 4. Any income in excess of the costs incurred by the association in providing reinsurance or administrative services pursuant to section 62E.07, clauses (e) and (f) shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 5. Each contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs, pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with section 62E.10, subdivision 5. Deviations in the claim experience of the state plan from Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the association contributing members. Association Contributing members shall share in the claims expense of the state plan and operating administrative expenses of the association in an amount equal to the ratio of the contributing member's total cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of Minnesota residents as divided into by the total cost of insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received by all association contributing members from or on behalf of Minnesota residents, as determined by the commissioner.

Subd. 6. The reinsurance contract shall provide for The association shall make an annual determination and assessment of each contributing member's liability, if any, and may make an annual fiscal year end assessment if necessary. Payment of the assessment shall be due within 30 days after the end of the association's fiscal year. The association may also, subject to the approval of the commissioner, the reinsurance contract may provide for interim assessments against the contributing members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an

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assessment shall be due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the assessed reinsurance payment assessment within 30 days of notification by the association shall be grounds for termination of the contributing member's membership. A contributing member which ceases to do accident and health insurance business within the state shall remain liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment, as determined herein, would not exceed ten dollars.

Subd. 7. Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 8. Any annual fiscal year end or interim assessment levied against a contributing member may be offset, in an amount equal to the assessment paid to the association, against the income tax or the premium tax payable by that contributing member pursuant to section 60A.15 for the year in which the annual fiscal year end or interim assessment is levied. The commissioner of revenue shall annually, on or before January 15, report to the chairmen of the senate finance, house appropriations, senate commerce and house financial institutions and insurance committees as to the total amount of income tax or premium tax offset claimed by contributing members during the preceding calendar year.

Sec. 9. Minnesota Statutes 1978, Section 62E.13, Subdivision 2, is amended to read:

Subd. 2. Upon the commissioner's approval of the policy forms and contracts submitted pursuant to chapter 62A, The association may select policies and contracts, or parts thereof, submitted by a member or members of the association to be the comprehensive health insurance plan, or by the association or others, to develop specifications for bids from any members which wish to be selected as a writing carrier to administer the state plan. ~~This~~ The selection of the writing carrier shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified medicare supplement plan, and the health maintenance organization contract.

Sec. 10. Minnesota Statutes 1978, Section 62E.14, Subdivision 1, is amended to read:

62E.14 ENROLLMENT BY AN ELIGIBLE PERSON. Subdivision 1. CERTIFICATE, CONTENTS. The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person ~~may~~ shall enroll by submission of a certificate of eligibility to the writing carrier. The certificate ~~may~~ shall provide the following.

(a) Name, address, age, and length of time at residence of the applicant:

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(b) Name.

(c) Evident pre-existing conditions substantially reduced by at least two other eligibility inconsistent with coverage substandard considered a standard

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(b) Name, address, and age of spouse and children if any, if they are to be insured;

(c) Evidence of rejection, or a requirement of restrictive riders, a rate up, or a pre-existing conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least two association members within six months of the date of the certificate, or other eligibility requirements adopted by rule by the commissioner which are not inconsistent with this chapter and which evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk; and

(d) A designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan. Upon ceasing to be a resident of Minnesota a person is no longer eligible to purchase or renew coverage under the state plan.

Sec. 11. REPEALER. Minnesota Statutes 1978, Section 62E.10, Subdivision 5, is repealed

Sec. 12. EFFECTIVE DATE. This act is effective the day following its final enactment. The provisions of section 62E.11, subdivision 8, shall expire on July 1, 1981.

Approved May 30, 1979.

CHAPTER 273—S.F.No.1218

An act relating to Polk and Norman Counties; permitting the imposition of a tax on removing gravel; providing for its administration; providing a penalty

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Every person engaged in the business of removing gravel from gravel pits or deposits of gravel in Polk or Norman County shall pay to the county an occupation tax in an amount the board of county commissioners determines necessary for the purposes set forth in section 5, but not more than ten cents on each cubic yard of gravel removed.

Sec. 2. Every person engaged in the removal of gravel shall at the times herein provided, file with the county auditor, under oath, a correct report in the form and containing the information he requires, covering each year. A report shall be filed on December 1, 1979, covering the period between the effective date of the act and December 1, 1979 and thereafter on December 1 of each year, covering the preceding year's operation. The operator shall compute the amount of the tax due on the basis of the information contained in the report. The tax computed in the report shall be due and payable to the county treasurer prior to the last business day of December.

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62A.041 MATERNITY BENEFITS; UNMARRIED WOMEN. Each group policy of accident and health insurance issued or renewed after June 4, 1971, shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an insured is a parent or an acknowledged or adjudicated parent of a dependent illegitimate child each group policy issued or renewed after July 1, 1976, shall provide the same coverage for that child as that provided for the child of an employee choosing dependent family coverage if the insured elects dependent family coverage.

Each individual policy of accident and health insurance shall provide the same coverage for maternity benefit to unmarried women and minor female dependents as that provided for married women. If the insured is a parent or an acknowledged or adjudicated parent of a dependent illegitimate child, each individual policy issued or renewed after July 1, 1976, shall also provide the same coverage for that child as that provided for the child of an insured choosing dependent family coverage if the insured elects dependent family coverage.

For the purposes of this section, the term "maternity benefits" shall not include elective, induced abortion whether performed in a hospital, other abortion facility, or the office of a physician.

[1971 c 680 s 1; 1973 c 651 s 1; 1976 c 121 s 3]

62A.042 FAMILY COVERAGE; COVERAGE OF NEWBORN INFANTS. Subdivision 1. Individual family policies; renewals. No policy of individual accident and sickness insurance which provides for insurance for more than one person under section 62A.03, subdivision 1, clause (3), shall be renewed to insure any person in this state or be delivered or issued for delivery to any person in this state unless such policy includes as insured members of the family any newborn infants immediately from the moment of birth and thereafter which insurance shall provide coverage for illness, injury, congenital malformation or premature birth.

Subd. 2. Group policies; renewals. No group accident and sickness insurance policy which provides for coverage of family members or other dependents of an employee or other member of the covered group shall be renewed to cover members of a group located in this state or delivered or issued for delivery in this state unless such policy includes as insured family members or dependents any newborn infants immediately from the moment of birth and thereafter which insurance shall provide coverage for illness, injury, congenital malformation or premature birth.

[1973 c 303 s 1]

62A.043 DENTAL PROCEDURES. Subdivision 1. The provisions of this section shall apply to all individual or group policies or subscriber contracts providing payment for care in this state, which policies or contracts are issued or renewed after August 1, 1976 by an accident and health insurance company regulated under this chapter, or a nonprofit health service plan corporation regulated under chapter 62C.

Subd. 2. Any policy or contract referred to in subdivision 1 which provides coverage for services which can be lawfully performed within the scope of the license of a duly licensed dentist or podiatrist, shall provide benefits for such services whether performed by a duly licensed physician, dentist or podiatrist.

[1973 c 430 s 1; 1976 c 207 s 1]

62A.044 PAYMENTS TO GOVERNMENTAL INSTITUTIONS. No group or individual policy of accident and sickness insurance issued or renewed after May 22, 1973 pursuant to this chapter, and no group or individual service plan or subscriber contract issued or renewed after May 22, 1973 pursuant to chapter 62C, shall contain any provision denying or prohibiting payments for services rendered by a hospital or medical institution owned or operated by the federal, state, or local government or practitioners therein in any instance wherein charges for such services are imposed against the policy holder or subscriber. The unit of government operating the institution may maintain an action for recovery of such charges.

[1973 c 471 s 1]

62A.045 PAYMENTS TO WELFARE RECIPIENTS. No policy of accident and sickness insurance issued or renewed after August 1, 1975, shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent

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[1975 c 247 s 1]

62A.05 CONSTRUCTION OF PROVISIONS. Subdivision 1. No policy provision which is not subject to section 62A.04 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to sections 62A.01 to 62A.09 hereof.

Subd. 2. A policy delivered or issued for delivery to any person in this state in violation of sections 62A.01 to 62A.09 hereof, shall be held valid but shall be construed as provided in sections 62A.01 to 62A.09 hereof. When any provision in a policy subject to sections 62A.01 to 62A.09 hereof, is in conflict with any provision of sections 62A.01 to 62A.09 hereof, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of sections 62A.01 to 62A.09 hereof.

[1967 c 395 art 3 s 5]

62A.06 STATEMENTS IN APPLICATION. Subdivision 1. Inclusion in policy. The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within 15 days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

Subd. 2. Alterations. No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Subd. 3. Effect of applicant's statement. The falsity of any statement in the application for any policy covered by sections 62A.01 to 62A.09 hereof, may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

[1967 c 395 art 3 s 6]

62A.07 RIGHTS OF INSURER, WHEN NOT WAIVED. The acknowledgment by an insurer of the receipt of notice given under any policy covered by sections 62A.01 to 62A.09 hereof, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

[1967 c 395 art 3 s 7]

62A.08 COVERAGE OF POLICY, CONTINUANCE IN FORCE. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

[1967 c 395 art 3 s 8]

62A.081 PAYMENTS TO FACILITIES OPERATED BY STATE OR LOCAL GOVERNMENT. Every group or individual policy of accident and sickness insurance issued or renewed after July 1, 1973 regulated by this chapter, and every group or in-

dividual service plan or subscriber contract issued or renewed after July 1, 1973 regulated by chapter 62C, providing care or payment for care in this state, shall provide payments for services rendered by a hospital or medical facility owned or operated by, or on behalf of, the state or any unit of local government, or practitioners therein, on the same basis as are made for like care in other facilities. The unit of government concerned may maintain an action for recovery of such payments.

[1973 c 765 s 24]

62A.09 LIMITATION. Nothing in sections 62A.01 to 62A.08 shall apply to or affect:

(1) any policy of workers' compensation insurance or any policy of casualty or fire and allied lines insurance with or without supplementary coverage therein; or

(2) any policy or contract of reinsurance; or

(3) any blanket or group policy of insurance; or

(4) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

[1967 c 395 art 3 s 9; 1975 c 359 s 23]

62A.10 GROUP INSURANCE. Subdivision 1. **Requirements.** Group accident and health insurance is hereby declared to be that form of accident and health insurance covering not less than two employees nor less than ten members, and which may include the employee's or member's dependents, consisting of husband, wife, children, and actual dependents residing in the household, written under a master policy issued to any governmental corporation, unit, agency, or department thereof, or to any corporation, copartnership, individual, employer, or to any association having a constitution or bylaws and formed in good faith for purposes other than that of obtaining insurance under the provisions of this chapter, where officers, members, employees, or classes or divisions thereof, may be insured for their individual benefit.

Any insurer authorized to write accident and health insurance in this state shall have power to issue group accident and health policies.

Subd. 2. Policy forms. No policy of group accident and health insurance may be issued or delivered in this state unless the same has been approved by the commissioner in accordance with section 62A.02, subdivisions 1 to 6. These forms shall contain the standard provisions relating and applicable to health and accident insurance and shall conform with the other requirements of law relating to the contents and terms of policies of accident and sickness insurance in so far as they may be applicable to group accident and health insurance, and also the following provisions:

(1) **Entire contract.** A provision that the policy and the application of the employer, or executive officer or trustee of any association, and the individual applications, if any, of the employees or members insured, shall constitute the entire contract between the parties, and that all statements made by the employer or any executive officer or trustee in behalf of the group to be insured, shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in the written application;

(2) **Master policy-certificates.** A provision that the insurer will issue a master policy to the employer, or to the executive officer or trustee of the association; and the insurer shall also issue to the employer or to the executive officer or trustee of the association, for delivery to the employee or member who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which he is entitled and to whom payable, together with a statement as to when and where the master policy, or a copy thereof, may be seen for inspection by the individual insured; this individual certificate may contain the names of, and insure the dependents of, the employee or member, as provided for herein;

(3) **New Insureds.** A provision that to the group or class thereof originally insured may be added, from time to time, all new employees of the employer or

members of the association eligible to and applying for insurance in that group or class and covered or to be covered by the master policy.

[1967 c 395 art 3 s 10; 1973 c 303 s 2]

62A.11 BLANKET ACCIDENT AND SICKNESS INSURANCE. Subdivision 1. Requirements. Blanket accident and sickness insurance is hereby declared to be that form of accident and sickness insurance covering special groups of persons as enumerated in one of the following paragraphs:

(1) Under a policy issued to any common carrier, which shall be deemed the policyholder, covering a group defined as all or any class of persons who may become passengers on such common carrier.

(2) Under a policy issued to an employer, who shall be deemed the policyholder, covering all employees or any group of employees defined by reference to exceptional hazards incident to such employment.

(3) Under a policy issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers.

(4) Under a policy issued in the name of any volunteer fire department, first aid, or other such volunteer group, which shall be deemed the policyholder, covering all of the members of such department or group.

(5) Under a policy issued to a sports team or to a camp, which team or camp or sponsor thereof shall be deemed the policyholder, covering members or campers.

(6) Under a policy issued to any other substantially similar group which, in the discretion of the commissioner, may be subject to the issuance of a blanket accident and sickness policy.

Subd. 2. Authority. Any insurer authorized to write accident and sickness insurance in this state shall have the power to issue blanket accident and sickness policies.

Subd. 3. Policy forms. No policy of blanket accident and sickness insurance may be issued or delivered in this state unless a copy of the form thereof has been approved by the commissioner and it contains in substance such of the provisions required for individual policies as may be applicable to blanket accident and sickness insurance and the following provisions:

(1) A provision that the policy and the application of the policyholder shall constitute the entire contract between the parties, and that, in the absence of fraud, all statements made by the policyholder shall be deemed representations and not warranties, and that no statement made for the purpose of affecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder, a copy of which has been furnished to such policyholder.

(2) A provision that to the group or class originally insured shall be added from time to time all new persons eligible for coverage.

Subd. 4. Application; certificate. An individual application shall not be required from a person covered under a blanket accident and sickness policy, nor shall it be necessary for the insurer to furnish each person a certificate.

Subd. 5. Benefits. All benefits under any blanket accident and sickness policy shall be payable to the person insured, or to his designated beneficiary, or beneficiaries, or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parent, guardian, or other person actually supporting him. Provided further, however, that the policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

Subd. 6. Legal liability. Nothing contained in this section shall be deemed to affect the legal liability of policyholders for the death of, or injury to, any such member of such group.

[1967 c 395 art 3 s 11]

62A.12 TRANSITION PROVISION AS TO INDIVIDUAL POLICIES, RIDERS OR ENDORSEMENTS. A policy, rider or endorsement, which could have been lawfully used or delivered or issued for delivery to any person in this state immediately before April 18, 1957, may be used or delivered or issued for delivery to any such person until January 1, 1959, without being subject to the provisions of sections 62A.03, 62A.04, or 62A.05.

[1967 c 395 art 3 s 12]

62A.13 COMMERCIAL TRAVELER INSURANCE COMPANIES. Any domestic assessment, health or accident association now licensed to do business in this state, which confines its membership to commercial travelers, professional men, and others whose occupation is of such character as to be ordinarily classified as no more hazardous than commercial travelers, and which does not pay any other commissions or compensations, other than prizes to members of nominal value in proportion to the membership fees charged for securing new members, may issue certificates of membership, which, with the application of the member and the bylaws of the association, shall constitute the contract between the association and the member. A printed copy of the bylaws and a copy of the application shall be attached to the membership certificate when issued, and a copy of any amendment to the bylaws shall be mailed to the members following their adoption. Certified copies of certificate, bylaws and amendments shall be filed with the commissioner of insurance and subject to his approval. The bylaws shall conform to the requirements of this chapter, so far as applicable, and wherever the word "policy" appears in this chapter, it shall, for the purpose of this section, be construed to mean the contract as herein defined.

[1967 c 395 art 3 s 13]

62A.14 HANDICAPPED CHILDREN. Subdivision 1. Individual family policies. An individual hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the policyholder within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two year period following the child's attainment of the limiting age.

Subd. 2. Group policies. A group hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, which provides that coverage of a dependent child of an employee or other member of the coverage group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two year period following the child's attainment of the limiting age.

[1969 c 436 s 1]

62A.145 SURVIVORS OF DECEASED EMPLOYEE; DEFINITIONS. Subdivision 1. For the purposes of this section and section 62A.146, the terms defined in this section shall have the meanings here given them.

Subd. 2. "Covered employee" means any person who, at the time of his death, was employed by any employer providing, offering or contributing to group insurance coverage for that employee who was so enrolled for the coverage.

Subd. 3. "Group insurance" means any policy or contract of accident and health protection, regardless of by whom underwritten, paid for in full or in part by an employer, which provides benefits, including cash payments for reimbursement of expen-

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ses and the provision of usual and needed health care and medical services as the result of any injury, sickness, disability or disease suffered by a group of employees, or any one of them, and the dependents of such employees.

Subd. 4. "Employer" means any natural person, company, corporation, partnership, association or firm which employs any employee.

Subd. 5. "Survivor" means any person who would be entitled to and be dependent upon economic support by an employee if that employee were alive; including any spouse and/or child or children as defined by the group insurance policy.

[1973 c 339 s 1]

62A.146 GROUP INSURANCE; CONTINUATION OF BENEFITS TO SURVIVORS. Every employer providing a policy or plan of accident and health protection and benefits for his employees, or any of them, and the dependents of such employees shall not, except upon the written consent of the survivor or survivors of any deceased covered employee, terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under such policy or plan of group insurance to such survivor or survivors within one year of the covered employee's death. Provided, however, that any survivor or survivors, in order to have the coverage and benefits extended for such one year period, as herein provided, may be required to pay the entire cost of such protection. Failure of the survivor to make premium payments in advance to the employer shall be a basis in itself for the termination of the coverage without the written consent heretofore required for such termination, but in event of termination by reason of the survivor's failure to make required premium payments, if any, written notice of such cancellation must be sent by the policyholder by mail to said survivor's last known address at least 15 days prior to such cancellation.

[1973 c 339 s 2]

62A.147 DISABLED EMPLOYEES' BENEFITS; DEFINITIONS. Subdivision 1. For the purposes of this section and section 62A.149, the terms defined in this section shall have the meanings here given them.

Subd. 2. "Covered employee" means any person who, at the time he suffered an injury resulting in total disability or became totally disabled by reason of illness, was employed by and receiving a salary, commission, hourly wage, or other remuneration for his services by any employer providing, offering or contributing to group insurance coverage for that employee who was so enrolled for the coverage.

Subd. 3. "Total disability" means (a) the inability of an injured or ill employee to engage in or perform the duties of his regular occupation or employment within the first two years of such disability and (b) after the first two years of such disability, the inability of the employee to engage in any paid employment or work for which he may, by his education and training, including rehabilitative training, be or reasonably become qualified.

Subd. 4. "Group insurance" means any policy or contract of accident and health protection, regardless of by whom underwritten, which provides benefits, including cash payments for reimbursement of expenses or the provision of usual needed health care and medical services as the result of any injury, sickness, disability or disease suffered by a group of employees, or any one of them, and which protection is paid for or otherwise provided in full or in part by an employer.

Subd. 5. "Employer" means any natural person, company, corporation, partnership, association, firm, or franchise which employs any employee.

Subd. 6. "Insurer" means any person, company, corporation including a nonprofit corporation, partnership, association, firm or franchise which underwrites or is by contract or other agreement obligated to provide accident and health protection benefits to any group of employees of any employer.

[1973 c 340 s 1]

62A.148 GROUP INSURANCE; PROVISION OF BENEFITS FOR DISABLED EMPLOYEES. No employer or insurer of that employer shall terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under any program or policy of group insurance to any covered employee who becomes totally disabled while employed by the employer solely on account of absence caused by such total disability. If the employee is required to pay all or any part of the pre-

mium for the extension of coverage, payment shall be made to the employer, by the employee.

[1973 c 340 s 2]

62A.149 BENEFITS FOR ALCOHOLICS AND DRUG DEPENDENTS. Subdivision 1. The provisions of this section shall apply to all group policies of accident and health insurance and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, and to a plan or policy that is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy unless the individual elects in writing to refuse benefits under this subdivision in exchange for an appropriate reduction in premiums or subscriber charges under the policy or plan, when the policies or subscriber contracts are issued or delivered in Minnesota or provide benefits to Minnesota residents enrolled thereunder.

Every insurance policy or subscriber contract included within the provisions of this subdivision, upon issuance or renewal, shall provide for payment of benefits for the treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident entitled to coverage thereunder on the same basis as coverage for other benefits when treatment is rendered in

(1) a licensed hospital,

(2) a residential treatment program as licensed by the state of Minnesota pursuant to diagnosis or recommendation by a doctor of medicine,

(3) a non-residential treatment program approved or licensed by the state of Minnesota.

Subd. 2. Coverage under subdivision 1, clauses (1) and (2) shall be for at least 20 percent of the total patient days allowed by the policy and in no event shall coverage be for less than 28 days in each 12 month benefit year. Coverage under subdivision 1, clause (3), shall be for at least 130 hours of treatment in a 12 month benefit year.

[1973 c 585 s 1,2; 1976 c 262 s 1; 1978 c 793 s 60]

62A.15 CHIROPRACTIC SERVICES IN ACCIDENT AND HEALTH AND NON-PROFIT HEALTH SERVICE POLICIES. Subdivision 1. Applicability. The provisions of this section shall apply to all group policies or subscriber contracts providing payment for care in this state, which are issued or renewed after August 1, 1973, and after August 1, 1976, for optometric services, by accident and health insurance companies regulated under this chapter, and nonprofit health service plan corporations regulated under chapter 62C.

Subd. 2. Chiropractic services. All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician shall also include chiropractic treatment and services of a chiropractor to the extent that the chiropractic services and treatment are within the scope of chiropractic licensure.

Subd. 3. Optometric services. All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician shall also include optometric treatment and services of an optometrist to the extent that the optometric services and treatment are within the scope of optometric licensure. This subdivision is intended to provide equal payment of benefits for optometric treatment and services and is not intended to change or add to the benefits provided for in such policies or contracts.

Subd. 4. Denial of benefits. No carrier referred to in subdivision 1 shall, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a duly licensed chiropractor.

[1973 c 252 s 1; 1976 c 192 s 1,2; 1976 c 242 s 1]

62A.151 HEALTH INSURANCE BENEFITS FOR EMOTIONALLY HANDICAPPED CHILDREN. No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D which provides coverage of or reimbursement for inpatient hospital and medical expenses shall be delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the commissioner of insur-

ance, after July 1, 1975 unless the policy or plan includes and provides health service benefits to any subscriber or other person covered thereunder, on the same basis as other benefits, for the treatment of emotionally handicapped children in a residential treatment facility licensed by the commissioner of public welfare. For purposes of this section "emotionally handicapped child" shall have the meaning set forth by the commissioner of public welfare in the rules and regulations relating to residential treatment facilities. The restrictions and requirements of this section shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy. The mandatory coverage under this section shall be on the same basis as inpatient hospital medical coverage provided under the policy or plan.

[1975 c 40 s 1]

62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES. Subdivision 1. The provisions of this section shall apply to all group policies or subscriber contracts which are issued or renewed within this state after August 1, 1975 by accident and health insurance companies regulated under this chapter, and nonprofit health service plan corporations regulated under chapter 62C.

Subd. 2. All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage, to at least the extent of 90 percent of the first \$600 of the cost of the usual and customary charges incurred over a 12-month period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient in a hospital, if such services are furnished by (1) a licensed or accredited hospital, (2) a community mental health center or mental health clinic approved or licensed by the commissioner of public welfare or other authorized state agency, or (3) by a consulting psychologist licensed under the provisions of sections 148.87 to 148.99, or by a psychiatrist licensed under chapter 147.

[1975 c 89 s 1]

62A.153 FREE STANDING AMBULATORY SURGICAL CENTERS. No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C shall be issued, renewed, continued, delivered, issued for delivery or executed in this state, or approved for issuance or renewal in this state by the commissioner of insurance unless the policy, plan or contract specifically provides coverage for a health care treatment or service rendered by a free standing ambulatory surgical center or facilities offering ambulatory medical service 24 hours a day seven days a week, which are not part of a hospital, but have been reviewed and approved by the state commissioner of health to provide the treatment or service, on the same basis as coverage provided for the same health care treatment or service rendered by a hospital.

[1976 c 45 s 1; 1977 c 305 s 45]

62A.16 GROUP HOSPITAL AND MEDICAL COVERAGE AND HEALTH CARE PLANS, APPLICABILITY. The provisions of sections 62A.16 and 62A.17 shall apply to all group insurance policies or group subscriber contracts providing coverage for hospital or medical expenses incurred by a Minnesota resident employed within this state. Sections 62A.16 and 62A.17 shall also apply to health care plans established by employers in this state through health maintenance organizations certified under chapter 62D.

[1974 c 101 s 1; 1976 c 142 s 1]

62A.17 TERMINATION OF EMPLOYMENT. Subdivision 1. Continuation of coverage. Every group insurance policy, group subscriber contract and health care plan included within the provisions of section 62A.16, except policies, contracts or health care plans covering employees of an agency of the federal government, shall contain a provision which permits every eligible employee whose employment is terminated, if the policy, contract or health care plan remains in force for active employees of the employer, to elect to continue the coverage for himself and his dependents.

Subd. 2. Responsibility of employee. Every eligible employee electing to continue coverage shall pay his former employer, on a monthly basis, the cost of the continued coverage. If the policy, contract or health care plan is administered by a trust every eligible employee electing to continue coverage shall pay the trust the cost

of continued coverage according to the eligibility rules established by the trust. The employee shall be eligible to continue the coverage until he becomes re-employed and eligible for health care coverage under a group policy, contract or plan sponsored by the same or another employer, or for a period of six months after the termination of employment, whichever is shorter.

Subd. 3. Eligibility for continued coverage. An employee shall be eligible to make the election for himself and his dependents provided for in subdivision 1 if:

(a) In the period preceding the termination of his employment, he and his dependents were covered through his employment by a group insurance policy, subscriber's contract or health care plan included within the provisions of section 62A.16;

(b) The termination of employment was for reasons other than the discontinuance of the business, bankruptcy, the employee's disability or retirement.

Subd. 4. Responsibility of employer. After timely receipt of the monthly payment from an eligible employee, if the employer, or the trustee if the policy, contract or health care plan is administered by a trust, fails to make the payment to the insurer, the nonprofit health service plan corporation or the health maintenance organization, with the result that the employee's coverage is terminated, the employer or the trust shall become liable for the employee's coverage to the same extent as the insurer, the nonprofit health service plan corporation or the health maintenance organization, would be if the coverage were still in effect.

Subd. 5. Notice of options. Upon the termination of employment of an eligible employee, the employer shall inform the employee within ten days after termination of:

(a) his right to elect to continue the coverage;

(b) the amount he must pay monthly to the employer to retain the coverage;

(c) the manner in which and the office of the employer to which the payment to the employer must be made; and

(d) the time by which the payments to the employer must be made to retain coverage.

If the policy, contract or health care plan is administered by a trust, the terminating employer is relieved of the obligation imposed by clauses (a) to (d). The trust shall inform the employee of the information required by clauses (a) to (d).

Notice may be in writing and sent by first class mail to the employee's last known address which the employee has provided the employer or trust. If the employer or trust fails to so notify the employee who is properly enrolled in the program, the employee shall have the option to retain coverage provided he makes this election within 60 days of the date his employment is terminated by making the proper payment to the employer or trust to provide continuous coverage.

A notice in substantially the following form shall be sufficient. As a terminated employee the law authorizes you to maintain your group medical insurance for a period of up to six months. To do so you must notify your former employer within ten days of this notice that you intend to retain such coverage and must make a monthly payment of \$..... to at by the of each month.

Subd. 6. Conversion to individual policy. A group insurance policy that provides post termination coverage as required by this section shall also include a provision allowing a covered employee or surviving spouse or dependent at the expiration of the post termination coverage provided by subdivision 2 to obtain from the insurer offering the group policy or group subscriber contract, at the employee's, spouse's or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual policy of insurance or an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.02 and the option of a number three qualified plan, a number two qualified plan, and a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3. A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, the spouse or a dependent in lieu of the optional coverage otherwise required by this subdivision.

The individual policy shall be renewable at the option of the individual as long as the individual is not covered under another qualified plan as defined in section 62E.02, subdivision 4, up to age 65 or to the day before the date of eligibility for coverage under Title XVIII of the Social Security Act, as amended. Any revisions in the table of

rate for the individual policy shall apply to the covered person's original age at entry, and shall apply equally to all similar policies issued by the insurer.

[1974 c 101 s 2; 1975 c 100 s 1-3; 1976 c 142 s 2,3; 1977 c 409 s 2]

62A.18 PROHIBITION AGAINST DISABILITY OFFSETS. No individual or group policy of accident and health insurance issued, amended, renewed, or delivered in this state on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit under the policy by the amount of, or in proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, the Railroad Retirement Act, any Veteran's Disability Compensation and Survivor Benefits Act, Workers' Compensation, or any similar federal or state law, as amended subsequent to the date of commencement of such benefit.

[1975 c 323 s 1]

62A.21 CONVERSION PRIVILEGES FOR INSURED FORMER SPOUSES. Subdivision 1. No policy of accident and health insurance providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis, which in addition to covering the insured also provides coverage to the spouse of the insured shall contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship except by reason of an entry of a valid decree of dissolution of marriage.

Subd. 2. Every policy described in subdivision 1 which contains a provision for termination of coverage of the spouse upon dissolution of marriage shall contain a provision to the effect that upon the entry of a valid decree of dissolution of marriage between the insured parties the spouse shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the company within 60 days following the entry of the decree, and upon the payment of the appropriate premium, an individual policy of accident and health insurance. The policy shall provide the coverage then being issued by the insurer which is most nearly similar to, but not greater than, the terminated coverages. Any and all probationary or waiting periods set forth in the policy shall be considered as being met to the extent coverage was in force under the prior policy.

Subd. 3. This section applies to every policy of accident and health insurance which is delivered, issued for delivery, renewed or amended on or after the effective date of this section.

[1977 c 186 s 1]

§ 62D.30

INSURANCE

Subd. 6. Each health maintenance organization for which a demonstration project is approved shall annually file a report with the commissioner summarizing the project's experience at the same time it files its annual report required by section 62D.08. The report shall be on a form developed by the commissioner and shall be separate from the annual report required by section 62D.08.

Subd. 7. The commissioner may rescind approval of a demonstration project if the commissioner makes any of the findings listed in section 62D.15, subdivision 1, with respect to the project for which it has not been granted a specific exemption, or if the commissioner finds that the project's operation is contrary to the information contained in the approved application. Added by Laws 1979, c. 268, § 1, eff. May 31, 1979.

42 U.S.C.A. § 1395 et seq.

Library References
Physicians and Surgeons C-4.
C.J.S. Physicians and Surgeons § 12.

CHAPTER 62E. HEALTH CARE [NEW]

COMPREHENSIVE HEALTH INSURANCE

- Sec. 62E.01 Citation.
- 62E.02 Definitions.
- 62E.03 Duties of the employer.
- 62E.035 Self insurer identification and reporting [New].
- 62E.04 Duties of insurers.
- 62E.05 Certification of qualified plans.
- 62E.06 Minimum benefits of qualified plan.
- 62E.07 Qualified medicare supplement plan.
- 62E.08 State plan premium.
- 62E.09 Duties of commissioner.
- 62E.10 Comprehensive health association.
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- Sec. 62E.12 Minimum benefits of comprehensive health insurance plan.
- 62E.13 Administration of plan.
- 62E.14 Enrollment by an eligible person.
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CATASTROPHIC HEALTH EXPENSE PROTECTION

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- 62E.52 Definitions.
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COMPREHENSIVE HEALTH INSURANCE

62E.01 Citation

Sections 62E.01 to 62E.17 may be cited as the Minnesota comprehensive health insurance act of 1976. Laws 1976, c. 296, art. 1, § 1, eff. July 1, 1976.

Title of Act:

An Act relating to health care; providing for establishment and administration of certain plans of health insurance to make minimum health care benefits available to all persons in the state; creating a comprehensive health care association; requiring review of hospital and insurance premium rates; providing protection against catastrophic health care expenses; regulating coverage of dental services by health maintenance organizations; appropriating money; amending Minnesota Statutes 1971, Sections 62A.02, Subdivisions 1 and 2; 62C.15, Subdivision 2; and 62D.12, by adding a subdivision. Laws 1976, c. 296.

1. Review Commentaries
Comprehensive Health Insurance Act of 1976. All provisions of the act are effective July 1, 1976. See also, 1976 Minn. Stat. Ann. 62E.01-17 (1976).

Medical benefit plans in Minnesota. Robert T. Strauss. 34 Bench and Bar No. 6, p. 19 (Nov. 1977).

Minnesota Comprehensive Health Insurance Act of 1977. By John F. Stone and Margo S. Struthers. 34 Bench and Bar No. 7, p. 27 (Jan. 1978).

Library References
Insurance C-4.2.
C.J.S. Insurance § 67.

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Validity 1

1. Validity

This act does not deny due process by being unreasonable or arbitrary exercise of state's power to regulate business of insurance, nor is it unconstitutionally vague. Insurers' Action Council, Inc. v. Heaton, D.C. 1976, 423 F.Supp. 921.

This act does not impair contractual obligations insofar as it was applicable to existing guaranteed renewable policies. Id.

This act does not violate the contract clause of the Minnesota Constitution. Insurers' Action Council, Inc. v. Heaton, D.C. 1976, 423 F.Supp. 921.

2. In general

Provisions of § 62E.03 relating to employer's obligation to offer specified form of group insurance to his employees were not preempted by Employee Retirement Income Security Act of 1974. Insurers' Action Council, Inc. v. Heaton, D.C. 1976, 423 F.Supp. 921.

62E.02 Definitions

Subdivision 1. For the words and phrases defined in this section.

Subd. 2. "Employer" means an individual, estate or corporation, instrumentality or government agency or more individuals who are jointly or severally liable.

Subd. 3. "Health maintenance organization" means a health maintenance organization licensed and operated in this state.

Subd. 4. "Qualified plan" means a plan which has been certified by the commissioner under section 62E.06.

Subd. 5. "Qualified minimum benefit plan" means a plan which has been certified by the commissioner under section 62E.06 and which provides minimum benefits which are less than those provided by those benefits.

Subd. 6. "Commissioner" means the commissioner of health care.

Subd. 7. "Dependent" means a child, stepchild, or grandchild of 19 years, a dependent child, or a financially dependent upon the insured who is disabled.

Subd. 8. "Employee" means an individual who is employed by or working for any employer. "Employee" does not include a contractor for less than 30 days by or for any contractor.

Subd. 9. "Plan of health care" means a plan of health care coverage, including coverage under a nonprofit health maintenance organization or a health insurance policy issued by an accident and health insurance organization.

Subd. 10. "Insurer" means an individual, estate or corporation, instrumentality or government agency or more individuals who are jointly or severally liable and offering or providing coverage of accident and health insurance organizations.

Subd. 11. "Accident and health insurance or nonprofit health maintenance organization" means a hospital, surgical and medical benefit plan which is (1) limited to disability benefits, (2) limited to medical payment coverage, (3) limited to provide payments on a non-accrued basis, (4) credit not assigned to the insured, (5) designated as accident and sickness insurance, (6) only coverage issued by the insurer which provides reasonable benefits, and (7) which is not subject to the provisions of chapter 62E. The provisions of chapter 62E do not apply to any other type of health insurance.

Subd. 12. "Disability benefit plan" means a plan of health care coverage which provides disability benefits on a non-accrued basis for surgical or hospital care.

Subd. 13. "Eligible person" means an individual who is a resident of Minnesota and meets the criteria of section 62E.03.

Subd. 14. "Minnesota comprehensive health insurance act" means the association created by this act.

Subd. 15. "Medicare" means the federal Social Security Act, Title XVIII.

62E.02 Definitions

Subdivision 1. For the purposes of sections 62E.01 to 62E.17, the terms and phrases defined in this section have the meanings given them.

Subd. 2. "Employer" means any person, partnership, association, trust, estate or corporation, including the state of Minnesota or any agency, instrumentality or governmental subdivision thereof, which employs ten or more individuals who are residents of this state.

Subd. 3. "Health maintenance organization" means a nonprofit corporation licensed and operated as provided in chapter 62D.

Subd. 4. "Qualified plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by section 62E.06 or the actuarial equivalent of those benefits.

Subd. 5. "Qualified medicare supplement plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by section 62E.07 or the actuarial equivalent of those benefits.

Subd. 6. "Commissioner" means the commissioner of insurance.

Subd. 7. "Dependent" means a spouse or unmarried child under the age of 19 years, a dependent child who is a student under the age of 25 and financially dependent upon the parent, or a dependent child of any age who is disabled.

Subd. 8. "Employee" means any Minnesota resident who has entered into the employment of or works under contract or service or apprenticeship with any employer. "Employee" does not include a person who has been employed for less than 30 days by his present employer, nor one who is employed less than 30 hours per week by his present employer, nor an independent contractor.

Subd. 9. "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of self insurance, individual accident and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health service plan, or coverage under a health maintenance organization subscriber contract.

Subd. 10. "Insurer" means those companies operating pursuant to chapters 62A or 62C and offering or, selling, issuing, or renewing policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations.

Subd. 11. "Accident and health insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical and medical care. "Policy" does not include coverage which 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 non-expense incurred basis, (5) credit accident and health insurance issued pursuant to chapter 62B, (6) designed solely to provide dental or vision care, (7) blanket accident and sickness insurance as defined in section 62A.11, or (8) accident only coverage issued by licensed and tested insurance agents or solicitors which provides reasonable benefits in relation to the cost of covered services. The provisions of clause (4) shall not apply to hospital indemnity coverage which is sold by an insurer to an applicant who is not then currently covered by a qualified plan.

Subd. 12. "Health benefits" means benefits offered to employees on an indemnity or prepaid basis which pay the costs of or provide medical, surgical or hospital care.

Subd. 13. "Eligible person" means an individual who is a resident of Minnesota and meets the enrollment requirements of section 62E.14.

Subd. 14. "Minnesota comprehensive health association" or "association" means the association created by section 62E.10.

Subd. 15. "Medicare" means part A and part B of the United States Social Security Act, Title XVIII, as amended, 42 U.S.C. Sections 1304, et seq.

Subd. 16. "Medicare supplement plan" means any plan of insurance protection which provides benefits for the costs of medical, surgical or hospital care and which is marketed as providing benefits which complement or supplement the benefits provided by medicare.

Subd. 17. "State plan premium" means the premium determined pursuant to section 62E.08.

Subd. 18. "Writing carrier" means the insurer or insurers and health maintenance organization or organizations selected by the association and approved by the commissioner to administer the comprehensive health insurance plan.

Subd. 19. "Fraternal beneficiary association" or "fraternal" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance in accordance with chapter 64A.

Subd. 20. "Comprehensive health insurance plan" or "state plan" means policies of insurance and contracts of health maintenance organization coverage offered by the association through the writing carrier.

Subd. 21. "Self insurer" means an employer or an employee welfare benefit fund or plan which directly or indirectly provides a plan of health coverage to its employees and administers the plan of health coverage itself or through an insurer, trust or agent except to the extent of accident and health insurance premium, subscriber contract charges or health maintenance organization contract charges. "Self insurer" does not include an employer engaged in the business of providing health care services to the public which provides health care services directly to its employees at no charge to them.

Subd. 22. "Self insurance" means a plan of health coverage offered by a self insurer.

Subd. 23. "Contributing member" means those companies operating pursuant to chapter 62A, paying premium taxes pursuant to section 60A.15, and offering, selling, issuing, or renewing policies or contracts of accident and health insurance.

Laws 1976, c. 296, art. 1, § 2, eff. July 1, 1976. Amended by Laws 1977, c. 409, §§ 4 to 7, eff. June 3, 1977; Laws 1979, c. 272, §§ 1, 2, eff. May 31, 1979.

1977 Amendment. Added "including the state of Minnesota or any agency, instrumentality or governmental subdivision thereof" to subd. 2. Deleted "on average of" as descriptive of 30 hours as it appears in subd. 8, and added "nor an independent contractor" at the end of that subdivision.

Revised subds. 11 and 21 which formerly read:

"Subd. 11. 'Accident and health insurance policy' or 'policy' means insurance or nonprofit health services plan contracts providing benefits for hospital, surgical and medical care. 'Policy' does not include coverage which is (1) limited to disability or income protection coverage, (2) automobile medical

payment coverage, (3) supplemental to liability insurance, (4) sold by fraternal and provides payments on a per diem, daily indemnity or non-expense incurred basis, or (5) credit accident and health insurance issued pursuant to Minnesota Statutes, Chapter 62H.

"Subd. 21. 'Self insurer' means an employer who directly provides a plan of health coverage to his employees and administers the plan of health coverage himself or through an insurer. 'Self insurer' does not include an employer engaged in the business of providing health care services to the public who provides health care services directly to his employees at no charge to them."

1979 Amendment. Added "issuing or renewing" to subd. 10. Added subd. 23.

62E.03 Duties of the employer

Subdivision 1. Each employer who provides or makes available to his employees a plan of health coverage shall make available to his employees employed in this state a plan or combination of plans which have been certified by the commissioner as a number two qualified plan. If the plan of health coverage does not meet the requirements of section 62E.06 for a number two qualified plan, the employer shall make available a supplemental plan of health benefits which, when combined with the existing plan of health benefits, constitutes a number two coverage plan. The plan or combinations of plans may be financed from funds contributed solely by the employer or solely by the employees or any combination thereof. The plans may consist of self insurance, health maintenance contracts, group policies or individual policies or any combination thereof.

Subd. 2. In the event 1, none of the employer's tax deduction pursuant to case of an employer who subdivision 1, clause (j) or clause at least a number two qualified lose his status as an exempt 1, clause (j) or clause (p), as Laws 1976, c. 296, art. 1, § 8, eff. June 3, 1977.

1977 Amendment. Substituted with subdivision 1 available at least a number qualified plan of health benefits employees employed in this state beginning of subd. 2 and in subsequent references to clause Law Review Commentaries Medical benefit plans in Robert F. Strauss, 34 Bench No. 5, p. 19 (Nov. 1977). Minnesota Comprehensive Health Insurance Act of 1977. By John

62E.035 Self Insurer Identification

The commissioner shall require engaged in self insurance in each calendar year and shall include and other information the self insurer's plan of health the commissioner of revenue shall of self insurers, and shall necessary to identify self insured pursuant to this section the commissioner.

Added by Laws 1979, c. 272, § 1. Library References Insurance § 9. C.J.S. Insurance § 73.

62E.04 Duties of Insurers

Subdivision 1. Individual described in section 62E.06, policies of accident and health insurance version policies, shall develop individual policy which meets the plan. An insurer or fraternal health insurance in this state person who applies and is eligible that insurer or fraternal.

Subd. 2. Medicare supplement care supplement plans in this state commissioner a medicare supplement a qualified medicare supplement care supplement plans in this state ment plan to each person who medicare supplement plan.

Subd. 3. Group policies. For section 62E.06, an insurer or fraternal health insurance in this state a group policy which provides the benefits required by that type of issuing group policies of accident offer each type of qualified plan dent and health insurance.

Subd. 2. In the event that an employer fails to comply with subdivision 1, none of the employer's costs for health benefits shall qualify as an income tax deduction pursuant to section 290.09, subdivision 2, clause (a)(1). In the case of an employer who meets the requirements of section 297A.25, subdivision 1, clause (j) or clause (p) if the employer fails to make available at least a number two qualified plan to his employees, the employer shall lose his status as an exempt organization under section 297A.25, subdivision 1, clause (j) or clause (p), as appropriate. Laws 1976, c. 296, art. 1, § 3, eff. Jan. 1, 1977. Amended by Laws 1977, c. 409, § 8, eff. June 3, 1977.

1977 Amendment. Substituted "comply with subdivision 1" for "make available at least a number two qualified plan of health benefits to his employees employed in this state" at the beginning of subd. 2 and included the subsequent references to clause (j).

Law Review Commentaries
Medical benefit plans in Minnesota. Robert F. Strauss. 34 Bench and Bar No. 5, p. 19 (Nov. 1977).

Minnesota Comprehensive Health Insurance Act of 1977. By John F. Stone

and Margo S. Struthers. 34 Bench and Bar No. 1, p. 27 (Jan. 1979).

Library References
Master and Servant § 10.
C.J.S. Master and Servant § 14.

1. In general
Provisions of this section relating to employer's obligation to offer specified forms of group insurance to his employees were not preempted by Employee Retirement Income Security Act of 1974. Insurers' Action Council, Inc. v. Heaton, D.C. 1978, 423 F.Supp. 921.

62E.035 Self Insurer Identification and reporting

The commissioner shall require self insurers to report annually that they are engaged in self insurance business. These reports shall be for the previous calendar year and shall include the self insurer's total cost of self insurance and other information the commissioner may by rule require relating to the self insurer's plan of health coverage. Upon request of the commissioner, the commissioner of revenue shall cooperate with the commissioner in the identification of self insurers, and shall modify forms and promulgate rules as may be necessary to identify self insurers. In adopting the forms and rules promulgated pursuant to this section the commissioner of revenue shall consult with the commissioner.

Added by Laws 1979, c. 272, § 3, eff. May 31, 1979.

Library References
Insurance § 9.
C.J.S. Insurance § 73.

62E.04 Duties of Insurers

Subdivision 1. Individual policies. For each type of qualified plan described in section 62E.06, an insurer or fraternal issuing individual policies of accident and health insurance in this state, other than group conversion policies, shall develop and file with the commissioner an individual policy which meets the minimum standards of that type of qualified plan. An insurer or fraternal issuing individual policies of accident and health insurance in this state shall offer each type of qualified plan to each person who applies and is eligible for accident and health insurance from that insurer or fraternal.

Subd. 2. Medicare supplement plan. An insurer or fraternal issuing medicare supplement plans in this state shall develop and file with the commissioner a medicare supplement policy which meets the minimum standards of a qualified medicare supplement plan. An insurer or fraternal issuing medicare supplement plans in this state shall offer a qualified medicare supplement plan to each person who is eligible for coverage and who applies for a medicare supplement plan.

Subd. 3. Group policies. For each type of qualified plan described in section 62E.06, an insurer or fraternal issuing group policies of accident and health insurance in this state shall develop and file with the commissioner a group policy which provides for each member of the group the minimum benefits required by that type of qualified plan. An insurer or fraternal issuing group policies of accident and health insurance in this state shall offer each type of qualified plan to each eligible applicant for group accident and health insurance.

Subd. 4. Major medical coverage. Each insurer and fraternal shall affirmatively offer coverage of major medical expenses to every applicant who applies to the insurer or fraternal for a new unqualified policy at the time of application and annually to every holder of an unqualified policy of accident and health insurance renewed by the insurer or fraternal. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of \$5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of \$250,000. The offer of coverage of major medical expenses may consist of the offer of a rider on an existing unqualified policy or a new policy which is a qualified plan.

Subd. 5. Effect of non-compliance. No policy of accident and health insurance may be issued or renewed in this state 180 days after July 1, 1976, by an insurer or a fraternal which has not complied with the requirements of this section.

Subd. 6. Reinsurance allowed. An insurer or fraternal may fulfill its obligations under this section by issuing the required coverages in their own name and reinsuring the risk and administration of the coverages with the association in accordance with section 62E.10, subdivision 7, clauses (c) and (f).

Subd. 7. Underwriting standards may apply. Nothing in this section shall require an insurer or fraternal to offer or issue a policy to any person who does not meet the underwriting or membership requirements of the insurer or fraternal.

Subd. 8. Reduction of benefits because of other services. No policy of accident and health insurance shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving benefits pursuant to chapters 256B and 256D, or sections 62E.51 to 62E.55 or 252.27; 260.251, subdivision 1a; 261.27; 393.07, subdivision 1 or 2.

Laws 1976, c. 296, art. 1, § 4, eff. July 1, 1976. Amended by Laws 1977, c. 409, §§ 9, 10, eff. June 3, 1977; Laws 1979, c. 174, § 3, eff. May 23, 1979; Laws 1979, c. 272, § 4, eff. May 31, 1979.

1977 Amendment. Revised Subd. 4 which formerly read:

"Each insurer and fraternal shall include coverage of major medical costs in every unqualified policy of accident and health insurance, unless the applicant for a new or renewal policy declines the coverage in writing. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of \$5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of \$250,000."

Added subd. 8.
1979 Amendments. Laws 1979, c. 174, deleted "issued or renewed after August

1, 1977" following "insurance" and added the alternative cites at the end of subd. 4.

Laws 1979, c. 174, § 6, provides: "This act is effective the day following its final enactment [eff. May 23, 1979] and applies to any policy or plan of private health care coverage issued or renewed on or after that date."

Laws 1979, c. 272, added "who applies to the insurer or fraternal" and "renewed by the insurer or fraternal" to the first sentence of subd. 4, and the last sentence of that subdivision.

Library References
Insurance — 133(1.2), 531.1.
C.J.S. Insurance § 263, 897, 959.

62E.05 Certification of qualified plans

Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified medicare supplement plan for the purposes of sections 62E.01 to 62E.17, the commissioner shall make a determination within 90 days as to whether the plan is qualified. All plans of health coverage shall be labelled as "qualified" or "non-qualified" on the front of the policy or evidence of insurance. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

Laws 1976, c. 296, art. 1, § 5, eff. July 1, 1976.

62E.06 Minimum benefit

Subdivision 1. Number defined as a number three or established by chapters 6, or not the policy is issued minimum standards:

(a) The minimum benefit provisions of this subdivision covered services in excess of per person. The coverage total annual out-of-pocket expense. The coverage shall be subject to \$250,000.

The \$3,000 limitation on the maximum lifetime benefit shall be of an actuarially equivalent benefit.

(b) Covered expenses shall include the following services and articles:

- (1) Hospital services;
- (2) Professional services for or conditions, other than out-of-pocket expenses of a physician or at his direction;
- (3) Drugs requiring a physician's prescription;
- (4) Services of a nursing home or services which would qualify as reimbursable services under medical insurance;
- (5) Services of a home health care agency;
- (6) Use of radium or other radioactive substances;
- (7) Oxygen;
- (8) Anesthetics;
- (9) Prostheses other than dentures;
- (10) Rental or purchase, as well as repair, of eyeglasses and hearing aids;
- (11) Diagnostic X-rays and fluoroscopy;
- (12) Oral surgery for partial or complete dentures, tooth root without the extraction of the mouth when not performed as a part of a dental procedure;

(13) Services of a physical therapist;

(14) Transportation provided to a facility qualified to treat the condition and transportation to a kidney dialysis center.

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

(1) Any charge for care for an injury in the course of employment or similar law, (2) for which benefit coverage is statutorily required to be provided by a liability insurance policy or, (3) if benefits are payable under another medicare or any other governmental law;

(2) Any charge for treatment for the repair of an injury or birth defect;

(3) Care which is primarily for the purpose of diagnosis and would not qualify as eligible services.

62E.06 Minimum benefits of qualified plan

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

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

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

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

- (1) Hospital services;
- (2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient medical or dental, which are rendered by a physician or at his direction;
- (3) Drugs requiring a physician's prescription;
- (4) Services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under medicare;
- (5) Services of a home health agency if the services would qualify as reimbursable services under medicare;
- (6) Use of radium or other radioactive materials;
- (7) Oxygen;
- (8) Anesthetics;
- (9) Prostheses other than dental;
- (10) Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;
- (11) Diagnostic X-rays and laboratory tests;
- (12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;
- (13) Services of a physical therapist; and
- (14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.

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

- (1) Any charge for care for injury or disease other than arising out of or falling within the scope of any workers' compensation law, or any charge for coverage voluntarily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (ii) for which benefits are payable under another policy of accident and health insurance, medicare or any other governmental program except as otherwise provided by law;
- (2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;
- (3) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare;

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

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

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

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (c), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(1) Well baby care, effective July 1, 1980;

(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician, effective July 1, 1982;

(3) Multiphasic screening and other diagnostic testing, effective July 1, 1982. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for services listed in this clause.

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

Subd. 2. Number two plan. A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by subdivision 1 except that the deductible shall not exceed \$500 per person.

Subd. 3. Number one plan. A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by subdivision 1 except that the deductible shall not exceed \$1,000 per person.

Subd. 4. Health maintenance plans. A health maintenance organization which provides the services required by chapter 62D shall be deemed to be providing a number three qualified plan.

Laws 1975, c. 359, § 23; Laws 1976, c. 206, art. 1, § 6, eff. July 1, 1976; Laws 1977, c. 409, § 11, eff. June 3, 1977; Laws 1979, c. 272, § 5, eff. May 31, 1979.

1977 Amendment. Revised this section which formerly provided:

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

"(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed \$500 per person. The deductible shall include a separate deductible for each of the following services or articles when prescribed by a physician:

"(1) Hospital services;

"(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient

mental or dental, which are rendered by a physician or at his direction;

"(3) Drugs requiring a physician's prescription;

"(4) Services of a nursing home for not more than 120 days in a year if the services commence within 14 days following confinement of at least three days in a hospital for the same condition;

"(5) Service of a home health agency up to a maximum of 180 visits per year;

"(6) Use of radium or other radioactive materials;

"(7) X-ray;

"(8) Prosthetic;

"(9) Services of a physical therapist;

"(10) Oral surgery for partially or completely missing upper and lower, a tooth root without the extraction of the entire tooth, or the gums and tissue of the mouth when not performed in connection with the extraction or repair of teeth; and

"(11) Services of a physical therapist.

"(b) Covered expenses for fees and articles specified in this division do not include the following:

"(1) Any charge for any care, injury or disease either (i) a part of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) benefits are payable without fault under coverage statutes required to be contained in any vehicle, or other liability policy or equivalent self-insurance (iii) for which benefits are payable under another policy of accident health insurance or medicare;

"(2) Any charge for treatment for cosmetic purposes other than for the repair of an injury or defect;

"(3) Any charge for travel or travel by ambulance to the health care institution qualified for the illness or injury;

"(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician;

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

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

"(c) Effective January 1, 1980, minimum benefits for a qualified plan shall include, in addition to those benefits specified in clause (a), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

"(1) Well baby care;

62E.07 Qualified medicare supplement

Any plan which provides benefits to supplement medicare and provide and copayment required under medicare covered services described in section 62B not paid by medicare. The coverage for a person on total annual out-of-pocket coverage may be subject to a maximum of \$100,000.

Laws 1976, c. 206, art. 1, § 7, eff. July 1, 1976.

62E.08 State plan premium

Subdivision 1. The association shall charge premiums to be charged for membership plan:

(a) The premium for the member of the association who is not a resident of Minnesota;

(b) The premium for the member of the association who is a resident of Minnesota;

(c) The premium for a qualified member of the association who is a resident of Minnesota and who is not a member of the association.

(d) The premium for a qualified member of the association who is a resident of Minnesota and who is not a member of the association.

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

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

"(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

"(3) Any charge for travel other than travel by ambulance to the nearest health care institution qualified to treat the illness or injury;

"(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician;

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

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

"(c) Effective January 1, 1980, the minimum benefits for a qualified plan shall include, in addition to those benefits specified in clause (a), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

"(1) Well baby care;

"(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician; and

"(3) Multiphasic screening and other diagnostic testing. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for services listed in this clause.

"Subd. 2. A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by the laws of this state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed \$500 per person.

"Subd. 3. A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by the laws of this state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed \$1,000 per person.

"Subd. 4. A health maintenance organization which provides the services required by Minnesota Statutes, Chapter 62B shall be deemed to be providing a number three qualified plan."

1979 Amendment Added to subd. 1(b)(14): "or a reasonable mileage rate for transportation to a kidney dialysis center for treatment". Deleted as the beginning words in subd. 1(1): effective July 1, 1980. Inserted the following effective dates in subd. 1(d) in clause (d)(1), July 1, 1980; in clause (d)(2), July 1, 1982; in clause (d)(3), July 1, 1982.

Law Review Commentaries
Medical benefit plans in Minnesota.
Robert F. Strauss. 31 Bench and Bar No. 5, p. 19 (Nov. 1977).

Minnesota Comprehensive Health Insurance Act of 1977. By John F. Stone and Margo S. Struthers. 31 Bench and Bar No. 7, p. 27 (Jun. 1978).

Library References
Insurance §531.1.
C.J.S. Insurance § 897, 980

62E.07 Qualified medicare supplement plan

Any plan which provides benefits to persons over the age of 65 years may be certified as a qualified medicare supplement plan if the plan is designed to supplement medicare and provides coverage of 50 percent of the deductible and copayment required under medicare and 80 percent of the charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by medicare. The coverage shall include a limitation of \$1,000 per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than \$100,000.

Laws 1970, c. 206, art. 1, § 7, eff. July 1, 1970.

62E.08 State plan premium

Subdivision 1. The association shall establish the following maximum premiums to be charged for membership in the comprehensive health insurance plan:

(a) The premium for the number one qualified plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in Minnesota;

(b) The premium for the number two qualified plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in Minnesota;

(c) The premium for a qualified medicare supplement plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers

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with the largest number of individuals enrolled in a qualified medicare supplement plan; and

(d) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

The five insurers whose rates are used to establish the premium for each type of coverage offered by the association shall be determined by the commissioner on the basis of information provided by all insurers annually at the commissioner's request, concerning the number of individual qualified plans and qualified medicare supplement plans or actuarially equivalent plans offered by the insurer and rates charged by the insurer for each type of plan offered by the insurer. In determining the insurers whose rates shall be used in establishing the premium, the commissioner shall utilize generally accepted actuarial principles and structurally compatible rates. Subject to this subdivision, the commissioner shall include any insurer operating pursuant to chapter 62C in establishing the premium. In establishing premiums pursuant to this section, the association shall utilize generally accepted actuarial principles.

Subd. 2. Subject to subdivision 1 of this section, the schedule of premiums for coverage under the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles. Laws 1976, c. 206, art. 1, § 8, eff. July 1, 1976. Amended by Laws 1977, c. 469, § 12, eff. June 3, 1977; Laws 1970, c. 272, § 6, eff. May 31, 1970.

1977 Amendment. Substituted 18 months for a year at the beginning of the section, modified subd. 2 accordingly.

1979 Amendment. Revised this section which formerly read:

"Subdivision 1. For the first eighteen months of operation of the comprehensive health insurance plan the association shall establish the following premiums to be charged for membership in the comprehensive health insurance plan:

"(a) The premium for the number one qualified plan shall be the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in Minnesota;

"(b) The premium for the number two qualified plan shall be the average of rates charged by the five insurers with the largest number of individuals

in a number two individual qualified plan of insurance in force in Minnesota; "(c) The premium for a qualified medicare supplement plan shall be the average of rates charged by the five insurers with the largest number of individuals enrolled in a qualified medicare supplement plan; and

"(d) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

"Subd. 2. For subsequent enrollees or renewals of membership, the schedule of premiums for membership in the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles."

Library References Insurance § 11. C.J.S. Insurance § 60 et seq.

62E.09 Duties of commissioner

The commissioner may:

(a) Formulate general policies to advance the purposes of sections 62E.01 to 62E.17;

(b) Supervise the creation of the Minnesota comprehensive health association within the limits described in section 62E.10;

(c) Approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the state plan coverage and premiums to be charged;

(d) Appoint advisory committees;

(e) Conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;

(f) Contract with the federal government or any other unit of government to ensure continuation of the state plan with other governmental assistance programs;

(g) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of sections 62E.01 to 62E.17, so that the residents of this state may best avail themselves of the health care benefits provided by these sections;

(h) Contract with insurance carriers to adopt, amend, supplement, carry out and make effective the provisions of section 62E.17. The commission shall promulgate rules.

Laws 1976, c. 206, art. 1, § 13, eff. June 3, 1977.

1977 Amendment. Deleted from the end of clause (h) the words "the commission shall also adopt, promulgate,

62E.10 Comprehensive health association

Subdivision 1. A comprehensive health association shall be created in the state of Minnesota with non-profit status and health maintenance organization status. The association shall be exempt from taxation under the laws of this state.

Subd. 2. Board of directors. The board of directors of the association shall be made up of members, subject to approval by the members or proxy. The vote shall be cast by the members. The board shall be self-insuring, accident and health insurance, or health maintenance organization insurance. In approving members, among other things, the board shall consider the ability of the members to pay the dues. Members of the board shall be compensated for expenses incurred in the performance of their duties. Meetings of the association shall be held at the call of the board.

Subd. 3. Mandatory membership. Membership in the association shall be mandatory for all persons in this state. The association shall submit to the commissioner for approval articles of association, bylaws and operating procedures. The commissioner thereof shall be subject to sections 15.041 to 15.052.

Subd. 4. Open meetings. All committees of the association shall be open to the public. Laws 1977, c. 471, § 705.

Subd. 5. Repealed by Laws 1977, c. 471, § 705.

Subd. 6. Antitrust exemption. The association, the members of the association, the members of the board of directors, and the members of the committees shall be exempt from sections 325.8011 to 325.8028.

Subd. 7. General powers. The association shall:

(a) Exercise the powers granted to it by the laws of this state;

(c) Enter into contracts with insurance carriers and other persons for the performance of the functions provided for in clause (d);

(d) Establish administrative and operating procedures of the association;

(e) Provide for the reinsuring of coverages required by sections 62E.01 to 62E.17.

(b) Contract with insurers and others for administrative services; and
(l) Adopt, amend, suspend and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of sections 62E.01 to 62E.17. The commissioner may until December 31, 1978 adopt emergency rules.

Laws 1976, c. 296, art. 1, § 9, eff. July 1, 1976. Amended by Laws 1977, c. 409, § 13, eff. June 3, 1977.

1977 Amendment. Deleted the following from the end of clause (a) and added clause (l): "the commissioner may also adopt, promulgate, repeal, and amend rules pursuant to the rule making provisions of Minnesota Statutes, Chapter 15, to carry out the provisions of sections 62E.01 to 62E.17;"

62E.10 Comprehensive health association

Subdivision 1. Creation; tax exemption. There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers, self insurers, fraternal and health maintenance organizations licensed or authorized to do business in this state. The comprehensive health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

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

Subd. 3. Mandatory membership. All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, or health maintenance organization business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 15.041 to 15.052.

Subd. 4. Open meeting. All meetings of the association, its board, and any committees of the association shall comply with the provisions of section 471.705.

Subd. 5. Repealed by Laws 1979, c. 272, § 11, eff. May 31, 1979.

Subd. 6. Antitrust exemption. In the performance of their duties as members of the association, the members shall be exempt from the provisions of sections 325.8011 to 325.8028.

Subd. 7. General powers. The association may:

- (a) Exercise the powers granted to insurers under the laws of this state;
- (b) Sue or be sued;

(c) Establish administrative and accounting procedures for the operation of the association;

(d) Establish administrative and accounting procedures for the operation of the association;

(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by sections 62E.04 and 62E.16 by members of the association;

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tion. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:

- (1) Individual qualified plans, excluding group conversions;
- (2) Group conversions;
- (3) Group qualified plans with fewer than 50 employees or members; and
- (4) Major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance; and

(f) Provide for the administration by the association of policies which are reinsured pursuant to clause (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.

Subd. 8. Department of state exemption. The association shall be exempt from the provisions of chapter 15.

L. vs 1976, c. 206, art. 1, § 10, eff. July 1, 1976. Amended by Laws 1977, c. 409, §§ 14 to 16, eff. June 3, 1977; Laws 1979, c. 272, § 7, eff. May 31, 1979.

1977 Amendment. Added "to promote the public health and welfare of the state of Minnesota" to the first sentence of subd. 1 as well as the last sentence of that subdivision. Added "accident and health insurance, self-insurance, or health maintenance organization" to subd. 3. Added the sentences to subd. 10(e)(4) relating to the reinsurance contracts.

1979 Amendment. Revised the terms of subds. 2 and 3 and added subd. 5. Revised subds. 2 and 3 and repeated subd. 5 read as follows:

"Subd. 2. The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. If the board of directors is not selected within 60 days after notice of the organizational meeting, the commissioner may appoint the

initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

"Subd. 3. All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, or health maintenance organization business in this state. The association shall submit bylaws and operating rules to the commissioner for approval.

"Subd. 5. All members shall enter into a contract with the association according to terms specified in section 62E.11. The contract of reinsurance shall be executed on or before January 1, 1977, for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year."

Library References

Insurance § 31.1.
C.J.S. Insurance § 91 et seq.

62E.11 Operation of contract

Subdivision 1. Upon provided by section 62E.14, health insurance plan b. carrier.

Subd. 2. Any employee enrolled in the comprehensive portion of the state plan writing carrier.

Subd. 3. Not less than writing carrier shall be t shall be used for the pay 62E.15, subdivision 3 and direct expenses, as specific

Subd. 4. Any income in providing reinsurance or clauses (e) and (f) shall be set losses due to claims expense plan premiums.

Subd. 5. Each contributing due to claims expenses of issued or approved for loss operating and administrative by the association incident of the state plan which excess of benefits shall be the liability members shall share in the administrative expenses of the contributing member's received from or on behalf of dependent and health insurance provided or on behalf of Minnesota

Subd. 6. The association contributing member's liability, assessment if necessary. The commissioner, provide for members as may be necessary in meeting the incurred and operating and administrative next annual fiscal year due within 30 days of receipt of a fiscal year end or in order to tender to the association for termination of the contract member which ceases to do business the state shall remain liable for which accident and health insurance decline to levy an assessment amount, as determined herein, and

Subd. 7. Not zeros, if any, held at interest and used by claims expenses of the state plan

Subd. 8. Any annual fiscal year contributing member may be offset to the association, against the that contributing member pursuant annual fiscal year end or interim revenue shall annually, on or before the senate finance, house appropriate

62E.11 Operation of comprehensive plan

Subdivision 1. Upon certification as an eligible person in the manner provided by section 62E.14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

Subd. 2. Any employer which has in its employ one or more eligible persons enrolled in the comprehensive health insurance plan may make all or any portion of the state plan premium payment to the state plan directly to the writing carrier.

Subd. 3. Not less than 87½ percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than 12½ percent shall be used for the payment of agent referral fees as authorized in section 62E.05, subdivision 3 and for payment of the writing carrier's direct and indirect expenses, as specified in section 62E.13, subdivision 7.

Subd. 4. Any income in excess of the costs incurred by the association in providing reinsurance or administrative services pursuant to section 62E.07, clauses (e) and (f) shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 5. Each contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the contributing member's total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium, received by all contributing members from or on behalf of Minnesota residents, as determined by the commissioner.

Subd. 6. The association shall make an annual determination of each contributing member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the contributing members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment shall be due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days shall be grounds for termination of the contributing member's membership. A contributing member which ceases to do accident and health insurance business within the state shall remain liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment, as determined herein, would not exceed ten dollars.

Subd. 7. Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 8. Any annual fiscal year end or interim assessment levied against a contributing member may be offset, in an amount equal to the assessment paid to the association, against the income tax or the premium tax payable by that contributing member pursuant to section 60A.15 for the year in which the annual fiscal year end or interim assessment is levied. The commissioner of revenue shall annually, on or before January 15, report to the chairmen of the senate finance, house appropriations, senate commerce and house financial

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Institutions and insurance committees as to the total amount of income tax or premium tax offset claimed by contributing members during the preceding calendar year.

Laws 1976, c. 296, art. 1, § 11, eff. Jan 1, 1977. Amended by Laws 1977, c. 409, § 17, eff. June 3, 1977; Laws 1979, c. 272, § 8, eff. May 31, 1979.

1977 Amendment. Revised subd. 5 which formerly read:

"Each member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with section 62E.10, subdivision 5. Deviations in the claim experience of the state plan from the premium payments allocated to the payment of benefits shall be the liability of the association members. Association members shall share in the excess costs of the state plan in an amount equal to the ratio of the member's total cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of Minnesota residents as divided into the total cost of self insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges received by all association members from or on behalf of Minnesota residents, as determined by the commissioner. The reinsurance contract shall provide for a retroactive determination of each member's liability and payment due within 30 days after each renewal date of the reinsurance contract. Failure by a member to tender to the association the assessed reinsurance payment within 30 days of notification by the association shall be grounds for termination of the member's membership.

"Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums."

1979 Amendment. Revised subd. 5 to appear as subds. 5 to 7 and added the provisions of subd. 8. Subd. 5 formerly read:

"Each member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs, pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with section 62E.10, subdivision 5. Deviations in the claim experience of the

state plan from the premium payments allocated to the payment of benefits shall be the liability of the association members. Association members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the member's total cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of Minnesota residents as divided into the total cost of self insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges received by all association members from or on behalf of Minnesota residents, as determined by the commissioner. The reinsurance contract shall provide for an annual determination and assessment of each member's liability, if any. Payment of the assessment shall be due within 30 days after the end of the association's fiscal year. Subject to the approval of the commissioner, the reinsurance contract may provide for interim assessments as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Failure by a member to tender to the association the assessed reinsurance payment within 30 days of notification by the association shall be grounds for termination of the member's membership.

"Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums."

Laws 1979, c. 272, § 12, provided in part that the provisions of section 62E-11, subd. 8, shall expire on July 1, 1981.

Law Review Commentaries

Medical benefit plans in Minnesota. Robert F. Strauss. 34 Bench and Bar No. 5, p. 19 (Nov. 1977).

Minnesota Comprehensive Health Insurance Act of 1977. By John F. Stone and Margo S. Struthers. 34 Bench and Bar No. 7, p. 27 (Jan. 1978).

Library References

Justices of the Peace § 34(1).
C.J.S. Justices of the Peace § 27.

62E.12 Minimum benefits of comprehensive health insurance plan

The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan, a number two qualified plan and a qualified medicine supplement plan. They shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

Laws 1976, c. 296, art. 1, § 12, eff. Jan. 1, 1977.

62E.13 Administration of plan

Subdivision 1. Any member of the association may submit to the commissioner the policies of accident and health insurance or the health maintenance organization contracts which are being proposed to serve in the com-

prehensive health insurance shall be prescribed by rule of

Subd. 2. The association submitted by a member or others, to develop specific be selected as a writing carrier of the writing carrier shall proven ability to handle large client claim paying capacity, ing the plan. The association two types of qualified plans, health maintenance organization

Subd. 3. The writing carrier payment functions required by provide these services for a period is approved by the commissioner a request to terminate within final decision on a request to be deemed to be an approval. Six year period, the association members of the association, shall follow the provisions of the subsequent three year period.

Subd. 4. The writing carrier in the plan an individual policy the insurance protection to which filed and to whom benefits are rate that coverage was obtained.

Subd. 5. The writing carrier commissioner on a monthly basis specific information to be contained the association prior to the effective

Subd. 6. All claims shall be provisions of sections 62E.01 to 6 paid by the state plan. Each claiming the procedure to be followed of payment.

Subd. 7. The writing carrier premiums received for its direct expenses shall include, but need not for that portion of the writing administration, management and assignable to the maintenance and attention shall approve cost accounting reports consistent with Direct and indirect expenses shall original submission of policy form

Subd. 8. The writing carrier shall under sections 62E.01 to 62E.17 to the commissioner with such funds

Subd. 9. Premiums received by health insurance plan are specified section 60A.15.

Laws 1976, c. 296, art. 1, § 13, eff. Jan. 1, 1977; Laws 1977, c. 409, § 18, 19, eff. June 3, 1977; Laws 1979, c. 272, § 13, eff. May 31, 1979.

1977 Amendment. Substituted reference to "Chapter 62A" for the reference to "Section 62A.10" at the beginning of subd. 2, as well as "may" for

prehensive health insurance plan. The time and manner of the submission shall be prescribed by rule of the commissioner.

Subd. 2. The association may select policies and contracts, or parts thereof, submitted by a member or members of the association, or by the association or others, to develop specifications for bids from any members which wish to be selected as a writing carrier to administer the state plan. The selection of the writing carrier shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified medicare supplement plan, and the health maintenance organization contract.

Subd. 3. The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the commissioner. The commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. Six months prior to the expiration of each three year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of subdivision 2 in selecting a writing carrier for the subsequent three year period.

Subd. 4. The writing carrier shall provide to all eligible persons enrolled in the plan an individual policy or certificate, setting forth a statement as to the insurance protection to which he is entitled, with whom claims are to be filed and to whom benefits are payable. The policy or certificate shall indicate that coverage was obtained through the association.

Subd. 5. The writing carrier shall submit to the association and the commissioner on a monthly basis a report on the operation of the state plan. Specific information to be contained in this report shall be determined by the association prior to the effective date of the state plan.

Subd. 6. All claims shall be paid by the writing carrier pursuant to the provisions of sections 62E.01 to 62E.17, and shall indicate that the claim was paid by the state plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

Subd. 7. The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses. Direct and indirect expenses shall include, but need not be limited to, a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses which are assignable to the maintenance and administration of the state plan. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses shall not include costs directly related to the original submission of policy forms prior to selection as the writing carrier.

Subd. 8. The writing carrier shall at all times when carrying out its duties under sections 62E.01 to 62E.17 be considered an agent of the association and the commissioner with civil liability subject to the provisions of section 3.751.

Subd. 9. Premiums derived by the writing carrier...

Laws 1976, c. 338, art. 1, § 3, eff. July 1, 1976. Amended by Laws 1977, c. 409, § 18, 19, eff. June 3, 1977; Laws 1979, c. 272, § 9, eff. May 31, 1979.

1977 Amendment. Substituted the reference to "Chapter 62A" for the reference to "Section 62A.10" at the beginning of subd. 2, as well as "may" for "shall" following the citation. Inserted "policy" as used in conjunction with "certificate" in subd. 4.

62E.15 Solicitation of eligible persons

Subdivision 1. The association pursuant to a plan approved by the commissioner shall disseminate appropriate information to the residents of this state regarding the existence of the comprehensive health insurance plan and the means of enrollment. Means of communication may include use of the press, radio and television, as well as publication in appropriate state offices and publications.

Subd. 2. The association shall devise and implement means of maintaining public awareness of the provisions of sections 62E.01 to 62E.17 and shall administer these sections in a manner which facilitates public participation in the state plan.

Subd. 3. The writing carrier shall pay an agent's referral fee of \$25 to each insurance agent who refers an applicant to the state plan, if the application is accepted. Selling or marketing of qualified state plans shall not be limited to the writing carrier or its agents. The referral fees shall be paid by the writing carrier from money received as premiums for the state plan.

Subd. 4. Every insurer which rejects or applies underwriting restrictions to an applicant for accident and health insurance shall notify the applicant of the existence of the state plan, the requirements for being accepted in it, and the procedure for applying to it.

Laws 1976, c. 296, art. 1, § 15, eff. July 1, 1976.

62E.16 Conversion privileges

Every program of self insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state, shall include, in addition to the provisions required by section 62A.17, the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions if the individual insured leaves the group regardless of the reason for leaving the group, or upon cancellation or termination of the coverage for the group except where uninterrupted and continuous group coverage is otherwise provided to the group. The person may exercise his right to conversion within 30 days of leaving the group or within 30 days following his receipt of due notice of cancellation or termination of coverage of the group and upon payment of premiums from the date of termination or cancellation. Due notice of cancellation or termination of coverage for a group shall be provided to each employee having coverage in the group by the insurer, self insurer or health maintenance organization cancelling or terminating the coverage except where reasonable evidence indicates that uninterrupted and continuous group coverage is otherwise provided to the group. Every employer having a policy of group accident and health insurance, group subscriber or contract of coverage by a health maintenance organization shall, upon request, provide the insurer or health maintenance organization a list of the names and addresses of covered employees. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue his coverage under the same or a different contract without the addition of underwriting restrictions until he would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived. An individual conversion contract issued by a health maintenance organization shall not be deemed to be an individual enrollment contract for the purposes of section 62D.10.

Laws 1976, c. 296, art. 1, § 16, eff. Jan. 1, 1977. Amended by Laws 1977, c. 266, § 1.

1977 Amendment. Inserted, in the first sentence, following "restrictions", the words "if the individual leaves the group" and added the alternative and exception at the end of the first sentence; and rewrote the second sentence which previously read: "The person

leaving the group may exercise his right to conversion within 30 days of leaving the group."

Library References

Insurance § 178.3(4).

C.J.S. Insurance § 323 et seq.

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62E.17 Dual option

Subdivision 1. An employer who employs in this state, on the average during a calendar quarter, 100 employees or more, other than employees engaged in seasonal employment as defined in section 268.07, subdivision 5, and who offers a health benefits plan to employees, whether (i) purchased from an insurer or a health maintenance organization, or (ii) provided on a self insured basis, shall, upon the next renewal of the health benefits plan contract, offer his employees a dual option to obtain health benefits through either an accident and health insurance policy or a health maintenance organization contract if one is available. An option need not be provided if less than 25 employees select that option.

Subd. 2. An employer may make the dual offers through an insurer, a health maintenance organization or on a self insured basis. If an offer is made on a self insured basis, the accident and health insurance type of coverage or health maintenance organization type of coverage shall meet the requirements of the laws of this state as to the services covered or benefits provided, but need not otherwise be approved by the commissioner or the commissioner of health.

Subd. 3. No insurer shall make acceptance of its offer to provide insurance coverage contingent on acceptance by the employer of health maintenance organization coverage by a particular health maintenance organization. No health maintenance organization shall make acceptance of its offer to provide health maintenance organization coverage contingent on acceptance by the employer of insurance coverage by a particular insurer. No offer to provide the accident and health insurance policy and the health maintenance organization contract shall combine the two in a single price package.

Subd. 4. The commissioner of health, in consultation with the commissioner, shall adopt rules to implement the provisions of this section. Laws 1976, c. 296, art. 1 § 17, eff. Jan. 1, 1977. Amended by Laws 1977, c. 305, § 45, eff. May 28, 1977.

1977 Amendment. Laws 1977, c. 305, § 45, directed that changes in names with relation to officials involved in state health functions be made generally throughout the statutes.

Library References
Insurance § 139.
C.J.S. Insurance § 332.

CATASTROPHIC HEALTH EXPENSE PROTECTION

62E.51 Citation

Sections 62E.51 to 62E.55 may be cited as the Minnesota catastrophic health expense protection act of 1976. Laws 1976, c. 296, art. 3, § 1, eff. July 1, 1977.

Law Review Commentaries
Comprehensive Health Insurance Act of 1976: An experiment in health coverage. John P. Stone and Margo S. Struthers. 34 Bench and Bar No. 10 p. 31 (April 1978).

Library References
Mental Health § 211.
C.J.S. Insane Persons § 69.

62E.52 Definitions

Subdivision 1. For the purposes of sections 62E.51 to 62E.55, the terms defined in this section have the meanings given them.

Subd. 2. "Eligible person" means any person who is a resident of Minnesota and who, while a resident of Minnesota, has been insured by the commissioner of health for a continuous period of 12 consecutive months.

(i) qualified expenses for himself and any dependents in any 12 consecutive months exceeding:

(a) 40 percent of his household income up to \$15,000, plus 50 percent of his household income between \$15,000 and \$25,000, plus 60 percent of his household income in excess of \$25,000; or

(b) \$2,500, whichever is greater; or

(2) qualified nursing home care for 12 consecutive months.

Subd. 3. "Qualified expenses" means the expenses for health services described in 62E.06, subd. 1, which are not otherwise payable by the person or his dependent.

Subd. 3a. "Qualified nursing home care" means nursing home care for a person 64 years of age or older.

Subd. 4. "Dependent" means a child, grandchild, or other person dependent upon the parent, or upon the parent.

Subd. 5. "Household income" means the total income of the person and all his dependents for the year in which the expenses are incurred.

Subd. 6. "Gross income" means the gross income as defined in division 3.

Subd. 7. "Commissioner" means the commissioner of health.

Subd. 8. "Third party" means any person other than the person or his dependents.

Laws 1976, c. 296, art. 3, § 2, § 1 to 3.

1977 Amendment. Laws 1977, c. 305, § 45, added subd. 2(3) and subd. 2a.

62E.53 Application for assistance

Subdivision 1. Any person who is an eligible person may submit an application to the commissioner of health for assistance. The application shall be filed with the commissioner of health within the month period for computing the person's household income.

Subd. 2. If the commissioner of health determines that a person is an eligible person, he shall pay:

(1) 90 percent of all qualified expenses in excess of:

(a) 40 percent of his household income between \$15,000 and \$25,000; or

(b) \$2,500;

whichever is greater for that person and his dependents.

(2) all qualified nursing home expenses in excess of 50 percent of his household income; however, that the payment is made until the end of the fiscal year.

Subd. 3. If the commissioner of health determines that a person is an eligible person and that the person is not otherwise covered by a health service provided to an eligible person, he may refuse to pay for the service provided to an eligible person as defined in 62E.06, subd. 1.

Subd. 4. The commissioner of health shall not be liable for the payment of any qualified expenses for which the person is not otherwise covered by a health service provided to an eligible person as defined in 62E.06, subd. 1.

Subd. 5. The commissioner of health shall not be liable for the payment of any qualified expenses for which the person is not otherwise covered by a health service provided to an eligible person as defined in 62E.06, subd. 1.

Subd. 6. The commissioner of health shall not be liable for the payment of any qualified expenses for which the person is not otherwise covered by a health service provided to an eligible person as defined in 62E.06, subd. 1.

Subd. 7. The commissioner of health shall not be liable for the payment of any qualified expenses for which the person is not otherwise covered by a health service provided to an eligible person as defined in 62E.06, subd. 1.

Subd. 8. The commissioner of health shall not be liable for the payment of any qualified expenses for which the person is not otherwise covered by a health service provided to an eligible person as defined in 62E.06, subd. 1.

Subd. 9. The commissioner of health shall not be liable for the payment of any qualified expenses for which the person is not otherwise covered by a health service provided to an eligible person as defined in 62E.06, subd. 1.

Subd. 10. The commissioner of health shall not be liable for the payment of any qualified expenses for which the person is not otherwise covered by a health service provided to an eligible person as defined in 62E.06, subd. 1.

(2) qualified nursing home expenses for himself and any dependents in any 12 consecutive months exceeding 20 percent of his household income.

Subd. 3. "Qualified expense" means any charge incurred subsequent to July 1, 1977 for a health service which is included in the list of covered services described in 62F.06, subdivision 1, and for which no third party is liable.

Subd. 3a. "Qualified nursing home expense" includes any charge incurred for nursing home services after 36 months of continuous care provided to a person 64 years of age or younger in long-term care facilities.

Subd. 4. "Dependent" means a spouse or unmarried child under the age of 19 years, a child who is a student under the age of 25 and financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

Subd. 5. "Household income" means the gross income of an eligible person and all his dependents 23 years of age or older for the calendar year preceding the year in which an application is filed pursuant to section 62E.53.

Subd. 6. "Gross income" means income as defined in section 290A.03, subdivision 3.

Subd. 7. "Commissioner" means the commissioner of public welfare.

Subd. 8. "Third party" means any person other than the eligible person or his dependents.

Laws 1976, c. 296, art. 3, § 2, eff. July 1, 1977. Amended by Laws 1977, c. 448, §§ 1 to 3.

1977 Amendment. Laws 1977, c. 448, inserted "23 years of age or older" in added subd. 2(c) and subd. 3a, and inserted subd. 5.

62E.53 Application for assistance

Subdivision 1. Any person who believes that he is or will become an eligible person may submit an application for state assistance to the commissioner. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the 12 month period for computing expenses began.

Subd. 2. If the commissioner determines that an applicant is an eligible person, he shall pay

(1) 90 percent of all qualified expenses of the eligible person and his dependents in excess of:

(a) 40 percent of his household income under \$15,000, plus 50 percent of his household income between \$15,000 and \$25,000, plus 60 percent of his household income in excess of \$25,000; or

(b) \$2,500;

whichever is greater for the 12 month period in which the applicant becomes an eligible person and

(2) all qualified nursing home expenses of the eligible person and his dependents in excess of 20 percent of his household income. Provided, however, that the payment of qualified nursing home expenses shall not be made until the end of the fiscal year. If the appropriation for the payment of qualified nursing home expenses is inadequate to pay all qualified nursing home expenses, the commissioner shall prorate the payments among all eligible persons in proportion to their share of the total of the qualified nursing home expenses of all eligible persons.

Subd. 3. The commissioner shall by rule establish procedures for determining whether and to what extent qualified expenses are reasonable charges. Unless otherwise provided for by rule, charges shall be reviewed for reasonableness by the same procedures used to review and limit reimbursement under the provisions of chapter 256B. If the commissioner determines that the charge for a health service is excessive, he may limit his payment to the reasonable charge for that service. If the commissioner determines that a health service provided to an eligible person was not medically necessary, he may refuse to pay for the service. The commissioner may contract with a review organization as defined in section 145.01, in making any determinations

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as to whether or not a charge is excessive and in making any determination as to whether or not a service was medically necessary. If the commissioner in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

Laws 1976, c. 296, art. 3, § 3, eff. July 1, 1977. Amended by Laws 1977, c. 409, § 21, eff. June 3, 1977; Laws 1977, c. 448, § 4.

1977 Amendments. Laws 1977, c. 409 revised subd. 2 which now appears as subds. 2 and 3. Subd. 2 formerly read: "If the commissioner determines that an applicant is an eligible person, he shall pay 90 percent of all qualified expenses of the eligible person and his dependents in excess of:

(a) 40 percent of his household income under \$15,000, plus 50 percent of his household income between \$15,000 and \$25,000, plus 60 percent of his household income in excess of \$25,000; or

(b) \$2,500; whichever is greater for the 12 month period in which the applicant becomes an eligible person. If the commissioner determines that the charge for a health service is excessive, he may limit his payment to the usual and customary charge for that service. If the commissioner determines that a health service provided to an eligible person was not

medically necessary, he may refuse to pay for the service. To the extent feasible, the commissioner shall contract with a review organization as defined in Minnesota Statutes, Section 145.61, in making any determinations as to whether or not a charge is excessive. To the extent feasible, the commissioner shall contract with a review organization as defined in Minnesota Statutes, Section 145.61, in making any determination as to whether or not a service was medically necessary. If the commissioner in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed."

Laws 1977, c. 448, added subd. 2(2).

62E.531 Third party liability

Subdivision 1. When the commissioner pays for or becomes liable for payments for health services under the provisions of sections 62E.51 to 62E.55, the department of public welfare shall have a lien for payments and liabilities for the services upon any and all causes of action which accrue to the person to whom the services were furnished, or to his legal representatives, as a result of injuries which directly or indirectly led to the incurring of qualified expenses.

The department may perfect and enforce its lien by following the procedures set forth in sections 514.69, 514.70, and 514.71, except that it shall have one year from the date when the last item of health service was furnished in which to file its verified lien statement. The statement shall be filed with the appropriate clerk of court in the county in which the recipient of the services resides or in the county in which the action was filed.

Subd. 2. Where a third party may be liable in whole or in part for payment for health services, the commissioner may consider the charges for the health services to be qualified expenses if the eligible person assigns any rights accruing by virtue of any third party liability to the commissioner to the extent necessary to reimburse the state for any payments made under the provisions of this section.

Subd. 3. Upon furnishing assistance under the provisions of sections 62E.51 to 62E.55, the department of public welfare shall be subrogated, to the extent of its payments for health services, to any rights the eligible person or his dependent may have under the terms of any plan of health coverage as the result of an accident, illness, or injury. The right of subrogation shall not be exercised until the expiration of the period of waiting time established in the plan of health coverage.

The attorney general, or the appropriate county attorney, acting upon direction from the attorney general, may institute or join a civil action against the issuer of the plan of health coverage to recover under this subdivision.

Added by Laws 1977, c. 409, § 22, eff. June 3, 1977.

Library References

Insurance Code § 1406 et seq.

62E.54 Duties of commissioner

Subdivision 1. The commissioner shall:

(a) Promulgate rules under sections 62E.51 to 62E.55.

(b) Establish application forms to be declared an official form.

(c) Investigate applications of qualified person and in determining whether or not the person is qualified.

Subd. 2. The commissioner shall:

(a) Enter into contracts with any person or organization established by section 62E.51 to 62E.55 to provide or pay for the delivery of health services.

(b) Enter into contracts with any person or organization to perform the duties imposed on the commissioner by sections 62E.51 to 62E.55.

Laws 1976, c. 296, art. 3, § 409, § 23, eff. June 3, 1977.

1977 Amendment. Added "emergency rules" to subd. 1.

62E.55 Appeals

The final decision of the commissioner on the part of an eligible person or dependent may be appealed by any interested person. Laws 1976, c. 296, art. 3, § 409, § 24, eff. June 3, 1977.

CHAPTER 62F.

- Sec. 62F.01 Citation; expiration
62F.02 Joint underwriting
62F.03 Definitions
62F.04 Authorization to issue
62F.05 Plan of operation
62F.06 Policy forms and rates
62F.07 Participation.

62F.01 Citation; expiration

Subdivision 1. Sections 62F.01 to 62F.07 shall be read in conjunction with sections 62E.51 to 62E.55.

Subd. 2. Sections 62F.01 to 62F.07 shall be read in conjunction with sections 62E.51 to 62E.55. Laws 1976, c. 242, § 2, eff. March 24, 1978.

1978 Amendment. Laws 1978, c. 242, § 2, added subd. 2 to this section. The expiration date of Sept. 1, 1978, is hereby extended to Sept. 1, 1979, by Laws 1978, c. 242, § 2, repeated.

Law Review Commentaries: Minnesota Statutes, Section 62F.01, 62F.02, 62F.03, 62F.04, 62F.05, 62F.06, 62F.07.

62F.02 Joint underwriting

Subdivision 1. Creation. Every health care provider licensed to provide health care services in this state shall be required to participate in a joint underwriting association to obtain and retain a license to practice.

Subd. 2. Directors. The association shall be composed of 11 persons chosen at a meeting of the association at a meeting called for that purpose.

INSURANCE

§ 62F.02

62E.54 Duties of commissioner

Subdivision 1. The commissioner shall:

- (a) Promulgate reasonable rules, including emergency rules, to implement sections 62E.51 to 62E.55.
- (b) Establish application forms and procedures for the use of persons seeking to be declared an eligible person; and
- (c) Investigate applications to determine whether or not the applicant is a qualified person and investigate claims from providers of health services to determine whether or not to pay them.

Subd. 2. The commissioner may:

(a) Enter into contracts with the United States or any state agency, instrumentality or political subdivision for the purpose of coordinating the program established by sections 62E.51 to 62E.55, with other programs which provide or pay for the delivery of health services;

(b) Enter into contracts with third parties to perform some or all of the duties imposed on the commissioner by sections 62E.53 and 62E.54.

Laws 1976, c. 206, art. 3, § 4, eff. July 1, 1977. Amended by Laws 1977, c. 409, § 23, eff. June 3, 1977.

1977 Amendment. Added "including emergency rules" to subd. 1(a).

62E.55 Appeals

The final decision of the commissioner denying an application for status as an eligible person or denying all or part of the charges for a health service may be appealed by any interested party pursuant to chapter 15.

Laws 1976, c. 206, art. 3, § 5, eff. July 1, 1977.

CHAPTER 62F. MEDICAL PRACTICE INSURANCE [NEW]

Sec.		Sec.	
62F.01	Citation; expiration date.	62F.08	Procedures.
62F.02	Joint underwriting association.	62F.09	Stabilization reserve fund.
62F.03	Definitions.	62F.10	Investigation.
62F.04	Authorization to issue insurance.	62F.11	Privileged communications.
62F.05	Plan of operation.	62F.12	Appeals; judicial review.
62F.06	Policy forms and rates.	62F.13	Public officers or employees.
62F.07	Participation.	62F.14	Annual statements.

62F.01 Citation; expiration date

Subdivision 1. Sections 62F.01 to 62F.14 may be cited as the "Temporary Joint Underwriting Association Act."

Subd. 2. Sections 62F.01 to 62F.14 expire September 1, 1980.

Laws 1976, c. 242, § 2, eff. April 14, 1976. Amended by Laws 1978, c. 571, § 1, eff. March 24, 1978.

1978 Amendment. Laws 1978, c. 571, § 1, added subd. 2 to this section fixing the expiration date of Sept. 1, 1980. Laws 1976, c. 242, § 16, which had provided an expiration date for sections 62F.01 to 62F.14 of two years after its effective date (including date was April 14, 1978).

Law Review Commentaries
 Release of joint underwriting: Merrin-
 ger release in Minnesota. John E. Si-
 monett. 1977, 3 Wm. Mitchell L.Rev. 1.

62F.02 Joint underwriting association

Subdivision 1. **Creation.** There is created a temporary joint underwriting association to provide medical malpractice insurance coverage to any licensed health care provider unable to obtain this insurance through ordinary methods. Every insurer authorized to write and writing personal injury liability insurance in this state shall be a member of the association as a condition to obtaining and retaining a license to write insurance in this state.

Subd. 2. **Directors.** The association shall have a board of directors composed of 11 persons chosen annually as follows: five persons elected by members of the association at a meeting called by the commissioners; three mem-

with or tuberculosis not otherwise expressly imposed or granted by law. ORS 556 §10]

414.090 [1953 c.204 §6; renumbered 414.860 and 556.350]

414.095 Exemptions applicable to payments. Neither medical assistance nor payments payable to vendors out of public assistance funds are transferable or assignable by law or in equity and none of the money paid or payable under the provisions of ORS 414.055 and this chapter is subject to execution, levy, attachment, garnishment or other legal process. ORS 556 §11; 1967 c.502 §14]

414.105 Recovery of certain medical assistance; certain transfers of property voidable. (1) The Adult and Family Services Division may recover from any person the amounts of medical assistance incorrectly paid on behalf of such person.

(2) Medical assistance pursuant to ORS 414.055 and this chapter paid on behalf of an individual who was 65 years of age or older when he received such assistance may be recovered from his estate, or if there be no estate the estate of the surviving spouse, if any, shall be charged for such aid paid to him or both; provided, however, that claim for such medical assistance correctly paid to him may be established against the estate, but there shall be no adjustment or recovery therefrom until after the death of the surviving spouse, if any, and only at a time when he has a surviving child who is under 21 years of age or is blind or permanently and totally disabled. Transfers of real or personal property by recipients of such aid without adequate consideration are voidable and may be recovered under subsection (2) of ORS 414.020.

(3) Except where there is a surviving spouse, or a surviving child who is under 21 years of age or is blind or permanently and totally disabled, the amount of any medical assistance paid under this chapter is a claim against the estate in any guardianship or conservatorship proceedings and may be paid pursuant to ORS 126.353. ORS 556 §12; 1967 c.502 §15; 1969 c.507 §2; 1971 c.334 §1; 1973 c.334 §1; part renumbered 416.280; 1975 c.388

INSURANCE AND SERVICE CONTRACTS

414.115 Medical assistance by insurance or service contracts. In lieu of providing one or more of the medical and remedial care and services available under medical assistance by direct payments to providers thereof and in lieu of providing such medical and remedial care and services made available pursuant to ORS 414.065, the Adult and Family Services Division shall use available medical assistance funds to purchase and pay premiums on policies of insurance, or enter into and pay the expenses on health care service contracts, or medical or hospital service contracts that provide one or more of the medical and remedial care and services available under medical assistance for the benefit of the categorically needy or the medically needy, or both. The policy of insurance or the contract by its terms, or the insurer or contractor by written acknowledgment to the division must guarantee:

(1) To provide medical and remedial care and services of the type, to the extent and according to standards prescribed under ORS 414.065;

(2) To pay providers of medical and remedial care and services the amount due, based on the number of days of care and the fees, charges and costs established under ORS 414.065, except as to medical or hospital service contracts issued by a hospital association which employs a method of accounting or payment on other than a fee-for-service basis;

(3) To provide medical and remedial care and services under policies of insurance or contracts in compliance with all laws, rules and regulations applicable thereto; and

(4) To provide such statistical data, records and reports relating to the provision, administration and costs of providing medical and remedial care and services to the division as may be required by the division for its records, reports and audits. [1967 c.502 §9; 1975 c.401 §1]

414.125 Rates on insurance or service contracts; requirements for insurer or contractor. (1) Any payment of available medical assistance funds for policies of insurance or service contracts shall be according to such uniform area-wide rates as the Adult and Family Services Division shall have established and which it may revise from time to time as may be necessary or practical, except that, in the case of a research and demonstra-

tion project entered into under ORS 411.135 special rates may be established.

(2) No premium or other periodic charge on any policy of insurance, health care service contract, or medical or hospital service contract shall be paid from available medical assistance funds unless the insurer or contractor issuing such policy or contract is by law authorized to transact business as an insurance company, health care service contractor or hospital association in this state. [1967 c.502 §10; 1975 c.509 §6]

414.135 Contracts with direct providers of care and services. The Adult and Family Services Division may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and remedial care and services available under medical assistance in consideration of services rendered and supplies furnished by them in accordance with the provisions of this chapter. Payment shall be made according to the rules of the division pursuant to the number of days and the fees, charges and costs established under ORS 414.065. The contractor must guarantee the division by written acknowledgment:

(1) To make all payments under this chapter promptly but not later than 30 days after receipt of the proper evidence establishing the validity of the provider's claim.

(2) To provide such data, records and reports to the division as may be required by the division. [1967 c.502 §11]

414.145 Implementation of ORS 414.115 to 414.135. The provisions of ORS 414.115, 414.125 or 414.135 shall be implemented whenever it appears to the Executive Department that such implementation will provide comparable benefits at equal or less cost than provision thereof by direct payments by the Adult and Family Services Division to the providers of medical assistance. [1967 c.502 §11a; 1975 c.401 §3]

MEDICAL ADVISORY COMMITTEE

414.205 Medical advisory committee. (1) A medical advisory committee is established, consisting of not more than 15 members to be appointed by the Governor from among persons in the health professions,

providers of medical and remedial care and services and the general public. In making his appointment, the Governor shall consult with appropriate professional and other interested organizations.

(2) Members shall serve at the pleasure of the Governor.

(3) Members of the advisory committee shall receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the Public Welfare Account. [1967 c.502 §18]

414.210 [1957 c.692 §1; repealed by 1963 c.631 §2]

414.215 Duties of committee. The medical advisory committee shall advise the Adult and Family Services Division on:

(1) Health and medical care and services to be provided pursuant to this chapter.

(2) Matters referred to it for study by the division. [1967 c.502 §19]

414.220 [1957 c.692 §2; repealed by 1963 c.631 §2]

414.225 Division to consult with and assist committee. (1) The Adult and Family Services Division shall consult with the medical advisory committee concerning the determinations required under ORS 414.055.

(2) The division shall provide secretarial services to the medical advisory committee. [1967 c.502 §20]

414.230 [1957 c.692 §5; repealed by 1963 c.631 §2]

414.240 [1957 c.692 §3; repealed by 1963 c.631 §2]

414.250 [1957 c.692 §4; repealed by 1963 c.631 §2]

414.260 [1957 c.692 §6; repealed by 1963 c.631 §2]

414.270 [1957 c.692 §7(1); repealed by 1963 c.631 §2]

414.280 [1957 c.692 §7(2); repealed by 1963 c.631 §2]

414.290 [1957 c.692 §7(3); repealed by 1963 c.631 §2]

414.300 [1957 c.692 §8; repealed by 1963 c.631 §2]

MISCELLANEOUS

414.305 Payment of cost of medical care for institutionalized persons. (1) The Adult and Family Services Division is hereby authorized to pay the cost of care for patients within Mental Health Division institutions under the medical assistance program established by this chapter.

(2) All moneys received by the Mental Health Division from the Adult and Family

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242 spouse and such children whose coverage under the policy terminates at the
243 same time, or (iii) to a child solely with respect to himself upon termination
244 of his coverage by reason of ceasing to be a qualified family member under
245 the group policy, if a conversion privilege is not otherwise provided above
246 with respect to such termination.

247 (17) If the benefit levels required in paragraphs (10) and (11) exceed the
248 benefit levels provided under the group policy, the conversion policy may
249 offer benefits which are substantially similar to those provided under the
250 group policy in lieu of those required in paragraphs (10) and (11).

251 (18) The insurer may elect to provide group insurance coverage in lieu
252 of the issuance of a converted individual policy.

253 (19) A notification of the conversion privilege shall be included in each
254 certificate of coverage.

255 (20) A converted policy which is delivered outside [state] must be on a
256 form which could be delivered in such other jurisdiction as a converted
257 policy had the group policy been issued in that jurisdiction.

1 Section 3. [*Severability.*] [Insert severability clause.]

1 Section 4. [*Repeal.*] [Insert repealer clause.]

1 Section 5. [*Effective Date.*] [Insert effective date.]

STATE
1980 SUGGESTED LEGISLATION
Vol. 39, The Council of State Governments

Comprehensive Health Insurance Act

This draft statute requires that employers in the state must include qualified catastrophic health insurance protection and minimum types of benefits for routine care in any policy provided to their employees pursuant to the individual's employment. This includes policies which are paid for partly or fully by the employee as well as those which are completely employer-paid. If only nonqualified plans are offered to employees, the employer may not deduct for tax purposes the cost of the insurance to him. In order to qualify, a plan must meet specified benefit levels and have no more than a maximum allowable deductible. This draft act also includes as Sections 18 and 19 a state catastrophic medical insurance plan under which the state will pay the medical expenses of those persons who incur uninsured medical expenses exceeding specified portions of their income.

This medical insurance plan is implemented by requiring in the statute that all insurers writing health insurance in the state must offer a qualified plan to their customers. A compulsory association of all insurers in the state is also to be formed under the act for the purpose of offering a qualified plan of insurance to those individuals whom the insurers have individually refused to insure. For those individuals who may be leaving employment at which they were enrolled in a qualified plan, the act provides mandatory conversion privileges enabling the individual to continue his insurance.

As the above indicates, this draft act is broad in scope and is directed toward multiple purposes. Among the related but separate purposes of the legislation are ensuring minimum standards for group health plans, creating an association of insurers as a resort for those individuals who could not otherwise obtain effective coverage, and providing catastrophic medical expense protection for all through employers and private insurers where possible and through the state welfare system where necessary.

This draft legislation is based on a 1976 Minnesota statute.

Suggested Legislation

(Title, enacting clause, etc.)

1 Section 1. [*Short Title.*] This act may be cited as the [state] Comprehen-
2 sive Health Insurance Act.

1 Section 2. [*Definitions.*] As used in this act:

2 (1) "Employer" means any person, partnership, association, trust,
3 estate, or corporation, which employs 10 or more individuals who are
4 residents of this state.

- 5 (2) "Health maintenance organization" means a nonprofit corporation
6 licensed and operated as provided in [appropriate state statute].
- 7 (3) "Qualified plan" means those health benefit plans which have been
8 certified by the commissioner as providing the minimum benefits required
9 by Section 6 of this act or the actuarial equivalent of those benefits.
- 10 (4) "Qualified Medicare supplement plan" means those health benefit
11 plans which have been certified by the commissioner as providing the
12 minimum benefits required by Section 7 of this act or the actuarial
13 equivalent of those benefits.
- 14 (5) "Commissioner" means the [commissioner of insurance].
- 15 (6) "Dependent" means a spouse or unmarried child under the age of
16 19 years, a dependent child who is a student under the age of 25 and finan-
17 cially dependent upon the parent, or a dependent child of any age who is
18 disabled. *or a household member who is financially dependent*
- 19 (7) "Employee" means any [state] resident who has entered into the
20 employment of or works under contract or service or apprenticeship with
21 any employer. "Employee" does not include a person who has been
22 employed for less than [30] days by his present employer, nor one who is
23 employed less than an average of [30] hours per week by his present
24 employer.
- 25 (8) "Plan of health coverage" means any plan or combination of plans
26 of coverage, including combinations of self-insurance, individual accident
27 and health insurance policies, group accident and health insurance policies,
28 coverage under a nonprofit health service plan, or coverage under a health
29 maintenance organization subscriber contract.
- 30 (9) "Insurer" means those companies operating pursuant to [ap-
31 propriate state statute] and offering or selling policies or contracts of acci-
32 dent and health insurance. "Insurer" does not include health maintenance
33 organizations.
- 34 (10) "Accident and health insurance policy" or "policy" means in-
35 surance or nonprofit health service plan contracts providing benefits for
36 hospital, surgical, and medical care. "Policy" does not include coverage
37 which is (i) limited to disability or income protection coverage, (ii)
38 automobile medical payment coverage, (iii) supplemental to liability in-
39 surance, (iv) sold by fraternal and provides payments on a per diem, daily
40 indemnity or nonexpense-incurred basis, or (v) credit accident and health
41 insurance issued pursuant to [appropriate state statute].
- 42 (11) "Health benefits" means benefits offered to employees on an in-
43 demnity or prepaid basis which pay the costs of or provide medical,
44 surgical, or hospital care.
- 45 (12) "Eligible person" means an individual who is a resident of [state]
46 and meets the enrollment requirements of Section 14 of this act. For pur-
47 poses of Sections 18, 19, and 20 only, "eligible person" means any person
48 who while a resident of [state] has been found by the [commissioner of
49 public welfare] to have incurred an obligation to pay qualified expenses for

- 50 himself and any dependents in any [12] consecutive months exceeding: (i)
51 [40] percent of his household income up to \$[15,000], plus [50] percent of
52 his household income between \$[15,000 and \$25,000], plus [60] percent of
53 his household income in excess of \$[25,000], or (ii) \$[2,500], whichever is
54 greater.
- 55 (13) "Comprehensive health association" or "association" means the
56 association created by Section 10 of this act.
- 57 (14) "Medicare" means Part A and Part B of the United States Social
58 Security Act, Title XVIII, as amended, 42 U.S.C. Sections 1394, et seq.
- 59 (15) "Medicare supplement plan" means any plan of insurance protec-
60 tion which provides benefits for the costs of medical, surgical, or hospital
61 care and which is marketed as providing benefits which complement or sup-
62 plement the benefits provided by Medicare.
- 63 (16) "State plan premium" means the premium determined pursuant
64 to Section 8 of this act.
- 65 (17) "Writing carrier" means the insurer or insurers and health
66 maintenance organization or organizations selected by the association and
67 approved by the commissioner to administer the comprehensive health in-
68 surance plan.
- 69 (18) "Fraternal beneficiary association" or "fraternal" means a cor-
70 poration, society, order, or voluntary association without capital stock
71 which sells health and accident insurance in accordance with [appropriate
72 state statute].
- 73 (19) "Comprehensive health insurance plan" or "state plan" means
74 policies of insurance and contracts of health maintenance organization
75 coverage offered by the association through the writing carrier.
- 76 (20) "Self-insurer" means an employer who directly provides a plan of
77 health coverage to his employees and administers the plan of health
78 coverage himself or through an insurer. "Self-insurer" does not include an
79 employer engaged in the business of providing health care services to the
80 public who provides health care services directly to his employees at no
81 charge to them.
- 82 (21) "Self-insurance" means a plan of health coverage offered by a
83 self-insurer.
- 84 (22) "Qualified expense" means any charge incurred subsequent to [in-
85 sert date] for a health service which is included in the list of covered services
86 described in Section 6(a), and for which no third party is liable.
- 87 (23) "Household income" means the gross income of an eligible person
88 and all his dependents for the calendar year preceding the year in which an
89 application is filed pursuant to Section 18.
- 90 (24) "Gross income" means income as defined in [appropriate state tax
91 statute].
- 92 (25) "Third party" means any person other than the eligible person or
93 his dependents.

2 (a) Each employer who provides or makes available to his employees a
3 plan of health coverage shall make available to his employees employed in
4 this state a plan or combination of plans which have been certified by the
5 commissioner as a number two qualified plan. If the plan of health coverage
6 does not meet the requirements of Section 6 for a number two qualified
7 plan, the employer shall make available a supplemental plan of health
8 benefits which, when combined with the existing plan of health benefits,
9 constitutes a number two coverage plan. The plan or combinations of plans
10 may be financed from funds contributed solely by the employer or solely by
11 the employees or any combination thereof. The plans may consist of self-
12 insurance, health maintenance contracts, group policies, or individual
13 policies or any combination thereof.
14 (b) In the event that an employer fails to make available at least a number
15 two qualified plan of health benefits to his employees employed in this
16 state, none of the employer's costs for health benefits shall qualify as an in-
17 come tax deduction pursuant to [appropriate state tax statute]. In the case
18 of an employer who meets the requirements of [state statute defining tax ex-
19 empt organizations], if the employer fails to make available at least a
20 number two qualified plan to his employees, the employer shall lose his
21 status as an exempt organization.

1 Section 4. [Duties of Insurers.]

2 (a) For each type of qualified plan described in Section 6, an insurer or
3 fraternal issuing individual policies of accident and health insurance in this
4 state, other than group conversion policies, shall develop and file with the
5 commissioner an individual policy which meets the minimum standards of
6 that type of qualified plan. An insurer or fraternal issuing individual
7 policies of accident and health insurance in this state shall offer each type of
8 qualified plan to each person who applies and is eligible for accident and
9 health insurance from that insurer or fraternal.

10 (b) An insurer or fraternal issuing Medicare supplement plans in this state
11 shall develop and file with the commissioner a Medicare supplement policy
12 which meets the minimum standards of a qualified Medicare supplement
13 plan. An insurer or fraternal issuing Medicare supplement plans in this state
14 shall offer a qualified Medicare supplement plan to each person who is eligi-
15 ble for coverage and who applies for a Medicare supplement plan.

16 (c) For each type of qualified plan described in Section 6, an insurer or
17 fraternal issuing group policies of accident and health insurance in this state
18 shall develop and file with the commissioner a group policy which provides
19 for each member of the group the minimum benefits required by that type
20 of qualified plan. An insurer or fraternal issuing group policies of accident
21 and health insurance in this state shall offer each type of qualified plan to
22 each eligible applicant for group accident and health insurance.

23 (d) Each insurer and fraternal shall include coverage of major medical
24 costs in every unqualified policy of accident and health insurance, unless the

25 applicant for a new or renewal policy declines the coverage in writing. The
26 coverage shall provide that when a covered individual incurs out-of-pocket
27 expenses of \$[5,000] or more within a calendar year for services covered in
28 Section 6(a), benefits shall be payable, subject to any copayment authorized
29 by the commissioner, up to a maximum lifetime limit of \$[250,000].

30 (e) No policy of accident and health insurance may be issued or renewed
31 in this state [180] days after [insert date] by an insurer or a fraternal which
32 has not complied with the requirements of this section.

33 (f) An insurer or fraternal may fulfill its obligations under this section by
34 issuing the required coverages in their own name and reinsuring the risk and
35 administration of the coverages with the association in accordance with
36 paragraphs (5) and (6) of Section 10(g).

37 (g) Nothing in this section shall require an insurer or fraternal to offer or
38 issue a policy to any person who does not meet the underwriting or member-
39 ship requirements of the insurer or fraternal.

1 Section 5. [Certification of Qualified Plans.] Upon application by an in-
2 surer, fraternal, or employer for certification of a plan of health coverage as
3 a qualified plan or a qualified Medicare supplement plan for the purposes
4 of Sections 1 to 17, the commissioner shall make a determination within
5 [90] days as to whether the plan is qualified. All plans of health coverage
6 shall be labeled as "qualified" or "nonqualified" on the front of the policy
7 or evidence of insurance. All qualified plans shall indicate whether they are
8 number one, two, or three coverage plans.

1 Section 6. [Minimum Benefits of Qualified Plan.]

2 (a) A plan of health coverage shall be certified as a number three qualified
3 plan if it otherwise meets the requirements established by [appropriate state
4 statute] and the other laws of this state and whether or not the policy is
5 issued in this state and meets or exceeds the following minimum standards:

6 (1) The minimum benefits for a covered individual shall, subject to the
7 other provisions of this subsection, be equal to at least [80] percent of the
8 cost of covered services in excess of an annual deductible which does not ex-
9 ceed \$[150] per person. The coverage shall include a limitation of \$[3,000]
10 per person on total annual out-of-pocket expenses for services covered
11 under this subsection. The coverage may be subject to a maximum lifetime
12 benefit of not less than \$[250,000]. Covered expenses shall be the usual and
13 customary charges for the following services and articles when prescribed
14 by a physician:

15 (i) Hospital services.

16 (ii) Professional services for the diagnosis or treatment of injuries,
17 illnesses, or conditions, other than outpatient mental or dental, which are
18 rendered by a physician or at his direction.

19 (iii) Drugs requiring a physician's prescription.

20 (iv) Services of a nursing home for not more than [120] days in a year
21 if the services commence within [14] days following confinement of at least

- 22 [three] days in a hospital for the same condition.
 23 (v) Service of a home health agency up to a maximum of [180] visits
 24 per year.
 25 (vi) Use of radium or other radioactive materials.
 26 (vii) Oxygen.
 27 (viii) Anesthetics.
 28 (ix) Prostheses.
 29 (x) Rent, or purchase, as appropriate, of durable medical equip-
 30 ment.
 31 (xi) Diagnostic X-rays and laboratory tests.
 32 (xii) Oral surgery for partially or completely unerupted impacted
 33 teeth, a tooth root without the extraction of the entire tooth, or the gums
 34 and tissues of the mouth when not performed in connection with the extrac-
 35 tion or repair of teeth.
 36 (xiii) Services of a physical therapist.
- 37 (2) Covered expenses for the services and articles specified in this
 38 subsection do not include the following:
- 39 (i) Any charge for any care for any injury or disease either arising out
 40 of an injury in the course of employment and subject to a worker's compen-
 41 sation or similar law, for which benefits are payable without regard to fault
 42 under coverage statutorily required to be contained in any motor vehicle or
 43 other liability insurance policy or equivalent self-insurance, or for which
 44 benefits are payable under another policy of accident and health insurance
 45 or Medicare.
- 46 (ii) Any charge for treatment for cosmetic purposes other than
 47 surgery for the repair of an injury or birth defect.
- 48 (iii) Any charge for travel other than travel by ambulance to the
 49 nearest health care institution qualified to treat the illness or injury.
- 50 (iv) Any charge for confinement in a private room to the extent it is
 51 in excess of the institution's charge for its most common semi-private room,
 52 unless a private room is prescribed as medically necessary by a physician.
- 53 (v) That part of any charge for services or articles rendered or
 54 prescribed by a physician, dentist, or other health care personnel which ex-
 55 ceeds the prevailing charge in the locality where the service is provided.
- 56 (vi) Any charge for services or articles the provision of which is not
 57 within the scope of authorized practice of the institution or individual
 58 rendering the services or articles.
- 59 (3) Effective [insert date], the minimum benefits for a qualified plan
 60 shall include, in addition to those benefits specified in subsection (a)(1),
 61 benefits for the following services subject to applicable deductibles, coin-
 62 surance provisions, and maximum lifetime benefit limitations:
- 63 (i) Well baby care.
 64 (ii) Physicians' services for routine checkups and annual physicals
 65 when prescribed by a physician.
 66 (iii) Multiphasic screening and other diagnostic testing. The commis-

- 67 sioner by rule shall prescribe reasonable limits on the reimbursement re-
 68 quired for these services.
- 69 (b) A plan of health coverage shall be certified as a number two qualified
 70 plan if it meets the requirements established by the laws of this state and
 71 provides for payment of [80] percent of the covered expenses required by
 72 this section in excess of a deductible which does not exceed \$[500] per per-
 73 son.
- 74 (c) A plan of health coverage shall be certified as a number one qualified
 75 plan if it meets the requirements established by the laws of this state and
 76 provides for payment of [80] percent of the covered expenses required by
 77 this section in excess of a deductible which does not exceed \$[1,000] per per-
 78 son.
- 79 (d) A health maintenance organization which provides the services re-
 80 quired by [appropriate state statute] shall be deemed to be providing a
 81 number three qualified plan.

1 Section 7. [Qualified Medicare Supplement Plan.] Any plan which pro-
 2 vides benefits to persons over the age of 65 years may be certified as a
 3 qualified Medicare supplement plan if the plan is designed to supplement
 4 Medicare and provides coverage of [50] percent of the deductible and
 5 copayment required under Medicare and [80] percent of the charges for
 6 covered services described in Section 6(a), which charges are not paid by
 7 Medicare. The coverage shall include a limitation of \$[1,000] per person on
 8 total annual out-of-pocket expenses for the covered services. The coverage
 9 may be subject to a maximum lifetime benefit of not less than \$[100,000].

1 Section 8. [State Plan Premium.]

2 (a) For the first year of operation of the comprehensive health insurance
 3 plan, the association shall establish the following premiums to be charged
 4 for membership in the comprehensive health insurance plan:

5 (1) The premium for the number one qualified plan shall be the average
 6 of rates charged by the [five] insurers with the largest number of individuals
 7 in a number one individual qualified plan of insurance in force in the state.

8 (2) The premium for the number two qualified plan shall be the average
 9 of rates charged by the [five] insurers with the largest number of individuals
 10 in a number two individual qualified plan of insurance in force in the state.

11 (3) The premium for a qualified Medicare supplement plan shall be the
 12 average of rates charged by the [five] insurers with the largest number of in-
 13 dividuals enrolled in a qualified Medicare supplement plan.

14 (4) The charge for health maintenance organization coverage shall be
 15 based on generally accepted actuarial principles.

16 (b) For the second and subsequent years, the schedule of premiums for
 17 membership in the comprehensive health insurance plan shall be designed to
 18 be self-supporting and based on generally accepted actuarial principles.

1 Section 9. [Duties of Commissioner.] The commissioner may:

(1) Formulate general policies to advance the purposes of Sections 1 to 17; the commissioner may also adopt, promulgate, repeal, and amend rules pursuant to the rulemaking provisions of [state administrative procedure act] to carry out the provisions of Sections 1 to 17.

(2) Supervise the creation of a comprehensive health association within the limits described in Section 10.

(3) Approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the state plan coverage and premiums to be charged.

(4) Appoint advisory committees.

(5) Conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association.

(6) Contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmental assistance programs.

(7) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of Sections 1 to 17, so that the residents of this state may best avail themselves of the health care benefits provided by these sections.

(8) Contract with insurers and others for administrative services.

Section 10. [Comprehensive Health Association.]

(a) There is established a comprehensive health association with membership consisting of all insurers, self-insurers, fraternal, and health maintenance organizations licensed or authorized to do business in this state.

(b) The board of directors of the association shall be made up of [seven] individuals selected by participating members, subject to approval by the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of residents in the previous calendar year, as determined by the commissioner. If the board of directors is not selected within [60] days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

(c) All members shall maintain their membership in the association as a

condition of doing business in this state. The association shall submit bylaws and operating rules to the commissioner for approval.

(d) All meetings of the association, its board, and any committees of the association shall comply with the provisions of [state open meetings act].

(e) All members shall enter into a contract with the association according to terms specified in Section 11. The contract of reinsurance shall be executed for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year.

(f) In the performance of their duties as members of the association, the members shall be exempt from the provisions of [state antitrust statute].

(g) The association may:

(1) Exercise the powers granted to insurers under the laws of this state.

(2) Sue or be sued.

(3) Enter into contracts with insurers, similar associations in other states, or other persons for the performance of administrative functions including the functions provided for in paragraphs (5) and (6) of this subsection.

(4) Establish administrative and accounting procedures for the operation of the association.

(5) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by Sections 4 and 16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are: (i) individual qualified plans, excluding group conversions; (ii) group conversions; (iii) group qualified plans with fewer than [50] employees or members; and (iv) major medical coverage. A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than [110] percent of the total anticipated expenses incurred by the association for the reinsurance.

(6) Provide for the administration by the association of policies which are reinsured pursuant to paragraph 5 of this subsection. Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than [110] percent of the total anticipated expenses incurred by the association for the administration.

2 (a) Upon certification as an eligible person in the manner provided by
3 Section 14, an eligible person may enroll in the comprehensive health in-
4 surance plan by payment of the state plan premium to the writing carrier.

5 (b) Any employer which has in its employ one or more eligible persons
6 enrolled in the comprehensive health insurance plan may make all or any
7 portion of the state plan premium payment to the state plan directly to the
8 writing carrier.

9 (c) Not less than [87½] percent of the state plan premium paid to the
10 writing carrier shall be used to pay claims, and not more than [12½] percent
11 shall be used for the payment of agent referral fees as authorized in Section
12 15(c) and for payment of the writing carrier's direct and indirect expenses,
13 as specified in Section 13(g).

14 (d) Any income in excess of the costs incurred by the association in pro-
15 viding reinsurance or administrative services shall be held at interest and used
16 by the association to offset losses due to claims expenses of the state plan
17 or allocated to reduce state plan premiums

18 (e) Each member of the association shall share the losses due to claims ex-
19 penses of the comprehensive health insurance plan pursuant to the terms of
20 the individual reinsurance contracts executed by the association with each
21 member in accordance with Section 10(e). Deviations in the claim ex-
22 perience of the state plan from the premium payments allocated to the pay-
23 ment of benefits shall be the liability of the association members. Associa-
24 tion members shall share in the excess costs of the state plan in an amount
25 equal to the ratio of the member's total cost of self-insurance, accident and
26 health insurance premium, subscriber contract charges, or health
27 maintenance organization contract charges received from or on behalf of
28 [state] residents as divided into the total cost of self-insurance, accident and
29 health insurance premium, subscriber contract charges, and health
30 maintenance organization contract charges received by all association
31 members from or on behalf of [state] residents, as determined by the com-
32 missioner. The reinsurance contract shall provide for a retroactive deter-
33 mination of each member's liability and payment due within [30] days after
34 each renewal date of the reinsurance contract. Failure by a member to
35 tender to the association the assessed reinsurance payment within [30] days
36 of notification by the association shall be grounds for termination of the
37 member's membership. Net gains, if any, from the operation of the state
38 plan shall be held at interest and used by the association to offset future
39 losses due to claims expenses of the state plan or allocated to reduce state
40 plan premiums.

1 Section 12. [Minimum Benefits of Comprehensive Health Insurance
2 Plan.] The association through its comprehensive health insurance plan
3 shall offer policies which provide the benefits of a number one qualified
4 plan, a number two qualified plan, and a qualified Medicare supplement
5 plan. They shall offer health maintenance organization contracts in those

6 areas of the state where a health maintenance organization has agreed to
7 make the coverage available and has been selected as a writing carrier.

1 Section 13. [Administration of Plan.]

2 (a) Any member of the association may submit to the commissioner the
3 policies of accident and health insurance or the health maintenance
4 organization contracts which are being proposed to serve in the compre-
5 hensive health insurance plan. The time and manner of the submission shall be
6 prescribed by rule of the commissioner.

7 (b) Upon the commissioner's approval of the policy forms and contracts
8 submitted pursuant to Section 10, the association shall select policies and
9 contracts submitted by a member or members of the association to be the
10 comprehensive health insurance plan. This selection shall be based upon
11 criteria including the member's proven ability to handle large group acci-
12 dent and health insurance cases, efficient claim paying capacity, and the
13 estimate of total charges for administering the plan. The association may
14 select separate writing carriers for the two types of qualified plans, the
15 qualified Medicare supplement plan, and the health maintenance organiza-
16 tion contract.

17 (c) The writing carrier shall perform all administrative and claims pay-
18 ment functions required by this section. The writing carrier shall provide
19 these services for a period of [three] years, unless a request to terminate is
20 approved by the commissioner. The commissioner shall approve or deny a
21 request to terminate within [90] days of its receipt. A failure to make a final
22 decision on a request to terminate within the specified period shall be
23 deemed to be an approval. [Six] months prior to the expiration of each
24 [three]-year period, the association shall invite submissions of policy forms
25 from members of the association, including the writing carrier. The associa-
26 tion shall follow the provisions of subsection (b) in selecting a
27 writing carrier for the subsequent three-year period.

28 (d) The writing carrier shall provide to all eligible persons enrolled in the
29 plan an individual certificate, setting forth a statement as to the insurance
30 protection to which he is entitled, with whom claims are to be filed and to
31 whom benefits are payable. The certificate shall indicate that coverage was
32 obtained through the association.

33 (e) The writing carrier shall submit to the association and the commis-
34 sioner on a monthly basis a report on the operation of the state plan.
35 Specific information to be contained in this report shall be determined by
36 the association prior to the effective date of the state plan.

37 (f) All claims shall be paid by the writing carrier pursuant to the provi-
38 sions of Sections 1 to 17 and shall indicate that the claim was paid
39 by the state plan. Each claim payment shall include information specifying
40 the procedure to be followed in the event of a dispute over the amount of
41 payment.

42 (g) The writing carrier shall be reimbursed from the state plan premiums
43 received for its direct and indirect expenses. Direct and indirect expenses

44 hall include, but need not be limited to, a pro rata reimbursement for that
45 portion of the writing carrier's administrative, printing, claims administra-
46 tion, management and building overhead expenses which are assignable to
47 the maintenance and administration of the state plan. The association shall
48 approve cost accounting methods to substantiate the writing carrier's cost
49 reports consistent with generally accepted accounting principles. Direct and
50 indirect expenses shall not include costs directly related to the original sub-
51 mission of policy forms prior to selection as the writing carrier.

52 (h) The writing carrier shall at all times when carrying out its duties under
53 Sections 1 to 17 be considered an agent of the association and the commis-
54 sioner with civil liability subject to the provisions of [appropriate state tort
55 liability statute].

56 (i) Premiums received by the writing carrier for the comprehensive health
57 insurance plan are specifically exempted from the provisions of Section 15 .

1 Section 14. [Enrollment by Eligible Person.]

2 (a) The comprehensive health insurance plan shall be open for enrollment
3 by eligible persons. An eligible person may enroll by submission of a cer-
4 tificate of eligibility to the writing carrier. The certificate shall provide the
5 following:

6 (1) Name, address, age, and length of time at residence of the appli-
7 cant.

8 (2) Name, address, and age of spouse and children, if any, if they are to
9 be insured.

10 (3) Evidence of rejection, or a requirement of restrictive riders, or a
11 preexisting conditions limitation on a qualified plan, the effect of which is
12 to substantially reduce coverage from that received by a person considered a
13 standard risk, by at least [two] association members within [six] months of
14 the date of the certificate.

15 (4) A designation of the coverage desired.

16 (b) Within [30] days of receipt of the certificate described in Section
17 14(a), the writing carrier shall either reject the application for failing to
18 comply with the requirements in Section 14(a) or forward the eligible person
19 a notice of acceptance and billing information. Insurance shall be effective
20 immediately upon receipt of the first month's state plan premium, and shall
21 be retroactive to the date of application, if the applicant otherwise complies
22 with the requirements of Sections 1 to 17. An eligible person may not pur-
23 chase more than one policy from the state plan.

24 (c) No person who obtains coverage pursuant to this section shall be
25 covered for any preexisting condition during the first [six] months of
26 coverage under the state plan if the person was diagnosed or treated for that
27 condition during the [90] days immediately preceding the filing of an ap-
28 plication.

1 Section 15. [Solicitation of Eligible Persons.]

2 (a) The association pursuant to a plan approved by the commissioner

3 shall disseminate appropriate information to the residents of this state
4 regarding the existence of the comprehensive health insurance plan and the
5 means of enrollment. Means of communication may include use of the
6 press, radio, and television, as well as publication in appropriate state of-
7 fices and publications.

8 (b) The association shall devise and implement means of maintaining
9 public awareness of the provisions of Sections 1 to 17 and shall administer
10 these sections in a manner which facilitates public participation in the state
11 plan.

12 (c) The writing carrier shall pay an agent's referral fee of \$[25] to each in-
13 surance agent who refers an applicant to the state plan, if the application is
14 accepted. Selling or marketing of qualified state plans shall not be limited to
15 the writing carrier or its agents. The referral fees shall be paid by the writing
16 carrier from money received as premiums for the state plan.

17 (d) Every insurer which rejects or applies underwriting restrictions to an
18 applicant for accident and health insurance shall notify the applicant of the
19 existence of the state plan, the requirements for being accepted in it, and the
20 procedure for applying to it.

1 Section 16. [Conversion Privileges.] Every program of self-insurance,
2 policy of group accident and health insurance or contract of coverage by a
3 health maintenance organization written or renewed in this state shall in-
4 clude the right to convert to an individual coverage qualified plan without
5 the addition of underwriting restrictions regardless of the reason for leaving
6 the group. The person leaving the group may exercise his right to conversion
7 within [30] days of leaving the group. Plans of health coverage shall also in-
8 clude a provision which, upon the death of the individual in whose name the
9 contract was issued, permits every other individual then covered under the
10 contract to elect, within the period specified in the contract, to continue his
11 coverage under the same or a different contract without the addition of
12 underwriting restrictions until he would have ceased to have been entitled to
13 coverage had the individual in whose name the contract was issued lived.

1 Section 17. [Dual Option.]

2 (a) An employer who employs in this state, on the average during a calen-
3 dar quarter, [100] employees or more, other than employees engaged in
4 seasonal employment, and who offers a health benefits plan to employees,
5 whether purchased from an insurer or a health maintenance organization,
6 or provided on a self-insured basis, shall, upon the next renewal of the
7 health benefits plan contract, offer his employees a dual option to obtain
8 health benefits through either an accident and health insurance policy or a
9 health maintenance organization contract if one is available. An option
10 need not be provided if fewer than [25] employees select that option.

11 (b) An employer may make the dual offers through an insurer, a health
12 maintenance organization or on a self-insured basis. If an offer is made on a
13 self-insured basis, the accident and health insurance type of coverage or

14 health maintenance organization type of coverage shall meet the re-
15 quirements of the laws of this state as to the services covered or benefits
16 provided, but need not otherwise be approved by the commissioner or the
17 board of health.

18 (c) No insurer shall make acceptance of its offer to provide insurance
19 coverage contingent on acceptance by the employer of health maintenance
20 organization coverage by a particular health maintenance organization. No
21 health maintenance organization shall make acceptance of its offer to pro-
22 vide health maintenance organization coverage contingent on acceptance by
23 the employer of insurance coverage by a particular insurer. No offer to pro-
24 vide the accident and health insurance policy and the health maintenance
25 organization contract shall combine the two in a single price package.

26 (d) The [board of health], in consultation with the commissioner, shall
27 adopt rules to implement the provisions of this section.

1 Section 18. [*Application for Assistance.*]

2 (a) Any person who believes that they are or will become an eligible per-
3 son may submit an application for state assistance to the [commissioner of
4 public welfare]. The application shall include a listing of expenses incurred
5 prior to the date of the application and shall designate the date on which the
6 [12]-month period for computing expenses began.

7 (b) If the [commissioner of public welfare] determines that an applicant is
8 an eligible person, he shall pay [90] percent of all qualified expenses of the
9 eligible person and his dependents in excess of: (1) [40] percent of his
10 household income under \$[15,000], plus [50] percent of his household in-
11 come between \$[15,000] and \$[25,000], plus [60] percent of his household
12 income in excess of \$[25,000]; or (2) \$[2,500], whichever is greater for the
13 [12]-month period in which the applicant becomes an eligible person. If the
14 [commissioner of public welfare] determines that the charge for a health
15 service is excessive, he may limit his payment to the usual and customary
16 charge for that service. If the [commissioner of public welfare] determines
17 that a health service provided to an eligible person was not medically
18 necessary, he may refuse to pay for the service. To the extent feasible, the
19 [commissioner of public welfare] shall contract with a review organization
20 in making any determinations as to whether or not a charge is excessive. To
21 the extent feasible, the [commissioner of public welfare] shall contract with
22 a review organization in making any determination as to whether or not a
23 service was medically necessary. If the [commissioner of public welfare], in
24 accordance with this section, refuses to pay all or a part of the charge for a
25 health service, the unpaid portion of the charge shall be deemed to be an un-
26 conscionable fee, against the public policy of this state, and unenforceable
27 in any action brought for the recovery of moneys owed.

1 Section 19. [*Duties of Commissioner.*]

2 (a) The [commissioner of public welfare] shall:

3 (1) Promulgate reasonable rules to implement Sections 18 to 20.

4 (2) Establish application forms and procedures for the use of persons
5 seeking to be declared eligible persons.

6 (3) Investigate applications to determine whether or not the applicant is
7 a qualified person and investigate claims from providers of health services
8 to determine whether or not to pay them.

9 (b) The [commissioner of public welfare] may:

10 (1) Enter into contracts with the United States or any state agency, in-
11 strumentality or political subdivision for the purpose of coordinating the
12 program established by this act, with other programs which provide or pay
13 for the delivery of health services.

14 (2) Enter into contracts with third parties to perform some or all of the
15 duties imposed on the [commissioner of public welfare] by Sections 18 and
16 19.

1 Section 20. [*Appeals.*] The final decision of the [commissioner of public
2 welfare] in denying an application for status as an eligible person or denying
3 all or part of the charges for a health service may be appealed by any in-
4 terested party pursuant to [state administrative procedure act].

1 Section 21. [*Severability.*] [Insert severability clause.]

1 Section 22. [*Repeal.*] [Insert repealer clause.]

1 Section 23. [*Effective Date.*] [Insert effective date.]

PART VI. ENFORCEMENT

[§392-91] Enforcement by the director. The director shall enforce the provisions of this chapter. The director may appoint such assistants and such clerical, stenographic and other help as may be necessary for the proper enforcement of this chapter subject to any civil service act relating to state employees. The salaries of all the foregoing appointees and employees shall be as fixed by law.

The director may adopt, amend, or repeal such rules and regulations as he deems necessary or suitable for the proper enforcement of this chapter. [L 1969, c 148, pt of §1]

PART VII. MISCELLANEOUS PROVISIONS

[§392-101] Limitation of fees. Any individual claiming benefits in any proceeding before the department or the referee may be represented by counsel or other duly authorized agent; but no such counsel or agent shall either charge or receive for such services more than an amount approved by the department or referee, and such amount shall in no case exceed ten per cent of the total amount of benefits received as a result of such proceeding. Any person who violates this section shall, for each such offense, be fined not less than \$50 nor more than \$500 or imprisoned not more than six months, or both. [L 1971, c 109, §1(m)]

[CHAPTER 393]
PREPAID HEALTH CARE ACT

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PART I. SHORT TITLE; PURPOSE; DEFINITIONS

[§393-1] Short title. This chapter shall be known as the Hawaii Prepaid Health Care Act. [L 1974, c 210, pt of §1]

[§393-2] Findings and purpose. The cost of medical care in case of sudden need may consume all or an excessive part of a person's resources. Prepaid health care plans offer a certain measure of protection against such emergencies. It is the purpose of this chapter in view of the spiraling cost of comprehensive medical care to provide this type of protection for the employees in this State. Although a large segment of the labor force in the State already enjoys coverage of this type either by virtue of collective bargaining agreements, employer-sponsored plans, or individual initiative, there is a need to extend that protection to workers who at present do not possess any or possess only inadequate prepayment coverage.

This chapter shall not be construed to interfere with or diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by this chapter or at least equivalent thereto. [L 1974, c 210, pt of §1]

[§393-3] Definitions generally. As used in this chapter, unless the context clearly requires otherwise:

- (1) "Department" means the department of labor and industrial relations.
- (2) "Director" means the director of labor and industrial relations.
- (3) "Employer" means any individual or type of organization, including any partnership, association, trust, estate, joint stock company, insurance company, or corporation, whether domestic or foreign, a debtor in possession or receiver or trustee in bankruptcy, or the legal representative of a deceased person, who has one or more regular employees in his employment. "Employer" does not include:
 - (A) The State, any of its political subdivisions, or any instrumentality of the State or its political subdivisions;

- (B) The United States government or any instrumentality of the United States;
- (C) Any other state or political subdivision thereof or instrumentality of such state or political subdivision;
- (D) Any foreign government or instrumentality wholly owned by a foreign government, if (i) the service performed in its employ is of a character similar to that performed in foreign countries by employees of the United States government or of an instrumentality thereof, and (ii) the United States Secretary of State has certified or certifies to the United States Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States government and of instrumentalities thereof.
- (4) "Employment" means service, including service in interstate commerce, performed for wages under any contract of hire, written or oral, expressed or implied, with an employer, except as otherwise provided in sections 393-4 and 393-5.
- (5) "Premium" means the amount payable to a prepaid health care plan contractor as consideration for his obligations under a prepaid health care plan.
- (6) "Prepaid health care plan" means any agreement by which any prepaid health care plan contractor undertakes in consideration of a stipulated premium:
- (A) Either to furnish health care, including hospitalization, surgery, medical or nursing care, drugs or other restorative appliances, subject to, if at all, only a nominal per service charge; or
- (B) To defray or reimburse, in whole or in part, the expenses of health care.
- (7) "Prepaid health care plan contractor" means:
- (A) Any medical group or organization which undertakes under a prepaid health care plan to provide health care; or
- (B) Any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or
- (C) Any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.
- (8) "Regular employee" means a person employed in the employment of any one employer for at least twenty hours per week but does not include a person employed in seasonal employment. "Seasonal employment" for the purposes of this paragraph means employment in a seasonal pursuit as defined in section 387-1 by a seasonal employer during a seasonal period or seasonal periods for the employer in the seasonal pursuit or employment by an employer engaged in the cultivating, harvesting, processing, canning, and warehousing of pineapple during its seasonal periods. The director by rule and regulation may determine the kind of employment that constitutes

seasonal employment.

- (9) "Wages" means all cash remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of his employer.

If the employee does not account to his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than \$20 a month in tips, the combined amount received by him from his employer and from tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

"Wages" do not include the amount of any payment specified in section 383-11 or 392-22 or chapter 386. [L 1974, c 210, pt of §1]

[§393-4] Place of performance. "Employment" includes an individual's entire service, performed within or both within and without this State if:

- (1) The service is localized in this State; or
- (2) The service is not localized in any state but some of the service is performed in this State and
 - (A) The individual's base of operation, or, if there is no base of operation, the place from which such service is directed or controlled, is in the State; or
 - (B) The individual's base of operation or place from which the service is directed or controlled is not in any state in which some part of the service is performed but the individual's residence is in this State. [L 1974, c 210, pt of §1]

[§393-5] Excluded services. "Employment" as defined in section 393-3 does not include the following services:

- (1) Service performed by an individual in the employ of an employer who, by the laws of the United States, is responsible for care and cost in connection with such service.
- (2) Service performed by an individual in the employ of his spouse, son, or daughter, and service performed by an individual under the age of twenty-one in the employ of his father or mother.
- (3) Service performed in the employ of a voluntary employee's beneficiary association providing for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or their designated beneficiaries, if
 - (A) Admission to membership in the association is limited to individuals who are officers or employees of the United States government, and
 - (B) No part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual.
- (4) Service performed by an individual for an employer as an insurance agent or as an insurance solicitor, if all such service

performed by the individual for the employer is performed for remuneration solely by way of commission.

- (5) Service performed by an individual for an employer as a real estate salesman or as a real estate broker, if all such service performed by the individual for the employer is performed for remuneration solely by way of commission.
- (6) Service performed by an individual who, pursuant to the Federal Economic Opportunity Act of 1964, is not subject to the provisions of law relating to federal employment, including unemployment compensation. [L 1974, c 210, pt of §1]

[§393-6] Principal and secondary employer defined; coercion, interference, etc. prohibited. If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the principal employer shall be the employer who pays him the most wages; provided that if one of the employers, who does not pay the most wages, employs the regular employee for at least thirty-five hours per week, the employee shall determine which of the employers shall be his principal employer. His other employers are secondary employers. An employer so designated as the principal employer shall remain as such principal employer for one year or until change of employment, whichever is earlier.

If an individual is concurrently a regular employee of a public entity which is not an employer as defined in section 393-3 and of an employer as defined in section 393-3 the latter shall be deemed to be a secondary employer.

An employer who, directly or indirectly, interferes with or coerces or attempts to coerce an employee in making a determination under this section shall be subject to the penalty provided under subsection 393-33(b). [L 1974, c 210, pt of § 1; am L 1975, c 51, §1]

[§393-7] Required health care benefits. (a) A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under this chapter if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type, as specified in section 393-12(a)(1) or (2), which have the largest numbers of subscribers in the State. This applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.

The director, after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection.

(b) A prepaid group health care plan shall also qualify for the mandatory health care benefits required under this chapter if it is demonstrated by the health care plan contractor offering such coverage to the satisfaction of the director after advice by the prepaid health care advisory council that the plan provides for sound basic hospital,

surgical, medical, and other health care benefits at a premium commensurate with the benefits included taking proper account of the limitations, co-insurance features, and deductibles specified in such plan. Coverage under a plan which provides aggregate benefits that are more limited than those provided by plans qualifying under subsection (a) shall be in compliance with section 393-11 only if the employer contributes at least half of the cost of the coverage of dependents under such plan.

(c) Subject to the provisions of subsections (a) and (b) without limiting the development of medically more desirable combinations and the inclusion of new types of benefits, a prepaid health care plan qualifying under this chapter shall include at least the following benefit types:

(1) Hospital benefits:

(A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering:

- (i) Room accommodations;
- (ii) Regular and special diets;
- (iii) General nursing services;
- (iv) Use of operating room, surgical supplies, anesthesia services, and supplies;
- (v) Drugs, dressings, oxygen, antibiotics, and blood transfusion services.

(B) Out-patient care:

- (i) Covering use of out-patient hospital;
- (ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.

(2) Surgical benefits:

(A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);

(B) After-care visits for a reasonable period;

(C) Anesthesiologist services.

(3) Medical benefits:

(A) Necessary home, office, and hospital visits by a licensed physician;

(B) Intensive medical care while hospitalized;

(C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radio-therapeutic services, necessary for diagnosis or treatment of injuries or diseases.

(5) Maternity benefits, at least if the employee has been covered by the prepaid health care plan for nine consecutive months prior to the delivery.

(d) The prepaid health care advisory council shall be appointed by the director and shall include representatives of the medical and public health professions, representatives of consumer interests, and persons experienced in prepaid health care protection. The membership of the council shall not exceed seven individuals. [L 1974, c 210, pt of §1]

[§393-11] Coverage of regular health care plan. Every employer monthly wages in an amount not less than the minimum hourly wage, specified in chapter 210 of the director, shall provide a prepaid group health care plan qualifying under this chapter. [L 1974, c 210, pt of §1]

[§393-12] Choice of plan type. Every employer required to provide coverage under this chapter shall be provided by:

(1) A plan which obligates the employer to furnish the required health care;

(2) A plan which obligates the employer to defray or reimburse the expenses of the employee. His election is binding for one year.

(b) Whether the employer elects coverage under subsection (a)(1) or in subsection (a)(2), the employer shall contribute the greater amount to the premium than the employer elected coverage with the respective type of coverage.

Subject to the provision of section 393-13, every employer shall provide coverage with the prepaid health care plan pursuant to this subsection for all health care services for all health care services of this type of coverage who are covered by the applicable collective bargaining agreement, except for employees covered by the first sentence. [L 1974, c 210, pt of §1]

[§393-13] Liability for payment. Every employer shall contribute at least the balance of the coverage required by this chapter; provided that in no event shall the contribution be more than 1.5 per cent of his wages of the employee's contribution is less than the employer shall be liable for the premium.

The employer shall withhold the premium with respect to pay periods as specified in this section. [L 1974, c 210, pt of §1]

[§393-14] Commencement of coverage. Every employer shall provide the coverage required by this chapter for all health care services who has been in his employ for four years thereafter at which coverage

PART II. MANDATORY COVERAGE

[§393-11] Coverage of regular employees by group prepaid health care plan. Every employer who pays to a regular employee monthly wages in an amount of at least 86.67 times the minimum hourly wage, specified in chapter 387, as rounded off by regulation of the director, shall provide coverage of such employee by a prepaid group health care plan qualifying under section 393-7 with a prepaid health care plan contractor in accordance with the provisions of this chapter. [L 1974, c 210, pt of §1]

[§393-12] Choice of plan type and of contractor. (a) Every employer required to provide coverage for his employees by a prepaid group health care plan under this chapter shall elect whether coverage shall be provided by:

(1) A plan which obligates the prepaid health care plan contractor to furnish the required health care benefits; or

(2) A plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care.

His election is binding for one year.

(b) Whether the employer elects a plan type described in subsection (a)(1) or in subsection (a)(2), the employer may elect the particular contractor but the employee shall not be obligated to contribute a greater amount to the premium than he would have to contribute had the employer elected coverage with the contractor providing the prevailing coverage of the respective type in the State.

Subject to the provision of section 393-20, the employer shall provide coverage with the prepaid health care plan contractor selected pursuant to this subsection for all his employees in the State electing this type of coverage who are covered by the provisions of this chapter, except for employees covered by the health care provisions of an applicable collective bargaining agreement as provided in section 393-19(b) first sentence. [L 1974, c 210, pt of §1]

[§393-13] Liability for payment of premium; withholding. Unless an applicable collective bargaining agreement specifies differently every employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance; provided that in no case shall the employee contribute more than 1.5 per cent of his wages; and provided that if the amount of the employee's contribution is less than one-half of the premium, the employer shall be liable for the whole remaining portion of the premium.

The employer shall withhold the employee's share from his wages with respect to pay periods as specified by the director. [L 1974, c 210, pt of §1]

[§393-14] Commencement of coverage. The employer shall provide the coverage required by this chapter for any regular employee, who has been in his employ for four consecutive weeks, at the earliest time thereafter at which coverage may be provided with the prepaid

health care plan contractor selected pursuant to this chapter. [L 1974, c 210, pt of §1]

[§393-15] Continuation of coverage in case of inability to earn wages. If an employee is hospitalized or otherwise prevented by sickness from working, the employer shall enable the employee to continue his coverage by contributing to the premium the amounts paid by the employer toward such premium prior to the employee's sickness for the period that such employee is hospitalized or prevented by sickness from working. This obligation shall not exceed a period of three months following the month during which the employee became hospitalized or disabled from working, or the period for which the employer has undertaken the payment of his regular wages in such case, whichever is longer. [L 1974, c 210, pt of §1]

[§393-16] Liability of secondary employer. An employer who has been notified by an employee, in the form prescribed by the director, that he is not the principal employer as defined in section 393-6 shall be relieved of the duty of providing the coverage required by this chapter until he is notified by the employee pursuant to section 393-18 that he has become the principal employer. He shall notify the director, in the form prescribed by the director, that he is relieved from the duty of providing coverage or of any change in that status. [L 1974, c 210, pt of §1]

[§393-17] Exemption of certain employees. (a) In addition to the exemption specified in section 393-16, an employer shall be relieved of his duty under section 393-11 with respect to any employee who has notified him, in the form specified by the director, that the employee is:

- (1) Protected by health insurance or any prepaid health care plan established under any law of the United States;
- (2) Covered as a dependent under a prepaid health care plan, entitling him to the health benefits required by this chapter;
- (3) A recipient of public assistance or covered by a prepaid health care plan established under the laws of the State governing medical assistance.

(b) Employers receiving notice of a claim of exemption under this section shall notify the director of such claim in the form prescribed by the director. [L 1974, c 210, pt of §1]

[§393-18] Termination of exemption. (a) If an exemption which has been claimed by an employee pursuant to section 393-17 terminates because of any change in the circumstances entitling the employee to claim such exemption, the employee shall promptly notify the principal employer of the termination of the exemption and the employer thereupon shall provide coverage as required by this chapter.

(b) If because of a change in the employment situation of an employee or a redetermination by an employee as provided in section 393-6, a principal employer becomes a secondary employer or a secondary employer becomes the principal employer, the employee shall promptly notify the employers affected of such change and the new

principal employer shall provide coverage as required by this chapter. [L 1974, c 210, pt of §1]

[§393-19] Freedom of collective bargaining. (a) In addition to the policy stated in section 393-2, nothing in this chapter shall be construed to limit the freedom of employees to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs thereof. A collective bargaining agreement may provide that the employer himself undertakes to provide the health care specified in the agreement.

(b) If the employees rendering particular types of services are not covered by the health care provisions of the applicable collective bargaining agreements to which their employer is a party, the provisions of this chapter shall be applicable with respect to them. An employer or group of employers shall be deemed to have complied with the provisions of this chapter if they undertake to provide health care services pursuant to a collective bargaining agreement and the services are available to all other employees not covered by such agreement. [L 1974, c 210, pt of §1]

[§393-20] Adjustment of employer-sponsored plans. Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the State and the majority of such employees are not subject to this chapter, the benefits applicable to the employees covered by this chapter shall be adjusted within one year after the effective date of this chapter so as to meet the requirements of this chapter. [L 1974, c 210, pt of §1]

[§393-21] Individual waivers prohibited; additional withholding for dependents. An employee may not waive individually all or part of the required health care benefits or agree to pay a greater share of the premium for such benefits than is required by this chapter.

Subject to section 393-7(b), an employee may consent to pay a greater share of his wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of his dependents under the plan providing such benefits for himself. [L 1974, c 210, pt of §1]

[§393-22] Exemption of followers of certain teachings or beliefs. This chapter shall not apply to any individual who pursuant to the teachings, faith, or belief of any group, depends for healing upon prayer or other spiritual means. [L 1974, c 210, pt of §1]

[§393-23] Joint provision of coverage. Employers may form associations for the purpose of jointly providing prepaid health care protection under this chapter for their employees with the contractors authorized to provide such coverage in the State. [L 1974, c 210, pt of §1]

PART III. ADMINISTRATION AND ENFORCEMENT

[\$393-31] Enforcement by the director. Except as otherwise provided in section 393-7 the director shall administer and enforce this chapter. The director may appoint such assistants and such clerical, stenographic, and other help as may be necessary for the proper administration and enforcement of this chapter subject to any civil service act relating to state employees. [L 1974, c 210, pt of §1]

[\$393-32] Rule making and other powers of the director. The director may adopt, amend, or repeal, pursuant to chapter 91, such rules and regulations as he deems necessary or suitable for the proper administration and enforcement of this chapter.

The director may round off the amounts specified in this chapter for the purpose of eliminating payments from the premium supplementation fund in other than even dollar amounts or other purposes.

The director may prescribe the filing of reports by prepaid health care plan contractors and prescribe the form and content of requests by employers for premium supplementation and the period for the payment thereof. [L 1974, c 210, pt of §1]

[\$393-33] Penalties. (a) If an employer fails to comply with section 393-11, 393-12, 393-13, or 393-15 he shall pay a penalty of not less than \$25 or of \$1 for each employee for every day during which such failure continues, whichever sum is greater. The penalty shall be assessed under rules and regulations promulgated pursuant to chapter 91 and shall be collected by the director and paid into the special fund for premium supplementation established by section 393-41. The director may, for good cause shown, remit all or any part of the penalty.

(b) Any employer, employee, or prepaid health care plan contractor who wilfully fails to comply with any other provision of this chapter or any rule or regulation thereunder may be fined not more than \$200 for each such violation. [L 1974, c 210, pt of §1]

PART IV. PREMIUM SUPPLEMENTATION

[\$393-41] Establishment of special premium supplementation fund. There is established in the treasury of the State, separate and apart from all public moneys or funds of the State, a special fund for premium supplementation which shall be administered exclusively for the purposes of this chapter. All premium supplementations payable under this part shall be paid from the fund. The fund shall consist of (1) all money appropriated by the State for the purposes of premium supplementation under this part and (2) all fines and penalties collected pursuant to this chapter. [L 1974, c 210, pt of §1]

[§393-42] Management of the fund. The director of finance shall be the treasurer and custodian of the premium supplementation fund and shall administer the fund in accordance with the directions of the director of labor and industrial relations. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any depository bank in which general funds of the State may be deposited but such moneys shall not be commingled with other state funds and shall be maintained in separate accounts on the books of the depository bank. Such moneys shall be secured by the depository bank to the same extent and in the same manner as required by the general depository law of the State; and collateral pledged for this purpose shall be kept separate and distinct from any other collateral pledged to secure other funds of the State. The director of finance shall be liable for the performance of his duties under this section as provided in chapter 37. [L 1974, c 210, pt of §1]

[§393-43] Disbursements from the fund. Expenditures of moneys in the premium supplementation fund shall not be subject to any provisions of law requiring specific appropriations or other formal release by the state officers of money in their custody. All payments from the fund shall be made upon warrants drawn upon the director of finance by the comptroller of the State supported by vouchers approved by the director. [L 1974, c 210, pt of §1]

[§393-44] Investment of moneys. With the approval of the department the director of finance may, from time to time, invest such moneys in the premium supplementation fund as are in excess of the amount deemed necessary for the payment of benefits for a reasonable future period. Such moneys may be invested in bonds of any political or municipal corporation or subdivision of the State, or any of the outstanding bonds of the State, or invested in bonds or interest-bearing notes or obligations of the State (including state director of finance's warrant notes issued pursuant to chapter 40), or of the United States, or those for which the faith and credit of the United States are pledged for the payment of principal and interest, or in federal land bank bonds or joint stock farm loan bonds. The investments shall at all times be so made that all the assets of the fund shall always be readily convertible into cash when needed for the payment of benefits. The director of finance shall dispose of securities or other properties belonging to the fund only under the direction of the director of labor and industrial relations. [L 1974, c 210, pt of §1]

[§393-45] Entitlement to premium supplementation. (a) An employer who employs less than eight employees entitled to coverage under this chapter and who provides coverage to such employees pursuant to section 393-7(a) shall be entitled to premium supplementation from the fund if the employer's share of the cost of providing such

Sec. 393-46 LABOR AND INDUSTRIAL RELATIONS

coverage as determined by sections 393-13 and 393-15 exceeds 1.5 per cent of the total wages payable to such employees and if the amount of such excess is greater than five per cent of the employer's income before taxes directly attributable to the business in which such employees are employed.

(b) The amount of the supplementation shall be that part of the employer's share of the premium cost which exceeds the limits specified in subsection (a). [L 1974, c 210, pt of §1]

[§393-46] Income directly attributable to the business. (a) "Income directly attributable to the business" means gross profits from the business minus deductions for:

- (1) Compensation of officers;
- (2) Salaries and wages, except wages paid by an individual proprietor to himself;
- (3) Repairs;
- (4) Taxes on business and business property;
- (5) Business advertising;
- (6) Amounts contributed to employee benefit plans;
- (7) Interest on business indebtedness;
- (8) Rent on business property; and
- (9) Other expenses necessary for the current conduct of business.

(b) Deductions shall not include:

- (1) Bad debts;
- (2) Contributions or gifts, other than those listed under subsection (a)(6);
- (3) Amortization and depreciation; or
- (4) Losses by fire, storm, casualty, or theft.

(c) The director may promulgate rules and regulations necessary to define income directly attributable to business for the purpose of section 393-45. [L 1974, c 210, pt of §1]

[§393-47] Claim of premium supplementation. An employer entitled to premium supplementation shall file a claim therefor in the manner provided by regulation of the director. The employer shall have the burden of proof of establishing his entitlement. [L 1974, c 210, pt of §1]

[PART V. TERMINATION OF CHAPTER]

[§393-51 Termination of chapter.] This chapter shall terminate upon the effective date of federal legislation that provides for voluntary prepaid health care for the people of Hawaii in manner at least as favorable as the health care provided by this chapter, or upon the effective date of federal legislation that provides for mandatory prepaid health care for the people of Hawaii. [L 1974, c 210, pt of §2]

§ 38-370b. Notice of cancellation of professional liability policy

Any insurance company doing business in this state shall provide a ninety-day notice to the insured of cancellation of or refusal to renew any professional liability policy.

(1976, P.A. 76-117, eff. April 29, 1976.)

Library References

Insurance § 229.
C.J.S. Insurance §§ 450, 473(6) et seq.

§ 38-370c. Mandatory provisions for professional liability insurance policies issued on a claims-made basis

Every professional liability insurance policy issued on a claims-made basis delivered, issued for delivery or renewed in this state on or after October 1, 1978 shall contain (1) a provision for the purchase of prior acts coverage and (2) a contractual right of the insured to purchase at any time during the policy period not later than thirty days after termination of such policy period coverage for all claims occurring during an insured policy period when made.

(S-91.)

CHAPTER 692

COMPREHENSIVE HEALTH CARE PLANS [NEW]

Sec.		Sec.	
38-371.	Definitions.	38-377.	Hospital and medical service corporations. Residual market mechanism. Insurance commissioner's powers concerning such mechanisms.
38-372.	Applicability of chapter. Individual and group comprehensive health care plans.	38-378.	Insurance commissioners' powers concerning comprehensive health care plans. Notification to purchasers of policy or contract term.
38-373.	Minimum standard benefits of comprehensive health care plans. Optional and excludable benefits. Carrier subrogation rights.	38-379.	Application to new or renewed group health policies and contracts. Other regulations.
38-374.	Additional requirements and eligibility under group comprehensive health care plans. Insurance commissioner's authority to coordinate benefits.	38-380.	Commission on hospitals and health care.
38-375.	Additional requirements for individual comprehensive health care plans. Carrier obligations concerning termination of coverage.	38-381.	Commissioner of social services. Contract authority concerning medical programs.
38-376.	Health Insurance Association. Classes of risk. Audits. Insurance commissioner's powers.		

§ 38-371. Definitions

For purposes of this chapter, the following terms shall have the following meanings:

(a) "Health insurance" means hospital and medical expenses incurred policies written on a direct basis, nonprofit service plan contracts and self-insured or self-funded employee health benefit plans. The term "health insurance" for purposes of this chapter shall not include accident only policies, disability income policies or coverages which are subject to regulation under chapters 682a and 690.

(b) "Carrier" means an insurer, hospital service corporation or medical service corporation or fraternal benefit society.

(c) "Insurer" means an insurance company licensed to transact accident and health insurance business in this state.

(d) "Self-insurer" means an employer or an employee welfare benefit fund or plan which provides payment for or reimbursement of the whole or any part of the cost of covered hospital or medical expenses for covered individuals. For purposes of this chapter, "self-insurer" shall not include any such employee welfare benefit fund or plan established prior to April 1, 1976, by any organization which is exempt from federal income taxes under the provisions of Section 501 of the United States Internal Revenue Code and amendments thereto and legal interpretations thereof, except any such organization described in Subsection (c)(15) of said Section 501.

(e) "Commissioner" means the insurance commissioner within the department of business regulation of the state of Connecticut.

(f) "Physician" means a doctor of medicine, osteopathy, chiropractic, naturopathy, podiatry, a qualified psychologist and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry, and subject to the provisions of section 20-138d, optometrists duly licensed under the provisions of chapter 380.

(g) "Qualified psychologist" means a person who is duly licensed or certified as a clinical psychologist and has a doctoral degree in and at least two years of supervised experience in clinical psychology in a licensed hospital or mental health center.

(h) "Skilled nursing facility" shall have the same meaning as "skilled nursing facility" as defined in Section 1305x, Chapter 7 of Title 42, United States Code.

(i) "Hospital" shall have the same meaning as "hospital" as defined in Section 1305x, Chapter 7 of Title 42, United States Code.

(j) "Home health agency" shall have the same meaning as "home health agency" as defined in Section 1305x, Chapter 7 of Title 42, United States Code.

(k) "Copayment" means the portion of a charge that is covered by a plan and not payable by the plan and which is thus the obligation of the covered individual to pay.

(l) "Resident employer" means any person, partnership, association, trust, estate, corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy or receiver or trustee, thereof, or the legal representative of a deceased person, including the state of Connecticut and each municipality therein, which has in its employ one or more individuals during any calendar year, commencing January 1, 1976. For purposes of this chapter, the term "resident employer" shall refer only to an employer with a majority of employees employed within the state of Connecticut.

(m) "Eligible employee" means, with respect to any employer, an employee who either is considered a fulltime employee, or who is expected to work at least twenty hours a week for at least twenty-six weeks during the next twelve months or who has actually worked at least twenty hours a week for at least twenty-six weeks in any continuous twelve month period.

(n) "Alcoholism treatment facility" shall have the same meaning as in section 38-262b.

(o) "Totally disabled" means with respect to an employee, the inability of the employee because of an injury or disease to perform the duties of any occupation for which he is suited by reason of education, training or experience, and, with respect to a dependent, the inability of the dependent because of an injury or disease to engage in substantially all of the normal activities of persons of like age and sex in good health.

(p) "Deductible" means the amount of covered expenses which must be accumulated during each calendar year before benefits become payable as additional covered expenses incurred.

(q) For purposes of this chapter, "disease or injury" shall include pregnancy and resulting childbirth or miscarriage.

(r) "Complications of pregnancy" means (1) conditions requiring hospital stays, when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (2) non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible. (1975, P.A. 75-616, § 1, eff. April 1, 1976; 1976, P.A. 76-399, § 2, eff. June 9, 1976; 1977, P.A. 77-614, § 163, eff. Jan. 1, 1978.)

1976 Amendment

Introductory paragraph: 1976, P.A. 76-399, § 2, substituted "sections 38-371 to 38-381" for "this act".

Subsection (a): 1976, P.A. 76-399, § 2, substituted, in the second sentence, "sections 38-371 to 38-381" for "this act".

Subsection (d): 1976, P.A. 76-399, § 2, amended the second sentence by substituting "sections 38-371 to 38-381" for "this act"; and by substituting "June 9, 1976" for "the effective date of this act".

Subsection (b): 1976, P.A. 76-399, § 2, substituted, in the second sentence, "sections 38-371 to 38-381" for "this act".

Subsections (e) to (r): Added by 1976, P.A. 76-399, § 2.

1977 Amendment

1977, P.A. 77-614, § 163, eff. Jan. 1, 1978, provides for insertion of the words "within the department of business regulation" following "insurance commissioner".

Library References

Words and Phrases (Perm. Ed.)

§ 38-372. Applicability of chapter. Individual and group comprehensive health care plans

(a)(1) Every carrier offering individual health insurance in this state shall, as a condition of transacting such health insurance, make an individual comprehensive health care plan described in section 38-375, available to every resident of this state who is not eligible for Medicare. An individual shall have a choice of the low option or middle option or high option deductible described in subsection (b) of section 38-373. Individual comprehensive health care plans may be made available through participation in the Health Reinsurance Association in accordance with section 38-376, or a residual market association, in accordance with section 38-377. The premium charged for such a plan which is not insured by or through the Health Reinsurance Association or any other residual market association may not exceed the premium which would be applicable through participation in such associations. The premium charged for such a plan insured by or through the Health Reinsurance Association shall be precisely the premium established for that particular classification under the Health Reinsurance Association.

(2) Every self-insurer whose plan covers three or more employees shall make an individual comprehensive health care plan, described in section 38-375, available under a conversion privilege to every person covered by the plan who is a resident of this state, who is not eligible for Medicare and whose coverage under the self-insured plan ceases as a result of layoff, death or termination of employment. An individual shall have the choice of the low option or middle option or high option deductible described in subsection

(b) of section 38-373. The individual comprehensive health care plans may be provided through a carrier or through participation in the Health Reinsurance Association in accordance with section 38-376. The premium charged for such a plan which is not insured by or through the Health Reinsurance Association may not exceed the premium established for that particular classification under the Health Reinsurance Association. The premium charged for such a plan which is insured by or through the Health Reinsurance Association shall be precisely the premium established for that particular classification under the Health Reinsurance Association.

(b) Every carrier offering group health insurance in this state shall, as a condition of transacting such health insurance, make a group comprehensive health care plan, as described in section 38-374, available to every resident employer of three or more eligible employees. An employer shall have the choice of the low option or middle option or high option deductible described in subsection (b) of section 38-373. Group comprehensive health care plans may be made available to resident employers of between three and twenty-five eligible employees through participation in the Health Reinsurance Association, in accordance with section 38-376 or the residual market association, in accordance with section 38-377. The premium charged for such a plan on groups of between three and twenty-five eligible employees which is not insured by or through the Health Reinsurance Association or a residual market association may not exceed the premium which would be applicable through participation in such associations. The premium charged for such a plan which is insured by or through the Health Reinsurance Association must be precisely the premium established for that particular classification under the Health Reinsurance Association.

(c) Except as provided in subdivision (c) of section 38-378, nothing in sections 38-371 to 38-381 shall preclude the right of carriers to transact other kinds of insurance for which they are authorized, nor preclude the right of carriers to transact any other lawful kind of health insurance.

(d) Nothing in sections 38-371 to 38-381 shall require a carrier to make available coverage under a group or individual comprehensive health care plan to any person or group who is already covered under such a plan. (1975, P.A. 75-616, § 2, eff. April 1, 1976.)

Library References

Insurance ☞ 467.3, 467.4, 467.5.
C.J.S. Insurance §§ 753 et seq., 893, 896.

§ 38-373. Minimum standard benefits of comprehensive health care plans. Optional and excludible benefits. Carrier subrogation rights

All individual and all group comprehensive health care plans shall include minimum standard benefits as described in this section.

(a) Except as provided in subsections (b) and (c), minimum standard benefits shall be benefits, including coverage for catastrophic illness, with a lifetime maximum of one million dollars per individual, for reasonable charges or, when applicable, the allowance agreed upon between a provider and a carrier for charges actually incurred, for the following health care services, rendered to an individual covered by such plan for the diagnosis or treatment of nonoccupational disease or injury: (1) hospital services; (2) professional services which are rendered by a physician or, at his direction, by a registered nurse, other than services for mental or dental conditions; (3) the diagnosis or treatment of mental conditions, as defined by the commissioner, rendered during the year by one or more physicians or other than an inpatient basis or, at their direction, by their staffs of registered nurses, up to a yearly maximum benefit of one thousand dollars; (4) legend drugs requiring a physician's prescription; (5) services of a skilled nursing fa-

illness for not more than one hundred twenty days in a calendar year, provided such services commence within fourteen days following a confinement of at least three consecutive days in a hospital for the same condition; (6) home health agency services, as defined by the commissioner, up to a maximum of one hundred eighty visits in a calendar year, provided such services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, provided further, in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, such home health agency services may commence irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such seven-day period, and the yearly benefit for medical social services, as hereinafter defined, shall not exceed two hundred dollars. "Medical social services" means services rendered, under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (a) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; (b) appropriate action and utilization of community resources to assist in resolving such problems; (c) participation in the development of treatment for such covered person; (7) use of radium or other radioactive materials; (8) oxygen; (9) anesthetics; (10) non-dental prosthesis; (11) rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed; (12) diagnostic x-rays and laboratory tests as defined by the commissioner; (13) oral surgery for: (A) Excision of partially or completely unerupted impacted teeth, or (B) excision of a tooth root without the extraction of the entire tooth; (14) services of a licensed physical therapist, rendered under the direction of a physician; (15) transportation by a local professional ambulance to the nearest health care institution qualified to treat the illness or injury; (16) certain other services which are medically necessary in the treatment or diagnosis of an illness or injury as may be designated or approved by the insurance commissioner within the department of business regulation; (17) confinement in a facility established primarily for the treatment of alcoholism and licensed for such care by the state, or in a part of a hospital used primarily for such treatment, shall be a covered expense for a period of at least forty-five days within any calendar year.

(b) Minimum standard benefits may include one or more of the following provisions: (1) Subject to the provisions of subsection (3) such plan may require deductibles. The "low option deductible" shall be two hundred dollars per person, the "middle option deductible" shall be five hundred dollars per person, and the "high option deductible" shall be seven hundred fifty dollars per person. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall be applied to that individual's deductible in the following calendar year. The two hundred dollar maximum, the five hundred dollar maximum and the seven hundred fifty dollar maximum may be adjusted yearly to correspond with the change in the medical care component of the consumer price index, as adjusted by the commissioner. The base year for such computation shall be the first full year of operation of such plan. (2) Subject to the provisions of subsection (3), such plan shall require a maximum copayment of twenty per cent for charges for all types of health care in excess of the deductible and fifty per cent for services listed in subdivision (3) of subsection (a) in excess of the deductible. (3) The sum of the deductible and copayments required in any calendar year under any option may not exceed a maximum limit of one thousand dollars per covered individual, or two thousand dollars per covered family; provided, covered expenses incurred after the applicable maximum limit has been

reached shall be paid at the rate of one hundred per cent, except that expenses incurred for treatment of mental and nervous conditions may be paid at the rate of fifty per cent as specified in subsection (3) of subsection (a). The one thousand dollar and two thousand dollar maximums shall be adjusted yearly to correspond with the change in the medical care component of the consumer price index as adjusted by the commissioner. (4) The plan shall limit benefits with respect to each pregnancy, other than a pregnancy involving complications of pregnancy, to a maximum of two hundred fifty dollars. (5) The plan may limit lifetime benefits to a maximum of not less than one million dollars per covered individual. (6) No pre-existing condition exclusion shall exclude coverage of any pre-existing condition unless: (A) The condition first manifested itself within the period of six months immediately prior to the effective date of coverage in such a manner as would cause a reasonably prudent person to seek diagnosis, care or treatment; (B) medical advice or treatment was recommended or received within the period of six months immediately prior to the effective date of coverage, or (C) the condition is pregnancy existing on the effective date of coverage. No policy shall exclude coverage for a loss due to pre-existing conditions for a period greater than twelve months following the effective date of coverage. Any individual comprehensive health care plan issued as a result of conversion from group health insurance or from a self insured group shall credit the time covered under such group health insurance toward any such exclusion.

(c) Plans providing minimum standard benefits need not provide benefits for the following: (1) Any charge for any care for any injury or disease either (A) arising out of and in the course of an employment subject to a workmen's compensation or similar law or (B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance; (2) any charge for treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered; (3) any charge for travel, other than transportation by local professional ambulance to the nearest health care institution qualified to treat the illness or injury; (4) any charge for private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room; (5) any charge by health care institutions to the extent that it is determined by the carrier that the charge exceeds the rates approved by the commission on hospital and health care; (6) any charge for services or articles to the extent that it exceeds the reasonable charge in the locality for the service; (7) any charge for services or articles which are determined not to be medically necessary; (8) any charge for services or articles the provisions of which is not within the scope of the license or certificate of the institution or individual rendering such services or articles; (9) any charge for services or articles furnished, paid for or reimbursed directly by or under any law of a government, except as otherwise provided herein; (10) any charge for services or articles for custodial care or designed primarily to assist an individual in meeting his activities of daily living; (11) any charge for services which would not have been made if no insurance existed or for which the covered individual is not legally obligated to pay; (12) any charge for eyeglasses, contact lenses or hearing aids or the fitting thereof; (13) any charge for dental care not specifically covered by this chapter; and (14) any charge for services of a registered nurse who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse.

(d) Whenever a covered individual who receives benefits for an injury has a right of recovery against any person or organization, a carrier that has paid such benefits to or for the insured person shall be subrogated to all such rights of recovery to the extent of its payments.

(e) The minimum standard benefits of any individual or group comprehensive health care plan may be satisfied by catastrophic coverage offered in conjunction with basic hospital or medical-surgical plans on an expense incurred or service basis as approved by the commissioner as providing at least equivalent benefits.

(1975, P.A. 75-616, § 3, eff. April 1, 1976; 1976, P.A. 76-399, § 3, eff. June 9, 1976; 1977, P.A. 77-614, § 163, eff. Jan. 1, 1979; 1978, P.A. 78-76, § 4.)

1976 Amendment

Subsection (a): 1976, P.A. 76-399, § 3, added subd. (17).

Subsection (b): 1976, P.A. 76-399, § 3, redesignated former subds. (4) and (5) as subds. (5) and (6); inserted subd. (4); and added to subd. (6), par. (C).

Subsection (c): 1976, P.A. 76-399, § 3, substituted, in subd. (13), "sections 38-371 to 38-381" for "this act" following "not specifically covered by".

1977 Amendment

1977, P.A. 77-614, § 163, eff. Jan. 1, 1979, provides for insertion of the words

"within the department of business regulation" following "insurance commissioner".

1978 Amendment

1978, P.A. 78-76, § 4, amended subsec. (c)(6) by adding the proviso following "days for the same condition", and by adding a second sentence defining "Medical social services".

Library References

Insurance 467.5.
C.J.S. Insurance § 893 et seq.

§ 38-374. Additional requirements and eligibility under group comprehensive health care plans. Insurance commissioner's authority to coordinate benefits

A group comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38-373, including the choice of the low option, middle option or high option deductible, and shall also conform in substance to the requirements of this section.

(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee; and (3) dependent unmarried children, who are under the age of nineteen or are full-time students under the age of twenty-three at an accredited institution of higher learning.

(b) The plan shall provide the option to continue coverage under each of the following circumstances until eligible for other group insurance: (1) Upon layoff or leave of absence, or termination of employment, other than as a result of death of the employee, continuation of coverage for such employee and his covered dependents to the end of the thirty-ninth week following the day on which the employee lost eligibility to participate in the group; (2) upon the death of the employee, continuation of coverage for the covered dependents of such employee to the end of the thirty-ninth week following the day on which the employee lost eligibility to participate in the group; (3) during an employee's absence due to illness or injury, continuation of coverage for such employee and his covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence; (4) upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination, shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted therefor within one year of the termination of the plan; (5) the coverage of any covered individual shall terminate: (A) As to a child, at the end of the month following the month in which the child marries, ceases to be dependent on the employee or attains the age of nineteen, whichever occurs first, except that if the child is a fulltime student at an accredited institution, the coverage may be continued while the child remains unmarried and a fulltime student, but not beyond the month following the month in which the child attains the age of twenty-three. If on the date

specified for termination of coverage on a dependent child, the child is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter: (B) as to the employee's spouse, at the end of the month following the month in which a divorce, annulment or legal separation is obtained; and (C) as to the employee or dependent as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act; (6) any continuation of coverage required by this section except subdivision (4) of subsection (b) may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium he would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay the entire premium at the group rate if coverage is continued in accordance with subdivision (1) of subsection (b) above, provided the employer shall not be legally obligated by this act to pay such premium if not paid timely by the employee.

(c) The commissioner shall promulgate regulations concerning coordination of benefits between the plan and other health insurance plans.

(d) The plan shall make available to Connecticut residents, in addition to any other conversion privilege available, a conversion privilege under which coverage shall be available immediately upon termination of coverage under the group plan. The terms and benefits offered under the conversion benefits shall be at least equal to the terms and benefits of an individual comprehensive health care plan.

(1975, P.A. 75-616, § 4, eff. April 1, 1976; 1976, P.A. 76-399, § 1, eff. June 9, 1976.)

1976 Amendment

Introductory paragraph: 1976, P.A. 76-399, § 1, substituted "section 38-373" for "section 3 of this act".

Subsection (b): 1976, P.A. 76-399, § 1, substituted "thirty-ninth week following the day on which the employee lost eligibility to participate in the group"

for "ninetieth day following the day on which such layoff, leave of absence or termination commenced" in subd. (1) and for "ninetieth day following the day on which death occurred" in subd. (2).

Library References

Insurance 467.5.
C.J.S. Insurance § 893 et seq.

§ 38-375. Additional requirements for individual comprehensive health care plans. Carrier obligations concerning termination of coverage

An individual comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38-373, including the choice of the low option, middle option or high option deductible, and shall also conform in substance to the requirements of this section. Each individual comprehensive health care plan shall contain provisions:

(1) Which obligate the carrier to continue the contract until the earlier of (A) the date on which the individual in whose name the contract was issued first becomes eligible for coverage under Title XVIII of the Social Security Act or under a group comprehensive health care plan or,

(B) the plan anniversary date at least sixty days prior to which the carrier has mailed to the individual at his last address shown on the carrier's records written notice of its decision not to continue coverage on a class basis only.

The carrier may reserve the right to adjust premiums by classes in accordance with its experience for policies or contracts not written by or through the Health Reinsurance Association, provided such premium may not exceed the premium established for that particular class by the Health Reinsurance Association;

(2) which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within such period as shall be specified in the contract, to continue the same coverage until such time as he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived; and

(3) under which the benefits payable shall be excess to all other sources of health insurance benefits, including benefits provided pursuant to any state or federal law other than Medicaid. (1975, P.A. 75-016, § 5, eff. April 1, 1976.)

Library References

Insurance § 467.4.

C.J.S. Insurance § 893, 896.

§ 38-376. Health Reinsurance Association. Classes of risk. Audits. Insurance commissioner's powers

There is hereby created a nonprofit legal entity to be known as the Health Reinsurance Association. All insurers and self insurers doing business in the state, as a condition to their authority to transact the applicable kinds of health insurance defined in section 38-371, shall be members of the association. The association shall perform its functions under a plan of operation established and approved under subdivision (a), and shall exercise its powers through a board of directors established under this section.

(a)(1) The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the net health insurance premium derived from this state in the previous calendar year. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the monies of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

(2) The board shall submit to the commissioner, a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this act must be made available. The commissioner shall, after notice and hearing, approve the plan of operation provided such plan is determined to be suitable to assure the fair, reasonable and equitable administration of the association, and provides for the sharing of association gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or if at any time thereafter the board fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the commis-

sioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall, in addition to requirements enumerated in sections 38-371 to 38-381:

(A) Establish procedures for the handling and accounting of assets and monies of the association;

(B) establish regular times and places for meetings of the board of directors;

(C) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;

(D) establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner;

(E) establish procedures to amend, subject to the approval of the commissioner, the plan of operations;

(F) establish procedures for the selection of an administering carrier and set forth the powers and duties of the administering carrier;

(G) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(H) establish procedures for the advertisement on behalf of all participating carriers of the general availability of the comprehensive coverage under sections 38-371 to 38-381.

(b) The association shall have the general powers and authority granted under the laws of this state to carriers to transact the kinds of insurance defined under section 38-371, and in addition thereto, the specific authority to:

(1) Enter into contracts necessary or proper to carry out the provisions and purposes of sections 38-371 to 38-381;

(2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating members;

(3) take such legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association;

(4) establish, with respect to health insurance provided by or on behalf of the association, appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the operational expenses of the association;

(5) Administer any type of reinsurance program, for or on behalf of participating members;

(6) Pool risks among participating members;

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by sections 38-371 to 38-381 in its own name or on behalf of participating members;

(8) Administer separate pools, separate accounts or other plans as deemed appropriate for separate members or groups of members;

(9) Operate and administer any combination of plans, pools, reinsurance arrangements or other mechanisms as deemed appropriate to best accomplish the fair and equitable operation of the association;

(10) Set limits on the amounts of reinsurance which may be ceded to the association by its members; and

(11) Appoint from among participating members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(c) Every member shall participate in the association in accordance with the provisions of this subdivision.

(1) A participating member shall determine the particular risks it elects to have written by or through the association. A member shall designate which of the following classes of risks it shall underwrite in the state, from which classes of risk it may elect to reinsure selected risks:

(A) Individual, excluding group conversion;

(B) Individual, including group conversion; and

(C) groups of between three and twenty-five employees or members.

(2) No member or employer shall be permitted to select out individual lives from an employer group to be insured by or through the association. Members electing to administer risks which are insured by or through the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk insured by or through the association cannot be withdrawn by the participating member except in accordance with the rules established by the association.

(3) Rates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. Separate scales of premium rates based on age shall apply for individual risks and group risks. Group rates may be adjusted for area variations in provider costs but individual rates shall not be adjusted for area variations in provider costs. Premium rates shall take into consideration the substantial extra morbidity and administrative expenses for association risks, reimbursement or reasonable expenses incurred for the writing of association risks and the level of rates charged by insurers for groups of ten lives. In no event shall the rate for a given classification or group be less than one hundred twenty-five per cent nor more than one hundred fifty per cent of the average group rate charged for that classification or group with similar characteristics under a policy covering ten lives. All rates shall be promulgated by the association through an actuarial committee consisting of five persons who are members of the American Academy of Actuaries. They shall be filed with the commissioner and may be disapproved within sixty days from the filing thereof if excessive, inadequate, or unfairly discriminatory.

(d)(1) Following the close of each fiscal year, the administering carrier shall determine the net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses for the year. Any net loss shall be assessed to all participating members in proportion to their respective shares of the total health insurance premiums earned in this state during the calendar year, or with paid losses in the year, coinciding with or ending during the fiscal year of the association or on any other equitable basis as may be provided in the plan of operations. For self insured members of the association, health insurance premiums earned shall be established by dividing the amount of paid health losses for the applicable period by eighty-five per cent. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums.

(2) Any net loss to the association represented by the excess of its actual expenses of administering policies issued by the association over the applicable expense allowance shall be separately assessed to those participating members who do not elect to administer their plans. All assessments shall be on an equitable formula established by the board.

(3) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association and the association shall have an annual audit of its operations by an independent certified public accountant. The annual audit shall be filed with the commissioner for his review and the association shall be subject to the provisions of section 38-7.

(e) All policy forms issued by or through the association shall conform in substance to prototype forms developed by the association, shall in all

other respects conform to the requirements of this act, and shall be approved by the commissioner. The commissioner may disapprove any such form if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy.

(f) The association shall not issue nor reissue comprehensive health care plan coverage with respect to any person who is already covered under an individual or group comprehensive health care plan, or who is eligible for Medicare or who is not a resident of this state.

(g) Benefits payable under a comprehensive health care plan insured by or reinsured through the association shall be paid net of all other health insurance benefits paid or payable through any other source, and net of all health insurance coverages provided by or pursuant to any other state or federal law including Title XVIII of the Social Security Act, Medicare, but excluding Medicaid.

(h) There shall be no liability on the part of and no cause of action of any nature shall arise against any carrier or its agents or its employees, the Health Reinsurance Association or its agents or its employees or the residual market mechanism established under the provisions of section 38-377 or its agents or its employees, or the commissioner or his representatives for any action taken by them in the performance of their duties under sections 38-371 to 38-381. This provision shall not apply to the obligations of a carrier, a self-insurer, the Health Reinsurance Association or the residual market mechanism for payment of benefits provided under a comprehensive health care plan.

(1975, P.A. 75-616, § 6, eff. April 1, 1976.)

Library References

Insurance 467.4.
C.J.S. Insurance §§ 893, 896.

§ 38-377. Hospital and medical service corporations. Residual market mechanism. Insurance commissioner's powers concerning such mechanisms

(a) Hospital and medical service corporations may elect to meet the obligations of section 38-372 by participating in the Health Reinsurance Association established in section 38-376, as a full member thereof, or by making comprehensive health care plans available directly through a subscriber contract or combination of contracts or by forming a separate residual market mechanism substantially similar to the association established in section 38-376.

(b) In the event that hospital and medical service corporations choose to form a separate residual market mechanism, the commissioner shall have the same regulatory powers over that residual market mechanism as he has over the Health Reinsurance Association, and such residual market mechanism shall have the same powers and duties as the association. Rating classifications under a residual market mechanism established under this section need not be the same as classifications established under the association, but any rates established by the residual market mechanism shall be approved by the commissioner. The commissioner shall promulgate regulations to carry out the requirements of this section.

(c) If the hospital and medical service corporations do not elect to participate in the Health Reinsurance Association, such hospital and medical service corporations shall be required to make an individual comprehensive health care plan available to every resident of this state who is not eligible for Medicare and whose coverage under a group or individual contract issued by such hospital or medical service corporation has terminated. Such coverage may be made available through a separate residual market mechanism established under this section.

(1975, P.A. 75-616, § 7, eff. April 1, 1976; 1976, P.A. 76-435, § 23, eff. June 9, 1976.)

1976 Amendment

Subsection (c): 1976, P.A. 76-495, § 29, substituted, in the first sentence, "or

individual" for "on" following "whose coverage under a group".

§ 38-378. Insurance commissioner's powers concerning comprehensive health care plans. Notification to purchasers of policy or contract terms

In order to provide reasonable simplification of terms and coverages of individual accident and sickness insurance policies and contracts, to facilitate public understanding and comparison, to eliminate provisions which may be misleading or unreasonably confusing in connection with either the purchase of such coverage or with the settlement of claims and to provide for full disclosure in the sale of such coverage:

(a) The commissioner shall issue regulations to establish specific standards for policy provisions used in individual health insurance policies or contracts, but not including group conversion policies or contracts, which shall be in addition to and in accordance with chapter 681 and other applicable laws of this state which may cover the terms of renewability, initial and subsequent conditions of eligibility, non-application of coverage provisions, coverage of dependents, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacements, recurrent conditions, pre-existing conditions, and the definition of the terms hospital, accident, sickness, injury, physician, accidental means, total disability, permanent disability, partial disability, nervous disorders, guaranteed renewable, and noncancellable.

(b) The commissioner shall adopt regulations, in accordance with chapter 54, that specify prohibited policy provisions not otherwise specifically authorized by statute which in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, any person insured under the policy, or any beneficiary.

(c) The commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits under each of the following categories of coverage in individual policies, other than conversion policies issued pursuant to a commercial conversion privilege under a group policy: basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage and specified accident coverage. Specified disease policies, riders and benefits shall be prohibited whether issued on a group or individual basis.

(d) Nothing in this section shall preclude the issuance of any policy which combines two or more of the categories of coverage enumerated in subsection (c), except that specified accident coverage shall not be combined with any other category of coverage. The commissioner shall prescribe the method of identification of policies based upon coverage provided.

(e) No policy shall be delivered or issued for delivery in this state which does not meet the prescribed minimum standards for the categories of coverage listed in subsection (c), provided nothing in this section shall preclude the issuance or delivery of any policy which does not meet such prescribed minimum standards of coverage so long as such policy is clearly identified as not meeting such prescribed standards.

(f) No such policy or contract shall be delivered in this state unless: (1) An outline of coverage described herein accompanies the policy or (2) the outline of coverage described in this section is delivered to the applicant at the time application is made and acknowledgement of receipt of certificate of delivery of such outline is provided the carrier with the application. In the event the policy or contract is issued on a basis other than that applied for, the outline of coverage properly describing the policy shall accompany the policy when it is delivered. The outline of coverage shall include:

(A) A statement identifying the applicable category or categories of coverage provided by the policy in accordance with this section; (B) a description of the principal benefits and coverage provided in the policy; (C) a statement of the exceptions, reductions and limitations contained in the policy or contract; (D) a statement of the renewal provisions including any reservation by the carrier of a right to change premiums; and (E) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(g) Notwithstanding the provisions of chapter 681, if a carrier elects to use a simplified application form, with or without any questions as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy shall cover loss developing after twelve months from any pre-existing condition not specifically excluded from coverage by the terms of the policy and, except as so provided, the policy shall not include wording that would permit a defense based upon pre-existing conditions.

(h) Regulations promulgated pursuant to this section shall specify an effective date applicable to policy and benefit riders delivered or issued for delivery in this state on and after such effective date which shall not be less than one hundred eighty days after the date of adoption or promulgation. (1975, P.A. 75-616, § 8, eff. April 1, 1976; 1976, P.A. 76-309, § 4, eff. June 9, 1976.)

1976 Amendment

Subsection (c): 1976, P.A. 76-399, § 4, amended the second sentence by inserting "riders and benefits" following

"Specified disease policies", and by adding "whether issued on a group or individual basis" at the end.

§ 38-379. Application to new or renewed group health policies and contracts. Other regulations

(a) In order to assure reasonable continuation of coverage and extension of benefits to the citizens of this state, all group health policies or contracts delivered or issued for delivery or renewal in this state on or after April 1, 1976 shall, subject to the provisions of subsection (e), contain those provisions described in subsections (b) and (d) of section 38-374.

(b) The commissioner shall, within one hundred eighty days after April 1, 1976, adopt regulations in accordance with the provisions of chapter 54, covering group coverage discontinuance and replacement.

(c) Nothing in this section shall alter or impair existing group policies or contracts which have been established pursuant to an agreement which resulted from collective bargaining, and the provisions required by this section shall become effective upon the next regular renewal and completion of such collective bargaining agreement. (1975, P.A. 75-616, § 9, eff. April 1, 1976.)

§ 38-380. Commission on hospitals and health care

In addition to the powers and duties already granted to it by law, the commission on hospitals and health care shall, within one year of April 1, 1976, adopt regulations designed to allow state professional standard review organizations established under U.S. Public Law 92-603 to extend their review of certain inpatient services to services received by all patients. Such regulations shall be adopted in accordance with the provisions of chapter 54. (1975, P.A. 75-616, § 10, eff. April 1, 1976; 1977, P.A. 77-118.)

Section 4-166 of reg.

1977 Amendment

1977, P.A. 77-118 substituted "allow" for "require" following "adopt regulations designed to", and substituted the

reference to U.S. Public Law "92-603" for "92-403".

§ 38-381. Commissioner of income maintenance. Contract authority concerning medicaid programs

The commissioner of income maintenance may enter into contractual agreements with any carrier or with the Health Reinsurance Association or a residual market mechanism to obtain appropriate administrative services, insurance benefits or any other insurance related services in connection with the state's medicaid program. All terms and provisions of any such contracts shall be mutually acceptable to the parties involved.

(1975, P.A. 75-616, § 11, eff. April 1, 1976; 1977, P.A. 77-614, §§ 521, 608, eff. Jan. 1, 1979; 1977, P.A. 77-614, § 587, eff. June 2, 1977; 1978, P.A. 78-303, § 85, eff. June 6, 1978.)

1977 Amendments

1977, P.A. 77-614, § 608, eff. Jan. 1, 1979, provided for change of term from "welfare commissioner" to "commissioner of income maintenance".

1977, P.A. 77-614, § 587, eff. June 2, 1977, as amended by 1978, P.A. 78-303, §

85, eff. June 6, 1978, authorized technical, grammatical, and punctuation changes with reference to 1977, P.A. 77-614 and the public acts of 1977 and 1978. For text of these provisions, see notes under § 2-56.

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CONSULT GENERAL INDEX POCKET PART

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