

90 MISSISSAUGA STATE HEALTH INSURANCE (FILE NO. 4)

795

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

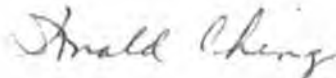
TWO

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
GOVERNOR



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March 24, 1980

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Very truly yours,



Donald D. H. Ching
Deputy Director

cc: ✓ Ms. Jan Sorice

**HEALTH CARE
FINANCING OPTIONS
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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

February 20, 1980 - 11:00 a.m.
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 subds 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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[62E.035] SELF insurance shall require relating to the commissioner, the comm of self ins necessary to identify self in section the comm

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62E.06 MINIMUM NUMBER THREE PLAN and plan if it otherwise other laws of the exceeds the follow

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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, ~~and~~ 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 ~~covered 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~~

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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 shall not include the following:

- (1) Any charges for the course of employment which benefits are contained in a self-insurance, or health insurance, provided by law;
- (2) Any charges for the repair of an injury or damage;
- (3) Care which does not qualify as eligible services under medicare;
- (4) Any charges for a physician's charge prescribed as medical services not have semi-private room considered to be 90 percent;
- (5) That part of a physician, dentist, or other health care provider's fee for the locality where the services are rendered;
- (6) Any charges for services rendered in an unauthorized practice;
- (7) Effective July 1, 1979, in addition to those services subject to apportionment weight limitations:
- (1) Well baby care;
- (2) Physicians' services rendered by a physician, effective July 1, 1979;
- (3) Multiphasic health checkups as prescribed by the commissioner by rule in accordance with the fees listed in this chapter;
- (4) Effective July 1, 1979, in addition to those benefits provided for medical procedures except for hospital fees provided for in this chapter.

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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
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Subd. 2. the association subject to approval initially organized time and place organizational person or proxy insurance, accident maintenance calendar not selected with may appoint the commissioner shall represented. M association for compensated by association and

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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 substar considered a stan

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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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who is eligible for or receiving medical assistance pursuant to chapter 256B.

[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 covered 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.148, 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.04 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]

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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 § 4.
C.J.S. Physicians and Surgeons § 12.

CHAPTER 62E. HEALTH CARE [NEW]

COMPREHENSIVE HEALTH INSURANCE

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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, 62E.02, 62E.03, 62E.035, 62E.04, 62E.05, 62E.06, 62E.07, 62E.08, 62E.09, 62E.10, 62E.11, 62E.12, 62E.13, 62E.14, 62E.15, 62E.16, 62E.17, 62E.51, 62E.52, 62E.53, 62E.531, 62E.54, 62E.55.

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 § 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 chapter, the definitions in this subdivision apply.

Subd. 2. "Employer" means an individual, estate or corporation, instrumentality or government agency or more individuals who are jointly or severally liable for the payment of health insurance.

Subd. 3. "Health maintenance organization" means an organization licensed and operated as a health maintenance organization.

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 person under the age of 19 years, a dependent child of a person who is financially dependent upon the person and is disabled.

Subd. 8. "Employee" means a person who is employed by or works 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 for the payment of health insurance.

Subd. 11. "Accident and health insurance" means insurance or nonprofit health insurance which provides coverage for (1) limited to disability medical payment coverage, (2) solely to provide payments on a non-accrued basis, (3) credit for accrued benefits, (4) designated for accident and sickness insurance only coverage issued by the insurer which provides reasonable benefits. The provisions of clause (1) which is subject to the provisions of clause (2) shall not apply to the extent that the provisions of clause (2) are more restrictive.

Subd. 12. "Disability benefit" means a benefit payable on a non-accrued basis for surgical or hospital care.

Subd. 13. "Eligible person" means a person 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.