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STATE

HEALTH

INSURANCE

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

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

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

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

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

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

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

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

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

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

Revised subds. 11 and 21 which formerly read:

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

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

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

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

62E.03 Duties of the employer

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

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

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

62E.035 Self Insurer Identification

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

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

62E.04 Duties of Insurers

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

Subd. 2. Medicare supplement care supplement plans in this state shall require a medicare supplement plan a qualified medicare supplement care supplement plans in this state to each person who is eligible for medicare supplement plan.

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

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

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

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

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

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

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

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

62E.035 Self Insurer Identification and reporting

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

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

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

62E.04 Duties of Insurers

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

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

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

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

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

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

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

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

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

**1977 Amendment.** Revised Subd. 4 which formerly read:

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

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

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

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

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

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

**62E.05 Certification of qualified plans**

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

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

**62E.06 Minimum benefit**

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

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

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

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

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

(13) Services of a physical therapist;

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

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

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

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

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





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

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

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

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

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

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

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

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

"(1) Well baby care;

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

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

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

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

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

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

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

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

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

62E.07 Qualified medicare supplement plan

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

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

62E.08 State plan premium

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

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

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

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



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

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

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

62E.10 Comprehensive health association

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

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

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

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

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

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

Subd. 7. General powers. The association may:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Library References

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

62E.11 Operation of contract

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

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

Subd. 3. Not less than writing carrier shall be used shall be used for the payment of claims and direct expenses, as specified in section 62E.15, subdivision 3 and

Subd. 4. Any income from providing reinsurance or other services under clauses (e) and (f) shall be set losses due to claims expenses and plan premiums.

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

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

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

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

**62E.11 Operation of comprehensive plan**

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

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

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

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

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

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

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

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

## § 62E.11

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

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

1977 Amendment. Revised subd. 5 which formerly read:

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

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

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

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

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

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

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

### Law Review Commentaries

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

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

### Library References

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

## 62E.12 Minimum benefits of comprehensive health insurance plan

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

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

## 62E.13 Administration of plan

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

prehensive health insurance shall be prescribed by rule of

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

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

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

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

Subd. 6. All claims shall be provided of sections 62E.01 to 62E.17 paid by the state plan. Each claim the procedure to be followed of payment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Laws 1976, c. 338, art. 1, § 3, eff. July 1, 1976. Amended by Laws 1977, c. 109, § 18, 19, eff. June 3, 1977; Laws 1979, c. 272, § 9, eff. May 31, 1979.

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



**62E.15 Solicitation of eligible persons**

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

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

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

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

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

**62E.16 Conversion privileges**

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

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

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

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

**Library References**

Insurance § 178.3(4).

C.J.S. Insurance § 323 et seq.

## § 62E.17

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### 62E.17 Dual option

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

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

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

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

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

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

## CATASTROPHIC HEALTH EXPENSE PROTECTION

### 62E.51 Citation

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

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

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

### 62E.52 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 62E.53 Application for assistance

Subdivision 1. Any person who is eligible for assistance may submit an application to the commissioner. The application shall be filed within 90 days of the date of the application month period for computing the household income.

Subd. 2. If the commissioner determines that a person is eligible for assistance, he shall pay:

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

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

(b) \$2,500; whichever is greater for the person or his dependent.

(2) all qualified nursing home expenses in excess of \$2,500; however, that the payment is made until the end of the fiscal year.

Subd. 3. If the commissioner determines that a person is eligible for assistance, the commissioner shall pay for the reasonable charges for health services provided to an eligible person in proportion to the reasonable charges for that service provided to an eligible person.

Subd. 4. The commissioner shall not be liable for the payment of any qualified expenses for health services provided to an eligible person under the provisions of chapter 62E.

Subd. 5. The commissioner shall not be liable for the payment of any qualified expenses for health services provided to an eligible person under the provisions of chapter 62E.

Subd. 6. The commissioner shall not be liable for the payment of any qualified expenses for health services provided to an eligible person under the provisions of chapter 62E.

Subd. 7. The commissioner shall not be liable for the payment of any qualified expenses for health services provided to an eligible person under the provisions of chapter 62E.

Subd. 8. The commissioner shall not be liable for the payment of any qualified expenses for health services provided to an eligible person under the provisions of chapter 62E.

Subd. 9. The commissioner shall not be liable for the payment of any qualified expenses for health services provided to an eligible person under the provisions of chapter 62E.

Subd. 10. The commissioner shall not be liable for the payment of any qualified expenses for health services provided to an eligible person under the provisions of chapter 62E.

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

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

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

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

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

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

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

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

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

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

#### 62E.53 Application for assistance

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

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

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

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

(b) \$2,500;

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

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

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

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as to whether or not a charge is excessive and in making any determination as to whether or not a service was medically necessary. If the commissioner in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

Laws 1976, c. 296, art. 3, § 3, eff. July 1, 1977. Amended by Laws 1977, c. 409, § 21, eff. June 3, 1977; Laws 1977, c. 448, § 4.

1977 Amendments. Laws 1977, c. 409 revised subd. 2 which now appears as subds. 2 and 3. Subd. 2 formerly read: "If the commissioner determines that an applicant is an eligible person, he shall pay 90 percent of all qualified expenses of the eligible person and his dependents in excess of:

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

(b) \$2,500; whichever is greater for the 12 month period in which the applicant becomes an eligible person. If the commissioner determines that the charge for a health service is excessive, he may limit his payment to the usual and customary charge for that service. If the commissioner determines that a health service provided to an eligible person was not

medically necessary, he may refuse to pay for the service. To the extent feasible, the commissioner shall contract with a review organization as defined in Minnesota Statutes, Section 145.61, in making any determinations as to whether or not a charge is excessive. To the extent feasible, the commissioner shall contract with a review organization as defined in Minnesota Statutes, Section 145.61, in making any determination as to whether or not a service was medically necessary. If the commissioner in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed."

Laws 1977, c. 448, added subd. 2(2).

62E.531 Third party liability

Subdivision 1. When the commissioner pays for or becomes liable for payments for health services under the provisions of sections 62E.51 to 62E.55, the department of public welfare shall have a lien for payments and liabilities for the services upon any and all causes of action which accrue to the person to whom the services were furnished, or to his legal representatives, as a result of injuries which directly or indirectly led to the incurring of qualified expenses.

The department may perfect and enforce its lien by following the procedures set forth in sections 514.69, 514.70, and 514.71, except that it shall have one year from the date when the last item of health service was furnished in which to file its verified lien statement. The statement shall be filed with the appropriate clerk of court in the county in which the recipient of the services resides or in the county in which the action was filed.

Subd. 2. Where a third party may be liable in whole or in part for payment for health services, the commissioner may consider the charges for the health services to be qualified expenses if the eligible person assigns any rights accruing by virtue of any third party liability to the commissioner to the extent necessary to reimburse the state for any payments made under the provisions of this section.

Subd. 3. Upon furnishing assistance under the provisions of sections 62E.51 to 62E.55, the department of public welfare shall be subrogated, to the extent of its payments for health services, to any rights the eligible person or his dependent may have under the terms of any plan of health coverage as the result of an accident, illness, or injury. The right of subrogation shall not be exercised until the expiration of the period of waiting time established in the plan of health coverage.

The attorney general, or the appropriate county attorney, acting upon direction from the attorney general, may institute or join a civil action against the issuer of the plan of health coverage to recover under this subdivision.

Added by Laws 1977, c. 409, § 22, eff. June 3, 1977.

Library References

Insurance Code § 1406 et seq.

62E.54 Duties of commissioner

Subdivision 1. The commissioner shall:

(a) Promulgate rules under sections 62E.51 to 62E.55.

(b) Establish application forms to be declared an official form.

(c) Investigate applications of qualified person and in determining whether or not the person is qualified.

Subd. 2. The commissioner shall:

(a) Enter into contracts with any person or organization established by section 62E.51 to 62E.55 to provide or pay for the delivery of health services.

(b) Enter into contracts with any person or organization to perform the duties imposed on the commissioner by sections 62E.51 to 62E.55.

Laws 1976, c. 296, art. 3, § 23, eff. June 3, 1977.

1977 Amendment. Added "emergency rules" to subd. 1.

62E.55 Appeals

The final decision of the commissioner on an appeal by an eligible person or dependent may be appealed by any interested person. Laws 1976, c. 296, art. 3, § 24.

CHAPTER 62F.

- Sec. 62F.01 Citation; expiration
62F.02 Joint underwriting
62F.03 Definitions
62F.04 Authorization to issue
62F.05 Plan of operation
62F.06 Policy forms and rates
62F.07 Participation.

62F.01 Citation; expiration

Subdivision 1. Sections 62F.01 to 62F.07

Joint Underwriting Association

Subd. 2. Sections 62F.01 to 62F.07

Laws 1976, c. 242, § 2, eff. March 24, 1978.

1978 Amendment. Laws 1978, c. 1, added subd. 2 to this section.

The expiration date of Sept. 1, 1978, is hereby extended to Sept. 1, 1979.

Laws 1978, c. 571, § 2, repealed this section.

Law Review Commentaries

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62E.54 Duties of commissioner

Subdivision 1. The commissioner shall:

- (a) Promulgate reasonable rules, including emergency rules, to implement sections 62E.51 to 62E.55.
- (b) Establish application forms and procedures for the use of persons seeking to be declared an eligible person; and
- (c) Investigate applications to determine whether or not the applicant is a qualified person and investigate claims from providers of health services to determine whether or not to pay them.

Subd. 2. The commissioner may:

(a) Enter into contracts with the United States or any state agency, instrumentality or political subdivision for the purpose of coordinating the program established by sections 62E.51 to 62E.55, with other programs which provide or pay for the delivery of health services;

(b) Enter into contracts with third parties to perform some or all of the duties imposed on the commissioner by sections 62E.53 and 62E.54.

Laws 1976, c. 206, art. 3, § 4, eff. July 1, 1977. Amended by Laws 1977, c. 409, § 23, eff. June 3, 1977.

1977 Amendment. Added "including emergency rules" to subd. 1(a).

62E.55 Appeals

The final decision of the commissioner denying an application for status as an eligible person or denying all or part of the charges for a health service may be appealed by any interested party pursuant to chapter 15.

Laws 1976, c. 206, art. 3, § 5, eff. July 1, 1977.

CHAPTER 62F. MEDICAL PRACTICE INSURANCE [NEW]

Sec.		Sec.	
62F.01	Citation; expiration date.	62F.08	Procedures.
62F.02	Joint underwriting association.	62F.09	Stabilization reserve fund.
62F.03	Definitions.	62F.10	Investigation.
62F.04	Authorization to issue insurance.	62F.11	Privileged communications.
62F.05	Plan of operation.	62F.12	Appeals; judicial review.
62F.06	Policy forms and rates.	62F.13	Public officers or employees.
62F.07	Participation.	62F.14	Annual statements.

62F.01 Citation; expiration date

Subdivision 1. Sections 62F.01 to 62F.14 may be cited as the "Temporary Joint Underwriting Association Act."

Subd. 2. Sections 62F.01 to 62F.14 expire September 1, 1980.

Laws 1976, c. 242, § 2, eff. April 14, 1976. Amended by Laws 1978, c. 571, § 1, eff. March 24, 1978.

1978 Amendment. Laws 1978, c. 571, § 1, added subd. 2 to this section fixing the expiration date of Sept. 1, 1980. Laws 1976, c. 242, § 16, which had provided an expiration date for sections 62F.01 to 62F.14 of two years after its effective date (including date was April 14, 1978).

Law Review Commentaries  
 Release of joint underwriting: Merrin-  
 get release in Minnesota. John E. Si-  
 monett. 1977, 3 Wm. Mitchell L.Rev. 1.

62F.02 Joint underwriting association

Subdivision 1. **Creation.** There is created a temporary joint underwriting association to provide medical malpractice insurance coverage to any licensed health care provider unable to obtain this insurance through ordinary methods. Every insurer authorized to write and writing personal injury liability insurance in this state shall be a member of the association as a condition to obtaining and retaining a license to write insurance in this state.

Subd. 2. **Directors.** The association shall have a board of directors composed of 11 persons chosen annually as follows: five persons elected by members of the association at a meeting called by the commissioners; three mem-



tion project entered into under ORS 411.135 special rates may be established.

(2) No premium or other periodic charge on any policy of insurance, health care service contract, or medical or hospital service contract shall be paid from available medical assistance funds unless the insurer or contractor issuing such policy or contract is by law authorized to transact business as an insurance company, health care service contractor or hospital association in this state. [1967 c.502 §10; 1975 c.509 §6]

**414.135 Contracts with direct providers of care and services.** The Adult and Family Services Division may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and remedial care and services available under medical assistance in consideration of services rendered and supplies furnished by them in accordance with the provisions of this chapter. Payment shall be made according to the rules of the division pursuant to the number of days and the fees, charges and costs established under ORS 414.065. The contractor must guarantee the division by written acknowledgment:

(1) To make all payments under this chapter promptly but not later than 30 days after receipt of the proper evidence establishing the validity of the provider's claim.

(2) To provide such data, records and reports to the division as may be required by the division. [1967 c.502 §11]

**414.145 Implementation of ORS 414.115 to 414.135.** The provisions of ORS 414.115, 414.125 or 414.135 shall be implemented whenever it appears to the Executive Department that such implementation will provide comparable benefits at equal or less cost than provision thereof by direct payments by the Adult and Family Services Division to the providers of medical assistance. [1967 c.502 §11a; 1975 c.401 §3]

**MEDICAL ADVISORY COMMITTEE**

**414.205 Medical advisory committee.** (1) A medical advisory committee is established, consisting of not more than 15 members to be appointed by the Governor from among persons in the health professions,

providers of medical and remedial care and services and the general public. In making his appointment, the Governor shall consult with appropriate professional and other interested organizations.

(2) Members shall serve at the pleasure of the Governor.

(3) Members of the advisory committee shall receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the Public Welfare Account. [1967 c.502 §18]

414.210 [1957 c.692 §1; repealed by 1963 c.631 §2]

**414.215 Duties of committee.** The medical advisory committee shall advise the Adult and Family Services Division on:

(1) Health and medical care and services to be provided pursuant to this chapter.

(2) Matters referred to it for study by the division. [1967 c.502 §19]

414.220 [1957 c.692 §2; repealed by 1963 c.631 §2]

**414.225 Division to consult with and assist committee.** (1) The Adult and Family Services Division shall consult with the medical advisory committee concerning the determinations required under ORS 414.055.

(2) The division shall provide secretarial services to the medical advisory committee. [1967 c.502 §20]

414.230 [1957 c.692 §5; repealed by 1963 c.631 §2]

414.240 [1957 c.692 §3; repealed by 1963 c.631 §2]

414.250 [1957 c.692 §4; repealed by 1963 c.631 §2]

414.260 [1957 c.692 §6; repealed by 1963 c.631 §2]

414.270 [1957 c.692 §7(1); repealed by 1963 c.631 §2]

414.280 [1957 c.692 §7(2); repealed by 1963 c.631 §2]

414.290 [1957 c.692 §7(3); repealed by 1963 c.631 §2]

414.300 [1957 c.692 §8; repealed by 1963 c.631 §2]

**MISCELLANEOUS**

**414.305 Payment of cost of medical care for institutionalized persons.** (1) The Adult and Family Services Division is hereby authorized to pay the cost of care for patients within Mental Health Division institutions under the medical assistance program established by this chapter.

(2) All moneys received by the Mental Health Division from the Adult and Family

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242 spouse and such children whose coverage under the policy terminates at the  
243 same time, or (iii) to a child solely with respect to himself upon termination  
244 of his coverage by reason of ceasing to be a qualified family member under  
245 the group policy, if a conversion privilege is not otherwise provided above  
246 with respect to such termination.

247 (17) If the benefit levels required in paragraphs (10) and (11) exceed the  
248 benefit levels provided under the group policy, the conversion policy may  
249 offer benefits which are substantially similar to those provided under the  
250 group policy in lieu of those required in paragraphs (10) and (11).

251 (18) The insurer may elect to provide group insurance coverage in lieu  
252 of the issuance of a converted individual policy.

253 (19) A notification of the conversion privilege shall be included in each  
254 certificate of coverage.

255 (20) A converted policy which is delivered outside [state] must be on a  
256 form which could be delivered in such other jurisdiction as a converted  
257 policy had the group policy been issued in that jurisdiction.

1 Section 3. [*Severability.*] [Insert severability clause.]

1 Section 4. [*Repeal.*] [Insert repealer clause.]

1 Section 5. [*Effective Date.*] [Insert effective date.]

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1980 SUGGESTED LEGISLATION  
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## Comprehensive Health Insurance Act

This draft statute requires that employers in the state must include qualified catastrophic health insurance protection and minimum types of benefits for routine care in any policy provided to their employees pursuant to the individual's employment. This includes policies which are paid for partly or fully by the employee as well as those which are completely employer-paid. If only nonqualified plans are offered to employees, the employer may not deduct for tax purposes the cost of the insurance to him. In order to qualify, a plan must meet specified benefit levels and have no more than a maximum allowable deductible. This draft act also includes as Sections 18 and 19 a state catastrophic medical insurance plan under which the state will pay the medical expenses of those persons who incur uninsured medical expenses exceeding specified portions of their income.

This medical insurance plan is implemented by requiring in the statute that all insurers writing health insurance in the state must offer a qualified plan to their customers. A compulsory association of all insurers in the state is also to be formed under the act for the purpose of offering a qualified plan of insurance to those individuals whom the insurers have individually refused to insure. For those individuals who may be leaving employment at which they were enrolled in a qualified plan, the act provides mandatory conversion privileges enabling the individual to continue his insurance.

As the above indicates, this draft act is broad in scope and is directed toward multiple purposes. Among the related but separate purposes of the legislation are ensuring minimum standards for group health plans, creating an association of insurers as a resort for those individuals who could not otherwise obtain effective coverage, and providing catastrophic medical expense protection for all through employers and private insurers where possible and through the state welfare system where necessary.

This draft legislation is based on a 1976 Minnesota statute.

### Suggested Legislation

(Title, enacting clause, etc.)

1 Section 1. [*Short Title.*] This act may be cited as the [state] Comprehen-  
2 sive Health Insurance Act.

1 Section 2. [*Definitions.*] As used in this act:

2 (1) "Employer" means any person, partnership, association, trust,  
3 estate, or corporation, which employs 10 or more individuals who are  
4 residents of this state.

- 5 (2) "Health maintenance organization" means a nonprofit corporation  
6 licensed and operated as provided in [appropriate state statute].
- 7 (3) "Qualified plan" means those health benefit plans which have been  
8 certified by the commissioner as providing the minimum benefits required  
9 by Section 6 of this act or the actuarial equivalent of those benefits.
- 10 (4) "Qualified Medicare supplement plan" means those health benefit  
11 plans which have been certified by the commissioner as providing the  
12 minimum benefits required by Section 7 of this act or the actuarial  
13 equivalent of those benefits.
- 14 (5) "Commissioner" means the [commissioner of insurance].
- 15 (6) "Dependent" means a spouse or unmarried child under the age of  
16 19 years, a dependent child who is a student under the age of 25 and finan-  
17 cially dependent upon the parent, or a dependent child of any age who is  
18 disabled. *or a household member who is financially dependent*
- 19 (7) "Employee" means any [state] resident who has entered into the  
20 employment of or works under contract or service or apprenticeship with  
21 any employer. "Employee" does not include a person who has been  
22 employed for less than [30] days by his present employer, nor one who is  
23 employed less than an average of [30] hours per week by his present  
24 employer.
- 25 (8) "Plan of health coverage" means any plan or combination of plans  
26 of coverage, including combinations of self-insurance, individual accident  
27 and health insurance policies, group accident and health insurance policies,  
28 coverage under a nonprofit health service plan, or coverage under a health  
29 maintenance organization subscriber contract.
- 30 (9) "Insurer" means those companies operating pursuant to [ap-  
31 propriate state statute] and offering or selling policies or contracts of acci-  
32 dent and health insurance. "Insurer" does not include health maintenance  
33 organizations.
- 34 (10) "Accident and health insurance policy" or "policy" means in-  
35 surance or nonprofit health service plan contracts providing benefits for  
36 hospital, surgical, and medical care. "Policy" does not include coverage  
37 which is (i) limited to disability or income protection coverage, (ii)  
38 automobile medical payment coverage, (iii) supplemental to liability in-  
39 surance, (iv) sold by fraternal and provides payments on a per diem, daily  
40 indemnity or nonexpense-incurred basis, or (v) credit accident and health  
41 insurance issued pursuant to [appropriate state statute].
- 42 (11) "Health benefits" means benefits offered to employees on an in-  
43 demnity or prepaid basis which pay the costs of or provide medical,  
44 surgical, or hospital care.
- 45 (12) "Eligible person" means an individual who is a resident of [state]  
46 and meets the enrollment requirements of Section 14 of this act. For pur-  
47 poses of Sections 18, 19, and 20 only, "eligible person" means any person  
48 who while a resident of [state] has been found by the [commissioner of  
49 public welfare] to have incurred an obligation to pay qualified expenses for

- 50 himself and any dependents in any [12] consecutive months exceeding: (i)  
51 [40] percent of his household income up to \$[15,000], plus [50] percent of  
52 his household income between \$[15,000 and \$25,000], plus [60] percent of  
53 his household income in excess of \$[25,000], or (ii) \$[2,500], whichever is  
54 greater.
- 55 (13) "Comprehensive health association" or "association" means the  
56 association created by Section 10 of this act.
- 57 (14) "Medicare" means Part A and Part B of the United States Social  
58 Security Act, Title XVIII, as amended, 42 U.S.C. Sections 1394, et seq.
- 59 (15) "Medicare supplement plan" means any plan of insurance protec-  
60 tion which provides benefits for the costs of medical, surgical, or hospital  
61 care and which is marketed as providing benefits which complement or sup-  
62 plement the benefits provided by Medicare.
- 63 (16) "State plan premium" means the premium determined pursuant  
64 to Section 8 of this act.
- 65 (17) "Writing carrier" means the insurer or insurers and health  
66 maintenance organization or organizations selected by the association and  
67 approved by the commissioner to administer the comprehensive health in-  
68 surance plan.
- 69 (18) "Fraternal beneficiary association" or "fraternal" means a cor-  
70 poration, society, order, or voluntary association without capital stock  
71 which sells health and accident insurance in accordance with [appropriate  
72 state statute].
- 73 (19) "Comprehensive health insurance plan" or "state plan" means  
74 policies of insurance and contracts of health maintenance organization  
75 coverage offered by the association through the writing carrier.
- 76 (20) "Self-insurer" means an employer who directly provides a plan of  
77 health coverage to his employees and administers the plan of health  
78 coverage himself or through an insurer. "Self-insurer" does not include an  
79 employer engaged in the business of providing health care services to the  
80 public who provides health care services directly to his employees at no  
81 charge to them.
- 82 (21) "Self-insurance" means a plan of health coverage offered by a  
83 self-insurer.
- 84 (22) "Qualified expense" means any charge incurred subsequent to [in-  
85 sert date] for a health service which is included in the list of covered services  
86 described in Section 6(a), and for which no third party is liable.
- 87 (23) "Household income" means the gross income of an eligible person  
88 and all his dependents for the calendar year preceding the year in which an  
89 application is filed pursuant to Section 18.
- 90 (24) "Gross income" means income as defined in [appropriate state tax  
91 statute].
- 92 (25) "Third party" means any person other than the eligible person or  
93 his dependents.

2 (a) Each employer who provides or makes available to his employees a  
3 plan of health coverage shall make available to his employees employed in  
4 this state a plan or combination of plans which have been certified by the  
5 commissioner as a number two qualified plan. If the plan of health coverage  
6 does not meet the requirements of Section 6 for a number two qualified  
7 plan, the employer shall make available a supplemental plan of health  
8 benefits which, when combined with the existing plan of health benefits,  
9 constitutes a number two coverage plan. The plan or combinations of plans  
10 may be financed from funds contributed solely by the employer or solely by  
11 the employees or any combination thereof. The plans may consist of self-  
12 insurance, health maintenance contracts, group policies, or individual  
13 policies or any combination thereof.  
14 (b) In the event that an employer fails to make available at least a number  
15 two qualified plan of health benefits to his employees employed in this  
16 state, none of the employer's costs for health benefits shall qualify as an in-  
17 come tax deduction pursuant to [appropriate state tax statute]. In the case  
18 of an employer who meets the requirements of [state statute defining tax ex-  
19 empt organizations], if the employer fails to make available at least a  
20 number two qualified plan to his employees, the employer shall lose his  
21 status as an exempt organization.

1 Section 4. [Duties of Insurers.]

2 (a) For each type of qualified plan described in Section 6, an insurer or  
3 fraternal issuing individual policies of accident and health insurance in this  
4 state, other than group conversion policies, shall develop and file with the  
5 commissioner an individual policy which meets the minimum standards of  
6 that type of qualified plan. An insurer or fraternal issuing individual  
7 policies of accident and health insurance in this state shall offer each type of  
8 qualified plan to each person who applies and is eligible for accident and  
9 health insurance from that insurer or fraternal.

10 (b) An insurer or fraternal issuing Medicare supplement plans in this state  
11 shall develop and file with the commissioner a Medicare supplement policy  
12 which meets the minimum standards of a qualified Medicare supplement  
13 plan. An insurer or fraternal issuing Medicare supplement plans in this state  
14 shall offer a qualified Medicare supplement plan to each person who is eligi-  
15 ble for coverage and who applies for a Medicare supplement plan.

16 (c) For each type of qualified plan described in Section 6, an insurer or  
17 fraternal issuing group policies of accident and health insurance in this state  
18 shall develop and file with the commissioner a group policy which provides  
19 for each member of the group the minimum benefits required by that type  
20 of qualified plan. An insurer or fraternal issuing group policies of accident  
21 and health insurance in this state shall offer each type of qualified plan to  
22 each eligible applicant for group accident and health insurance.

23 (d) Each insurer and fraternal shall include coverage of major medical  
24 costs in every unqualified policy of accident and health insurance, unless the

25 applicant for a new or renewal policy declines the coverage in writing. The  
26 coverage shall provide that when a covered individual incurs out-of-pocket  
27 expenses of \$[5,000] or more within a calendar year for services covered in  
28 Section 6(a), benefits shall be payable, subject to any copayment authorized  
29 by the commissioner, up to a maximum lifetime limit of \$[250,000].

30 (e) No policy of accident and health insurance may be issued or renewed  
31 in this state [180] days after [insert date] by an insurer or a fraternal which  
32 has not complied with the requirements of this section.

33 (f) An insurer or fraternal may fulfill its obligations under this section by  
34 issuing the required coverages in their own name and reinsuring the risk and  
35 administration of the coverages with the association in accordance with  
36 paragraphs (5) and (6) of Section 10(g).

37 (g) Nothing in this section shall require an insurer or fraternal to offer or  
38 issue a policy to any person who does not meet the underwriting or member-  
39 ship requirements of the insurer or fraternal.

1 Section 5. [Certification of Qualified Plans.] Upon application by an in-  
2 surer, fraternal, or employer for certification of a plan of health coverage as  
3 a qualified plan or a qualified Medicare supplement plan for the purposes  
4 of Sections 1 to 17, the commissioner shall make a determination within  
5 [90] days as to whether the plan is qualified. All plans of health coverage  
6 shall be labeled as "qualified" or "nonqualified" on the front of the policy  
7 or evidence of insurance. All qualified plans shall indicate whether they are  
8 number one, two, or three coverage plans.

1 Section 6. [Minimum Benefits of Qualified Plan.]

2 (a) A plan of health coverage shall be certified as a number three qualified  
3 plan if it otherwise meets the requirements established by [appropriate state  
4 statute] and the other laws of this state and whether or not the policy is  
5 issued in this state and meets or exceeds the following minimum standards:

6 (1) The minimum benefits for a covered individual shall, subject to the  
7 other provisions of this subsection, be equal to at least [80] percent of the  
8 cost of covered services in excess of an annual deductible which does not ex-  
9 ceed \$[150] per person. The coverage shall include a limitation of \$[3,000]  
10 per person on total annual out-of-pocket expenses for services covered  
11 under this subsection. The coverage may be subject to a maximum lifetime  
12 benefit of not less than \$[250,000]. Covered expenses shall be the usual and  
13 customary charges for the following services and articles when prescribed  
14 by a physician:

15 (i) Hospital services.

16 (ii) Professional services for the diagnosis or treatment of injuries,  
17 illnesses, or conditions, other than outpatient mental or dental, which are  
18 rendered by a physician or at his direction.

19 (iii) Drugs requiring a physician's prescription.

20 (iv) Services of a nursing home for not more than [120] days in a year  
21 if the services commence within [14] days following confinement of at least

- 22 [three] days in a hospital for the same condition.  
 23 (v) Service of a home health agency up to a maximum of [180] visits  
 24 per year.  
 25 (vi) Use of radium or other radioactive materials.  
 26 (vii) Oxygen.  
 27 (viii) Anesthetics.  
 28 (ix) Prostheses.  
 29 (x) Rent, or purchase, as appropriate, of durable medical equip-  
 30 ment.  
 31 (xi) Diagnostic X-rays and laboratory tests.  
 32 (xii) Oral surgery for partially or completely unerupted impacted  
 33 teeth, a tooth root without the extraction of the entire tooth, or the gums  
 34 and tissues of the mouth when not performed in connection with the extrac-  
 35 tion or repair of teeth.  
 36 (xiii) Services of a physical therapist.  
 37 (2) Covered expenses for the services and articles specified in this  
 38 subsection do not include the following:  
 39 (i) Any charge for any care for any injury or disease either arising out  
 40 of an injury in the course of employment and subject to a worker's compen-  
 41 sation or similar law, for which benefits are payable without regard to fault  
 42 under coverage statutorily required to be contained in any motor vehicle or  
 43 other liability insurance policy or equivalent self-insurance, or for which  
 44 benefits are payable under another policy of accident and health insurance  
 45 or Medicare.  
 46 (ii) Any charge for treatment for cosmetic purposes other than  
 47 surgery for the repair of an injury or birth defect.  
 48 (iii) Any charge for travel other than travel by ambulance to the  
 49 nearest health care institution qualified to treat the illness or injury.  
 50 (iv) Any charge for confinement in a private room to the extent it is  
 51 in excess of the institution's charge for its most common semi-private room,  
 52 unless a private room is prescribed as medically necessary by a physician.  
 53 (v) That part of any charge for services or articles rendered or  
 54 prescribed by a physician, dentist, or other health care personnel which ex-  
 55 ceeds the prevailing charge in the locality where the service is provided.  
 56 (vi) Any charge for services or articles the provision of which is not  
 57 within the scope of authorized practice of the institution or individual  
 58 rendering the services or articles.  
 59 (3) Effective [insert date], the minimum benefits for a qualified plan  
 60 shall include, in addition to those benefits specified in subsection (a)(1),  
 61 benefits for the following services subject to applicable deductibles, coin-  
 62 surance provisions, and maximum lifetime benefit limitations:  
 63 (i) Well baby care.  
 64 (ii) Physicians' services for routine checkups and annual physicals  
 65 when prescribed by a physician.  
 66 (iii) Multiphasic screening and other diagnostic testing. The commis-

- 67 sioner by rule shall prescribe reasonable limits on the reimbursement re-  
 68 quired for these services.  
 69 (b) A plan of health coverage shall be certified as a number two qualified  
 70 plan if it meets the requirements established by the laws of this state and  
 71 provides for payment of [80] percent of the covered expenses required by  
 72 this section in excess of a deductible which does not exceed \$[500] per per-  
 73 son.  
 74 (c) A plan of health coverage shall be certified as a number one qualified  
 75 plan if it meets the requirements established by the laws of this state and  
 76 provides for payment of [80] percent of the covered expenses required by  
 77 this section in excess of a deductible which does not exceed \$[1,000] per per-  
 78 son.  
 79 (d) A health maintenance organization which provides the services re-  
 80 quired by [appropriate state statute] shall be deemed to be providing a  
 81 number three qualified plan.

1 Section 7. [Qualified Medicare Supplement Plan.] Any plan which pro-  
 2 vides benefits to persons over the age of 65 years may be certified as a  
 3 qualified Medicare supplement plan if the plan is designed to supplement  
 4 Medicare and provides coverage of [50] percent of the deductible and  
 5 copayment required under Medicare and [80] percent of the charges for  
 6 covered services described in Section 6(a), which charges are not paid by  
 7 Medicare. The coverage shall include a limitation of \$[1,000] per person on  
 8 total annual out-of-pocket expenses for the covered services. The coverage  
 9 may be subject to a maximum lifetime benefit of not less than \$[100,000].

1 Section 8. [State Plan Premium.]

2 (a) For the first year of operation of the comprehensive health insurance  
 3 plan, the association shall establish the following premiums to be charged  
 4 for membership in the comprehensive health insurance plan:

5 (1) The premium for the number one qualified plan shall be the average  
 6 of rates charged by the [five] insurers with the largest number of individuals  
 7 in a number one individual qualified plan of insurance in force in the state.

8 (2) The premium for the number two qualified plan shall be the average  
 9 of rates charged by the [five] insurers with the largest number of individuals  
 10 in a number two individual qualified plan of insurance in force in the state.

11 (3) The premium for a qualified Medicare supplement plan shall be the  
 12 average of rates charged by the [five] insurers with the largest number of in-  
 13 dividuals enrolled in a qualified Medicare supplement plan.

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

16 (b) For the second and subsequent years, the schedule of premiums for  
 17 membership in the comprehensive health insurance plan shall be designed to  
 18 be self-supporting and based on generally accepted actuarial principles.

1 Section 9. [Duties of Commissioner.] The commissioner may:

(1) Formulate general policies to advance the purposes of Sections 1 to 17; the commissioner may also adopt, promulgate, repeal, and amend rules pursuant to the rulemaking provisions of [state administrative procedure act] to carry out the provisions of Sections 1 to 17.

(2) Supervise the creation of a comprehensive health association within the limits described in Section 10.

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

(4) Appoint advisory committees.

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

(6) Contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmental assistance programs.

(7) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of Sections 1 to 17, so that the residents of this state may best avail themselves of the health care benefits provided by these sections.

(8) Contract with insurers and others for administrative services.

#### Section 10. [Comprehensive Health Association.]

(a) There is established a comprehensive health association with membership consisting of all insurers, self-insurers, fraternal, and health maintenance organizations licensed or authorized to do business in this state.

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

(c) All members shall maintain their membership in the association as a

condition of doing business in this state. The association shall submit bylaws and operating rules to the commissioner for approval.

(d) All meetings of the association, its board, and any committees of the association shall comply with the provisions of [state open meetings act].

(e) All members shall enter into a contract with the association according to terms specified in Section 11. The contract of reinsurance shall be executed for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year.

(f) In the performance of their duties as members of the association, the members shall be exempt from the provisions of [state antitrust statute].

(g) The association may:

(1) Exercise the powers granted to insurers under the laws of this state.

(2) Sue or be sued.

(3) Enter into contracts with insurers, similar associations in other states, or other persons for the performance of administrative functions including the functions provided for in paragraphs (5) and (6) of this subsection.

(4) Establish administrative and accounting procedures for the operation of the association.

(5) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by Sections 4 and 16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are: (i) individual qualified plans, excluding group conversions; (ii) group conversions; (iii) group qualified plans with fewer than [50] employees or members; and (iv) major medical coverage. A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than [110] percent of the total anticipated expenses incurred by the association for the reinsurance.

(6) Provide for the administration by the association of policies which are reinsured pursuant to paragraph 5 of this subsection. Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than [110] percent of the total anticipated expenses incurred by the association for the administration.

2 (a) Upon certification as an eligible person in the manner provided by  
3 Section 14, an eligible person may enroll in the comprehensive health in-  
4 surance plan by payment of the state plan premium to the writing carrier.

5 (b) Any employer which has in its employ one or more eligible persons  
6 enrolled in the comprehensive health insurance plan may make all or any  
7 portion of the state plan premium payment to the state plan directly to the  
8 writing carrier.

9 (c) Not less than [87½] percent of the state plan premium paid to the  
10 writing carrier shall be used to pay claims, and not more than [12½] percent  
11 shall be used for the payment of agent referral fees as authorized in Section  
12 15(c) and for payment of the writing carrier's direct and indirect expenses,  
13 as specified in Section 13(g).

14 (d) Any income in excess of the costs incurred by the association in pro-  
15 viding reinsurance or administrative services shall be held at interest and used  
16 by the association to offset losses due to claims expenses of the state plan  
17 or allocated to reduce state plan premiums

18 (e) Each member of the association shall share the losses due to claims ex-  
19 penses of the comprehensive health insurance plan pursuant to the terms of  
20 the individual reinsurance contracts executed by the association with each  
21 member in accordance with Section 10(e). Deviations in the claim ex-  
22 perience of the state plan from the premium payments allocated to the pay-  
23 ment of benefits shall be the liability of the association members. Associa-  
24 tion members shall share in the excess costs of the state plan in an amount  
25 equal to the ratio of the member's total cost of self-insurance, accident and  
26 health insurance premium, subscriber contract charges, or health  
27 maintenance organization contract charges received from or on behalf of  
28 [state] residents as divided into the total cost of self-insurance, accident and  
29 health insurance premium, subscriber contract charges, and health  
30 maintenance organization contract charges received by all association  
31 members from or on behalf of [state] residents, as determined by the com-  
32 missioner. The reinsurance contract shall provide for a retroactive deter-  
33 mination of each member's liability and payment due within [30] days after  
34 each renewal date of the reinsurance contract. Failure by a member to  
35 tender to the association the assessed reinsurance payment within [30] days  
36 of notification by the association shall be grounds for termination of the  
37 member's membership. Net gains, if any, from the operation of the state  
38 plan shall be held at interest and used by the association to offset future  
39 losses due to claims expenses of the state plan or allocated to reduce state  
40 plan premiums.

1 Section 12. [Minimum Benefits of Comprehensive Health Insurance  
2 Plan.] The association through its comprehensive health insurance plan  
3 shall offer policies which provide the benefits of a number one qualified  
4 plan, a number two qualified plan, and a qualified Medicare supplement  
5 plan. They shall offer health maintenance organization contracts in those

6 areas of the state where a health maintenance organization has agreed to  
7 make the coverage available and has been selected as a writing carrier.

1 Section 13. [Administration of Plan.]

2 (a) Any member of the association may submit to the commissioner the  
3 policies of accident and health insurance or the health maintenance  
4 organization contracts which are being proposed to serve in the compre-  
5 hensive health insurance plan. The time and manner of the submission shall be  
6 prescribed by rule of the commissioner.

7 (b) Upon the commissioner's approval of the policy forms and contracts  
8 submitted pursuant to Section 10, the association shall select policies and  
9 contracts submitted by a member or members of the association to be the  
10 comprehensive health insurance plan. This selection shall be based upon  
11 criteria including the member's proven ability to handle large group acci-  
12 dent and health insurance cases, efficient claim paying capacity, and the  
13 estimate of total charges for administering the plan. The association may  
14 select separate writing carriers for the two types of qualified plans, the  
15 qualified Medicare supplement plan, and the health maintenance organiza-  
16 tion contract.

17 (c) The writing carrier shall perform all administrative and claims pay-  
18 ment functions required by this section. The writing carrier shall provide  
19 these services for a period of [three] years, unless a request to terminate is  
20 approved by the commissioner. The commissioner shall approve or deny a  
21 request to terminate within [90] days of its receipt. A failure to make a final  
22 decision on a request to terminate within the specified period shall be  
23 deemed to be an approval. [Six] months prior to the expiration of each  
24 [three]-year period, the association shall invite submissions of policy forms  
25 from members of the association, including the writing carrier. The associa-  
26 tion shall follow the provisions of subsection (b) in selecting a  
27 writing carrier for the subsequent three-year period.

28 (d) The writing carrier shall provide to all eligible persons enrolled in the  
29 plan an individual certificate, setting forth a statement as to the insurance  
30 protection to which he is entitled, with whom claims are to be filed and to  
31 whom benefits are payable. The certificate shall indicate that coverage was  
32 obtained through the association.

33 (e) The writing carrier shall submit to the association and the commis-  
34 sioner on a monthly basis a report on the operation of the state plan.  
35 Specific information to be contained in this report shall be determined by  
36 the association prior to the effective date of the state plan.

37 (f) All claims shall be paid by the writing carrier pursuant to the provi-  
38 sions of Sections 1 to 17 and shall indicate that the claim was paid  
39 by the state plan. Each claim payment shall include information specifying  
40 the procedure to be followed in the event of a dispute over the amount of  
41 payment.

42 (g) The writing carrier shall be reimbursed from the state plan premiums  
43 received for its direct and indirect expenses. Direct and indirect expenses

44 hall include, but need not be limited to, a pro rata reimbursement for that  
45 portion of the writing carrier's administrative, printing, claims administration,  
46 management and building overhead expenses which are assignable to  
47 the maintenance and administration of the state plan. The association shall  
48 approve cost accounting methods to substantiate the writing carrier's cost  
49 reports consistent with generally accepted accounting principles. Direct and  
50 indirect expenses shall not include costs directly related to the original sub-  
51 mission of policy forms prior to selection as the writing carrier.

52 (h) The writing carrier shall at all times when carrying out its duties under  
53 Sections 1 to 17 be considered an agent of the association and the commis-  
54 sioner with civil liability subject to the provisions of [appropriate state tort  
55 liability statute].

56 (i) Premiums received by the writing carrier for the comprehensive health  
57 insurance plan are specifically exempted from the provisions of Section 15.

1 Section 14. [Enrollment by Eligible Person.]

2 (a) The comprehensive health insurance plan shall be open for enrollment  
3 by eligible persons. An eligible person may enroll by submission of a cer-  
4 tificate of eligibility to the writing carrier. The certificate shall provide the  
5 following:

6 (1) Name, address, age, and length of time at residence of the appli-  
7 cant.

8 (2) Name, address, and age of spouse and children, if any, if they are to  
9 be insured.

10 (3) Evidence of rejection, or a requirement of restrictive riders, or a  
11 preexisting conditions limitation on a qualified plan, the effect of which is  
12 to substantially reduce coverage from that received by a person considered a  
13 standard risk, by at least [two] association members within [six] months of  
14 the date of the certificate.

15 (4) A designation of the coverage desired.

16 (b) Within [30] days of receipt of the certificate described in Section  
17 14(a), the writing carrier shall either reject the application for failing to  
18 comply with the requirements in Section 14(a) or forward the eligible person  
19 a notice of acceptance and billing information. Insurance shall be effective  
20 immediately upon receipt of the first month's state plan premium, and shall  
21 be retroactive to the date of application, if the applicant otherwise complies  
22 with the requirements of Sections 1 to 17. An eligible person may not pur-  
23 chase more than one policy from the state plan.

24 (c) No person who obtains coverage pursuant to this section shall be  
25 covered for any preexisting condition during the first [six] months of  
26 coverage under the state plan if the person was diagnosed or treated for that  
27 condition during the [90] days immediately preceding the filing of an ap-  
28 plication.

1 Section 15. [Solicitation of Eligible Persons.]

2 (a) The association pursuant to a plan approved by the commissioner

3 shall disseminate appropriate information to the residents of this state  
4 regarding the existence of the comprehensive health insurance plan and the  
5 means of enrollment. Means of communication may include use of the  
6 press, radio, and television, as well as publication in appropriate state of-  
7 fices and publications.

8 (b) The association shall devise and implement means of maintaining  
9 public awareness of the provisions of Sections 1 to 17 and shall administer  
10 these sections in a manner which facilitates public participation in the state  
11 plan.

12 (c) The writing carrier shall pay an agent's referral fee of \$[25] to each in-  
13 surance agent who refers an applicant to the state plan, if the application is  
14 accepted. Selling or marketing of qualified state plans shall not be limited to  
15 the writing carrier or its agents. The referral fees shall be paid by the writing  
16 carrier from money received as premiums for the state plan.

17 (d) Every insurer which rejects or applies underwriting restrictions to an  
18 applicant for accident and health insurance shall notify the applicant of the  
19 existence of the state plan, the requirements for being accepted in it, and the  
20 procedure for applying to it.

1 Section 16. [Conversion Privileges.] Every program of self-insurance,  
2 policy of group accident and health insurance or contract of coverage by a  
3 health maintenance organization written or renewed in this state shall in-  
4 clude the right to convert to an individual coverage qualified plan without  
5 the addition of underwriting restrictions regardless of the reason for leaving  
6 the group. The person leaving the group may exercise his right to conversion  
7 within [30] days of leaving the group. Plans of health coverage shall also in-  
8 clude a provision which, upon the death of the individual in whose name the  
9 contract was issued, permits every other individual then covered under the  
10 contract to elect, within the period specified in the contract, to continue his  
11 coverage under the same or a different contract without the addition of  
12 underwriting restrictions until he would have ceased to have been entitled to  
13 coverage had the individual in whose name the contract was issued lived.

1 Section 17. [Dual Option.]

2 (a) An employer who employs in this state, on the average during a calen-  
3 dar quarter, [100] employees or more, other than employees engaged in  
4 seasonal employment, and who offers a health benefits plan to employees,  
5 whether purchased from an insurer or a health maintenance organization,  
6 or provided on a self-insured basis, shall, upon the next renewal of the  
7 health benefits plan contract, offer his employees a dual option to obtain  
8 health benefits through either an accident and health insurance policy or a  
9 health maintenance organization contract if one is available. An option  
10 need not be provided if fewer than [25] employees select that option.

11 (b) An employer may make the dual offers through an insurer, a health  
12 maintenance organization or on a self-insured basis. If an offer is made on a  
13 self-insured basis, the accident and health insurance type of coverage or

14 health maintenance organization type of coverage shall meet the re-  
15 quirements of the laws of this state as to the services covered or benefits  
16 provided, but need not otherwise be approved by the commissioner or the  
17 board of health.

18 (c) No insurer shall make acceptance of its offer to provide insurance  
19 coverage contingent on acceptance by the employer of health maintenance  
20 organization coverage by a particular health maintenance organization. No  
21 health maintenance organization shall make acceptance of its offer to pro-  
22 vide health maintenance organization coverage contingent on acceptance by  
23 the employer of insurance coverage by a particular insurer. No offer to pro-  
24 vide the accident and health insurance policy and the health maintenance  
25 organization contract shall combine the two in a single price package.

26 (d) The [board of health], in consultation with the commissioner, shall  
27 adopt rules to implement the provisions of this section.

1 Section 18. [*Application for Assistance.*]

2 (a) Any person who believes that they are or will become an eligible per-  
3 son may submit an application for state assistance to the [commissioner of  
4 public welfare]. The application shall include a listing of expenses incurred  
5 prior to the date of the application and shall designate the date on which the  
6 [12]-month period for computing expenses began.

7 (b) If the [commissioner of public welfare] determines that an applicant is  
8 an eligible person, he shall pay [90] percent of all qualified expenses of the  
9 eligible person and his dependents in excess of: (1) [40] percent of his  
10 household income under \$[15,000], plus [50] percent of his household in-  
11 come between \$[15,000] and \$[25,000], plus [60] percent of his household  
12 income in excess of \$[25,000]; or (2) \$[2,500], whichever is greater for the  
13 [12]-month period in which the applicant becomes an eligible person. If the  
14 [commissioner of public welfare] determines that the charge for a health  
15 service is excessive, he may limit his payment to the usual and customary  
16 charge for that service. If the [commissioner of public welfare] determines  
17 that a health service provided to an eligible person was not medically  
18 necessary, he may refuse to pay for the service. To the extent feasible, the  
19 [commissioner of public welfare] shall contract with a review organization  
20 in making any determinations as to whether or not a charge is excessive. To  
21 the extent feasible, the [commissioner of public welfare] shall contract with  
22 a review organization in making any determination as to whether or not a  
23 service was medically necessary. If the [commissioner of public welfare], in  
24 accordance with this section, refuses to pay all or a part of the charge for a  
25 health service, the unpaid portion of the charge shall be deemed to be an un-  
26 conscionable fee, against the public policy of this state, and unenforceable  
27 in any action brought for the recovery of moneys owed.

1 Section 19. [*Duties of Commissioner.*]

2 (a) The [commissioner of public welfare] shall:

3 (1) Promulgate reasonable rules to implement Sections 18 to 20.

4 (2) Establish application forms and procedures for the use of persons  
5 seeking to be declared eligible persons.

6 (3) Investigate applications to determine whether or not the applicant is  
7 a qualified person and investigate claims from providers of health services  
8 to determine whether or not to pay them.

9 (b) The [commissioner of public welfare] may:

10 (1) Enter into contracts with the United States or any state agency, in-  
11 strumentality or political subdivision for the purpose of coordinating the  
12 program established by this act, with other programs which provide or pay  
13 for the delivery of health services.

14 (2) Enter into contracts with third parties to perform some or all of the  
15 duties imposed on the [commissioner of public welfare] by Sections 18 and  
16 19.

1 Section 20. [*Appeals.*] The final decision of the [commissioner of public  
2 welfare] in denying an application for status as an eligible person or denying  
3 all or part of the charges for a health service may be appealed by any in-  
4 terested party pursuant to [state administrative procedure act].

1 Section 21. [*Severability.*] [Insert severability clause.]

1 Section 22. [*Repeal.*] [Insert repealer clause.]

1 Section 23. [*Effective Date.*] [Insert effective date.]

## PART VI. ENFORCEMENT

[§392-91] Enforcement by the director. The director shall enforce the provisions of this chapter. The director may appoint such assistants and such clerical, stenographic and other help as may be necessary for the proper enforcement of this chapter subject to any civil service act relating to state employees. The salaries of all the foregoing appointees and employees shall be as fixed by law.

The director may adopt, amend, or repeal such rules and regulations as he deems necessary or suitable for the proper enforcement of this chapter. [L 1969, c 148, pt of §1]

## PART VII. MISCELLANEOUS PROVISIONS

[§392-101] Limitation of fees. Any individual claiming benefits in any proceeding before the department or the referee may be represented by counsel or other duly authorized agent; but no such counsel or agent shall either charge or receive for such services more than an amount approved by the department or referee, and such amount shall in no case exceed ten per cent of the total amount of benefits received as a result of such proceeding. Any person who violates this section shall, for each such offense, be fined not less than \$50 nor more than \$500 or imprisoned not more than six months, or both. [L 1971, c 109, §1(m)]

[CHAPTER 393]  
PREPAID HEALTH CARE ACT

## PART I. SHORT TITLE; PURPOSE, DEFINITIONS

## SECTION

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- [393-51] TERMINATION OF CHAPTER

## PART I. SHORT TITLE; PURPOSE; DEFINITIONS

[§393-1] Short title. This chapter shall be known as the Hawaii Prepaid Health Care Act. [L 1974, c 210, pt of §1]

[§393-2] Findings and purpose. The cost of medical care in case of sudden need may consume all or an excessive part of a person's resources. Prepaid health care plans offer a certain measure of protection against such emergencies. It is the purpose of this chapter in view of the spiraling cost of comprehensive medical care to provide this type of protection for the employees in this State. Although a large segment of the labor force in the State already enjoys coverage of this type either by virtue of collective bargaining agreements, employer-sponsored plans, or individual initiative, there is a need to extend that protection to workers who at present do not possess any or possess only inadequate prepayment coverage.

This chapter shall not be construed to interfere with or diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by this chapter or at least equivalent thereto. [L 1974, c 210, pt of §1]

[§393-3] Definitions generally. As used in this chapter, unless the context clearly requires otherwise:

- (1) "Department" means the department of labor and industrial relations.
- (2) "Director" means the director of labor and industrial relations.
- (3) "Employer" means any individual or type of organization, including any partnership, association, trust, estate, joint stock company, insurance company, or corporation, whether domestic or foreign, a debtor in possession or receiver or trustee in bankruptcy, or the legal representative of a deceased person, who has one or more regular employees in his employment. "Employer" does not include:
  - (A) The State, any of its political subdivisions, or any instrumentality of the State or its political subdivisions;

- (B) The United States government or any instrumentality of the United States;
- (C) Any other state or political subdivision thereof or instrumentality of such state or political subdivision;
- (D) Any foreign government or instrumentality wholly owned by a foreign government, if (i) the service performed in its employ is of a character similar to that performed in foreign countries by employees of the United States government or of an instrumentality thereof, and (ii) the United States Secretary of State has certified or certifies to the United States Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States government and of instrumentalities thereof.
- (4) "Employment" means service, including service in interstate commerce, performed for wages under any contract of hire, written or oral, expressed or implied, with an employer, except as otherwise provided in sections 393-4 and 393-5.
- (5) "Premium" means the amount payable to a prepaid health care plan contractor as consideration for his obligations under a prepaid health care plan.
- (6) "Prepaid health care plan" means any agreement by which any prepaid health care plan contractor undertakes in consideration of a stipulated premium:
- (A) Either to furnish health care, including hospitalization, surgery, medical or nursing care, drugs or other restorative appliances, subject to, if at all, only a nominal per service charge; or
- (B) To defray or reimburse, in whole or in part, the expenses of health care.
- (7) "Prepaid health care plan contractor" means:
- (A) Any medical group or organization which undertakes under a prepaid health care plan to provide health care; or
- (B) Any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or
- (C) Any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.
- (8) "Regular employee" means a person employed in the employment of any one employer for at least twenty hours per week but does not include a person employed in seasonal employment. "Seasonal employment" for the purposes of this paragraph means employment in a seasonal pursuit as defined in section 387-1 by a seasonal employer during a seasonal period or seasonal periods for the employer in the seasonal pursuit or employment by an employer engaged in the cultivating, harvesting, processing, canning, and warehousing of pineapple during its seasonal periods. The director by rule and regulation may determine the kind of employment that constitutes

seasonal employment.

- (9) "Wages" means all cash remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of his employer.

If the employee does not account to his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than \$20 a month in tips, the combined amount received by him from his employer and from tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

"Wages" do not include the amount of any payment specified in section 383-11 or 392-22 or chapter 386. [L 1974, c 210, pt of §1]

[§393-4] Place of performance. "Employment" includes an individual's entire service, performed within or both within and without this State if:

- (1) The service is localized in this State; or
- (2) The service is not localized in any state but some of the service is performed in this State and
  - (A) The individual's base of operation, or, if there is no base of operation, the place from which such service is directed or controlled, is in the State; or
  - (B) The individual's base of operation or place from which the service is directed or controlled is not in any state in which some part of the service is performed but the individual's residence is in this State. [L 1974, c 210, pt of §1]

[§393-5] Excluded services. "Employment" as defined in section 393-3 does not include the following services:

- (1) Service performed by an individual in the employ of an employer who, by the laws of the United States, is responsible for care and cost in connection with such service.
- (2) Service performed by an individual in the employ of his spouse, son, or daughter, and service performed by an individual under the age of twenty-one in the employ of his father or mother.
- (3) Service performed in the employ of a voluntary employee's beneficiary association providing for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or their designated beneficiaries, if
  - (A) Admission to membership in the association is limited to individuals who are officers or employees of the United States government, and
  - (B) No part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual.
- (4) Service performed by an individual for an employer as an insurance agent or as an insurance solicitor, if all such service

performed by the individual for the employer is performed for remuneration solely by way of commission.

- (5) Service performed by an individual for an employer as a real estate salesman or as a real estate broker, if all such service performed by the individual for the employer is performed for remuneration solely by way of commission.
- (6) Service performed by an individual who, pursuant to the Federal Economic Opportunity Act of 1964, is not subject to the provisions of law relating to federal employment, including unemployment compensation. [L 1974, c 210, pt of §1]

**[§393-6] Principal and secondary employer defined; coercion, interference, etc. prohibited.** If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the principal employer shall be the employer who pays him the most wages; provided that if one of the employers, who does not pay the most wages, employs the regular employee for at least thirty-five hours per week, the employee shall determine which of the employers shall be his principal employer. His other employers are secondary employers. An employer so designated as the principal employer shall remain as such principal employer for one year or until change of employment, whichever is earlier.

If an individual is concurrently a regular employee of a public entity which is not an employer as defined in section 393-3 and of an employer as defined in section 393-3 the latter shall be deemed to be a secondary employer.

An employer who, directly or indirectly, interferes with or coerces or attempts to coerce an employee in making a determination under this section shall be subject to the penalty provided under subsection 393-33(b). [L 1974, c 210, pt of § 1; am L 1975, c 51, §1]

**[§393-7] Required health care benefits.** (a) A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under this chapter if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type, as specified in section 393-12(a)(1) or (2), which have the largest numbers of subscribers in the State. This applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.

The director, after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection.

(b) A prepaid group health care plan shall also qualify for the mandatory health care benefits required under this chapter if it is demonstrated by the health care plan contractor offering such coverage to the satisfaction of the director after advice by the prepaid health care advisory council that the plan provides for sound basic hospital,

surgical, medical, and other health care benefits at a premium commensurate with the benefits included taking proper account of the limitations, co-insurance features, and deductibles specified in such plan. Coverage under a plan which provides aggregate benefits that are more limited than those provided by plans qualifying under subsection (a) shall be in compliance with section 393-11 only if the employer contributes at least half of the cost of the coverage of dependents under such plan.

(c) Subject to the provisions of subsections (a) and (b) without limiting the development of medically more desirable combinations and the inclusion of new types of benefits, a prepaid health care plan qualifying under this chapter shall include at least the following benefit types:

(1) Hospital benefits:

(A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering:

- (i) Room accommodations;
- (ii) Regular and special diets;
- (iii) General nursing services;
- (iv) Use of operating room, surgical supplies, anesthesia services, and supplies;
- (v) Drugs, dressings, oxygen, antibiotics, and blood transfusion services.

(B) Out-patient care:

- (i) Covering use of out-patient hospital;
- (ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.

(2) Surgical benefits:

(A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);

(B) After-care visits for a reasonable period;

(C) Anesthesiologist services.

(3) Medical benefits:

(A) Necessary home, office, and hospital visits by a licensed physician;

(B) Intensive medical care while hospitalized;

(C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radio-therapeutic services, necessary for diagnosis or treatment of injuries or diseases.

(5) Maternity benefits, at least if the employee has been covered by the prepaid health care plan for nine consecutive months prior to the delivery.

(d) The prepaid health care advisory council shall be appointed by the director and shall include representatives of the medical and public health professions, representatives of consumer interests, and persons experienced in prepaid health care protection. The membership of the council shall not exceed seven individuals. [L 1974, c 210, pt of §1]

[§393-11] Coverage of regular health care plan. Every employer shall provide coverage for employee monthly wages in an amount not less than the minimum hourly wage, specified in chapter 210 of the director, shall provide a prepaid group health care plan qualifying under this chapter. [L 1974, c 210, pt of §1]

[§393-12] Choice of plan type. Every employer required to provide coverage under this chapter shall provide a group health care plan under this chapter. His election shall be provided by:

(1) A plan which obligates the employer to furnish the required health care;

(2) A plan which obligates the employer to defray or reimburse the expenses of the employee. His election is binding for one year.

(b) Whether the employer elects coverage under subsection (a)(1) or in subsection (a)(2), the employer shall contribute the greater amount to the premium than the employee elected coverage with the respective type of coverage.

Subject to the provision of section 393-11, every employer shall provide coverage with the prepaid health care plan pursuant to this subsection for all health care services for this type of coverage who are covered by the applicable collective bargaining agreement. [L 1974, c 210, pt of §1]

[§393-13] Liability for payment. Every employer shall contribute at least the balance of the coverage required by this chapter; provided that in no event shall the contribution be more than 1.5 per cent of his wages of the employee's contribution is less than the employer shall be liable for the premium.

The employer shall withhold the premium with respect to pay periods as specified in this section. [L 1974, c 210, pt of §1]

[§393-14] Commencement of coverage. Every employer shall provide the coverage required by this chapter for an employee who has been in his employ for four years prior to the time thereafter at which coverage

## PART II. MANDATORY COVERAGE

[§393-11] Coverage of regular employees by group prepaid health care plan. Every employer who pays to a regular employee monthly wages in an amount of at least 86.67 times the minimum hourly wage, specified in chapter 387, as rounded off by regulation of the director, shall provide coverage of such employee by a prepaid group health care plan qualifying under section 393-7 with a prepaid health care plan contractor in accordance with the provisions of this chapter. [L 1974, c 210, pt of §1]

[§393-12] Choice of plan type and of contractor. (a) Every employer required to provide coverage for his employees by a prepaid group health care plan under this chapter shall elect whether coverage shall be provided by:

- (1) A plan which obligates the prepaid health care plan contractor to furnish the required health care benefits; or
  - (2) A plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care.
- His election is binding for one year.

(b) Whether the employer elects a plan type described in subsection (a)(1) or in subsection (a)(2), the employer may elect the particular contractor but the employee shall not be obligated to contribute a greater amount to the premium than he would have to contribute had the employer elected coverage with the contractor providing the prevailing coverage of the respective type in the State.

Subject to the provision of section 393-20, the employer shall provide coverage with the prepaid health care plan contractor selected pursuant to this subsection for all his employees in the State electing this type of coverage who are covered by the provisions of this chapter, except for employees covered by the health care provisions of an applicable collective bargaining agreement as provided in section 393-19(b) first sentence. [L 1974, c 210, pt of §1]

[§393-13] Liability for payment of premium; withholding. Unless an applicable collective bargaining agreement specifies differently every employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance; provided that in no case shall the employee contribute more than 1.5 per cent of his wages; and provided that if the amount of the employee's contribution is less than one-half of the premium, the employer shall be liable for the whole remaining portion of the premium.

The employer shall withhold the employee's share from his wages with respect to pay periods as specified by the director. [L 1974, c 210, pt of §1]

[§393-14] Commencement of coverage. The employer shall provide the coverage required by this chapter for any regular employee, who has been in his employ for four consecutive weeks, at the earliest time thereafter at which coverage may be provided with the prepaid

health care plan contractor selected pursuant to this chapter. [L 1974, c 210, pt of §1]

**[§393-15] Continuation of coverage in case of inability to earn wages.** If an employee is hospitalized or otherwise prevented by sickness from working, the employer shall enable the employee to continue his coverage by contributing to the premium the amounts paid by the employer toward such premium prior to the employee's sickness for the period that such employee is hospitalized or prevented by sickness from working. This obligation shall not exceed a period of three months following the month during which the employee became hospitalized or disabled from working, or the period for which the employer has undertaken the payment of his regular wages in such case, whichever is longer. [L 1974, c 210, pt of §1]

**[§393-16] Liability of secondary employer.** An employer who has been notified by an employee, in the form prescribed by the director, that he is not the principal employer as defined in section 393-6 shall be relieved of the duty of providing the coverage required by this chapter until he is notified by the employee pursuant to section 393-18 that he has become the principal employer. He shall notify the director, in the form prescribed by the director, that he is relieved from the duty of providing coverage or of any change in that status. [L 1974, c 210, pt of §1]

**[§393-17] Exemption of certain employees.** (a) In addition to the exemption specified in section 393-16, an employer shall be relieved of his duty under section 393-11 with respect to any employee who has notified him, in the form specified by the director, that the employee is:

- (1) Protected by health insurance or any prepaid health care plan established under any law of the United States;
- (2) Covered as a dependent under a prepaid health care plan, entitling him to the health benefits required by this chapter;
- (3) A recipient of public assistance or covered by a prepaid health care plan established under the laws of the State governing medical assistance.

(b) Employers receiving notice of a claim of exemption under this section shall notify the director of such claim in the form prescribed by the director. [L 1974, c 210, pt of §1]

**[§393-18] Termination of exemption.** (a) If an exemption which has been claimed by an employee pursuant to section 393-17 terminates because of any change in the circumstances entitling the employee to claim such exemption, the employee shall promptly notify the principal employer of the termination of the exemption and the employer thereupon shall provide coverage as required by this chapter.

(b) If because of a change in the employment situation of an employee or a redetermination by an employee as provided in section 393-6, a principal employer becomes a secondary employer or a secondary employer becomes the principal employer, the employee shall promptly notify the employers affected of such change and the new

principal employer shall provide coverage as required by this chapter. [L 1974, c 210, pt of §1]

**[§393-19] Freedom of collective bargaining.** (a) In addition to the policy stated in section 393-2, nothing in this chapter shall be construed to limit the freedom of employees to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs thereof. A collective bargaining agreement may provide that the employer himself undertakes to provide the health care specified in the agreement.

(b) If the employees rendering particular types of services are not covered by the health care provisions of the applicable collective bargaining agreements to which their employer is a party, the provisions of this chapter shall be applicable with respect to them. An employer or group of employers shall be deemed to have complied with the provisions of this chapter if they undertake to provide health care services pursuant to a collective bargaining agreement and the services are available to all other employees not covered by such agreement. [L 1974, c 210, pt of §1]

**[§393-20] Adjustment of employer-sponsored plans.** Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the State and the majority of such employees are not subject to this chapter, the benefits applicable to the employees covered by this chapter shall be adjusted within one year after the effective date of this chapter so as to meet the requirements of this chapter. [L 1974, c 210, pt of §1]

**[§393-21] Individual waivers prohibited; additional withholding for dependents.** An employee may not waive individually all or part of the required health care benefits or agree to pay a greater share of the premium for such benefits than is required by this chapter.

Subject to section 393-7(b), an employee may consent to pay a greater share of his wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of his dependents under the plan providing such benefits for himself. [L 1974, c 210, pt of §1]

**[§393-22] Exemption of followers of certain teachings or beliefs.** This chapter shall not apply to any individual who pursuant to the teachings, faith, or belief of any group, depends for healing upon prayer or other spiritual means. [L 1974, c 210, pt of §1]

**[§393-23] Joint provision of coverage.** Employers may form associations for the purpose of jointly providing prepaid health care protection under this chapter for their employees with the contractors authorized to provide such coverage in the State. [L 1974, c 210, pt of §1]

PART III. ADMINISTRATION AND ENFORCEMENT

**[\$393-31] Enforcement by the director.** Except as otherwise provided in section 393-7 the director shall administer and enforce this chapter. The director may appoint such assistants and such clerical, stenographic, and other help as may be necessary for the proper administration and enforcement of this chapter subject to any civil service act relating to state employees. [L 1974, c 210, pt of §1]

**[\$393-32] Rule making and other powers of the director.** The director may adopt, amend, or repeal, pursuant to chapter 91, such rules and regulations as he deems necessary or suitable for the proper administration and enforcement of this chapter.

The director may round off the amounts specified in this chapter for the purpose of eliminating payments from the premium supplementation fund in other than even dollar amounts or other purposes.

The director may prescribe the filing of reports by prepaid health care plan contractors and prescribe the form and content of requests by employers for premium supplementation and the period for the payment thereof. [L 1974, c 210, pt of §1]

**[\$393-33] Penalties.** (a) If an employer fails to comply with section 393-11, 393-12, 393-13, or 393-15 he shall pay a penalty of not less than \$25 or of \$1 for each employee for every day during which such failure continues, whichever sum is greater. The penalty shall be assessed under rules and regulations promulgated pursuant to chapter 91 and shall be collected by the director and paid into the special fund for premium supplementation established by section 393-41. The director may, for good cause shown, remit all or any part of the penalty.

(b) Any employer, employee, or prepaid health care plan contractor who wilfully fails to comply with any other provision of this chapter or any rule or regulation thereunder may be fined not more than \$200 for each such violation. [L 1974, c 210, pt of §1]

PART IV. PREMIUM SUPPLEMENTATION

**[\$393-41] Establishment of special premium supplementation fund.** There is established in the treasury of the State, separate and apart from all public moneys or funds of the State, a special fund for premium supplementation which shall be administered exclusively for the purposes of this chapter. All premium supplementations payable under this part shall be paid from the fund. The fund shall consist of (1) all money appropriated by the State for the purposes of premium supplementation under this part and (2) all fines and penalties collected pursuant to this chapter. [L 1974, c 210, pt of §1]

**[§393-42] Management of the fund.** The director of finance shall be the treasurer and custodian of the premium supplementation fund and shall administer the fund in accordance with the directions of the director of labor and industrial relations. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any depository bank in which general funds of the State may be deposited but such moneys shall not be commingled with other state funds and shall be maintained in separate accounts on the books of the depository bank. Such moneys shall be secured by the depository bank to the same extent and in the same manner as required by the general depository law of the State; and collateral pledged for this purpose shall be kept separate and distinct from any other collateral pledged to secure other funds of the State. The director of finance shall be liable for the performance of his duties under this section as provided in chapter 37. [L 1974, c 210, pt of §1]

**[§393-43] Disbursements from the fund.** Expenditures of moneys in the premium supplementation fund shall not be subject to any provisions of law requiring specific appropriations or other formal release by the state officers of money in their custody. All payments from the fund shall be made upon warrants drawn upon the director of finance by the comptroller of the State supported by vouchers approved by the director. [L 1974, c 210, pt of §1]

**[§393-44] Investment of moneys.** With the approval of the department the director of finance may, from time to time, invest such moneys in the premium supplementation fund as are in excess of the amount deemed necessary for the payment of benefits for a reasonable future period. Such moneys may be invested in bonds of any political or municipal corporation or subdivision of the State, or any of the outstanding bonds of the State, or invested in bonds or interest-bearing notes or obligations of the State (including state director of finance's warrant notes issued pursuant to chapter 40), or of the United States, or those for which the faith and credit of the United States are pledged for the payment of principal and interest, or in federal land bank bonds or joint stock farm loan bonds. The investments shall at all times be so made that all the assets of the fund shall always be readily convertible into cash when needed for the payment of benefits. The director of finance shall dispose of securities or other properties belonging to the fund only under the direction of the director of labor and industrial relations. [L 1974, c 210, pt of §1]

**[§393-45] Entitlement to premium supplementation.** (a) An employer who employs less than eight employees entitled to coverage under this chapter and who provides coverage to such employees pursuant to section 393-7(a) shall be entitled to premium supplementation from the fund if the employer's share of the cost of providing such

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coverage as determined by sections 393-13 and 393-15 exceeds 1.5 per cent of the total wages payable to such employees and if the amount of such excess is greater than five per cent of the employer's income before taxes directly attributable to the business in which such employees are employed.

(b) The amount of the supplementation shall be that part of the employer's share of the premium cost which exceeds the limits specified in subsection (a). [L 1974, c 210, pt of §1]

[§393-46] Income directly attributable to the business. (a) "Income directly attributable to the business" means gross profits from the business minus deductions for:

- (1) Compensation of officers;
- (2) Salaries and wages, except wages paid by an individual proprietor to himself;
- (3) Repairs;
- (4) Taxes on business and business property;
- (5) Business advertising;
- (6) Amounts contributed to employee benefit plans;
- (7) Interest on business indebtedness;
- (8) Rent on business property; and
- (9) Other expenses necessary for the current conduct of business.

(b) Deductions shall not include:

- (1) Bad debts;
- (2) Contributions or gifts, other than those listed under subsection (a)(6);
- (3) Amortization and depreciation; or
- (4) Losses by fire, storm, casualty, or theft.

(c) The director may promulgate rules and regulations necessary to define income directly attributable to business for the purpose of section 393-45. [L 1974, c 210, pt of §1]

[§393-47] Claim of premium supplementation. An employer entitled to premium supplementation shall file a claim therefor in the manner provided by regulation of the director. The employer shall have the burden of proof of establishing his entitlement. [L 1974, c 210, pt of §1]

[PART V. TERMINATION OF CHAPTER]

[§393-51 Termination of chapter.] This chapter shall terminate upon the effective date of federal legislation that provides for voluntary prepaid health care for the people of Hawaii in manner at least as favorable as the health care provided by this chapter, or upon the effective date of federal legislation that provides for mandatory prepaid health care for the people of Hawaii. [L 1974, c 210, pt of §2]

§ 38-370b. Notice of cancellation of professional liability policy

Any insurance company doing business in this state shall provide a ninety-day notice to the insured of cancellation of or refusal to renew any professional liability policy.

(1976, P.A. 76-117, eff. April 29, 1976.)

Library References

Insurance § 229.

C.J.S. Insurance §§ 450, 473(6) et seq.

§ 38-370c. Mandatory provisions for professional liability insurance policies issued on a claims-made basis

Every professional liability insurance policy issued on a claims-made basis delivered, issued for delivery or renewed in this state on or after October 1, 1978 shall contain (1) a provision for the purchase of prior acts coverage and (2) a contractual right of the insured to purchase at any time during the policy period not later than thirty days after termination of such policy period coverage for all claims occurring during an insured policy period when made.

(S-91.)

CHAPTER 692

COMPREHENSIVE HEALTH CARE PLANS [NEW]

Sec.		Sec.	
38-371.	Definitions.	38-377.	Hospital and medical service corporations. Residual market mechanism. Insurance commissioner's powers concerning such mechanisms.
38-372.	Applicability of chapter. Individual and group comprehensive health care plans.	38-378.	Insurance commissioners' powers concerning comprehensive health care plans. Notification to purchasers of policy or contract term.
38-373.	Minimum standard benefits of comprehensive health care plans. Optional and excludable benefits. Carrier subrogation rights.	38-379.	Application to new or renewed group health policies and contracts. Other regulations.
38-374.	Additional requirements and eligibility under group comprehensive health care plans. Insurance commissioner's authority to coordinate benefits.	38-380.	Commission on hospitals and health care.
38-375.	Additional requirements for individual comprehensive health care plans. Carrier obligations concerning termination of coverage.	38-381.	Commissioner of social services. Contract authority concerning medical programs.
38-376.	Health Insurance Association. Classes of risk. Audits. Insurance commissioner's powers.		

§ 38-371. Definitions

For purposes of this chapter, the following terms shall have the following meanings:

(a) "Health insurance" means hospital and medical expenses incurred policies written on a direct basis, nonprofit service plan contracts and self-insured or self-funded employee health benefit plans. The term "health insurance" for purposes of this chapter shall not include accident only policies, disability income policies or coverages which are subject to regulation under chapters 682a and 690.

(b) "Carrier" means an insurer, hospital service corporation or medical service corporation or fraternal benefit society.

(c) "Insurer" means an insurance company licensed to transact accident and health insurance business in this state.

(d) "Self-insurer" means an employer or an employee welfare benefit fund or plan which provides payment for or reimbursement of the whole or any part of the cost of covered hospital or medical expenses for covered individuals. For purposes of this chapter, "self-insurer" shall not include any such employee welfare benefit fund or plan established prior to April 1, 1976, by any organization which is exempt from federal income taxes under the provisions of Section 501 of the United States Internal Revenue Code and amendments thereto and legal interpretations thereof, except any such organization described in Subsection (c)(15) of said Section 501.

(e) "Commissioner" means the insurance commissioner within the department of business regulation of the state of Connecticut.

(f) "Physician" means a doctor of medicine, osteopathy, chiropractic, naturopathy, podiatry, a qualified psychologist and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry, and subject to the provisions of section 20-138d, optometrists duly licensed under the provisions of chapter 380.

(g) "Qualified psychologist" means a person who is duly licensed or certified as a clinical psychologist and has a doctoral degree in and at least two years of supervised experience in clinical psychology in a licensed hospital or mental health center.

(h) "Skilled nursing facility" shall have the same meaning as "skilled nursing facility" as defined in Section 1305x, Chapter 7 of Title 42, United States Code.

(i) "Hospital" shall have the same meaning as "hospital" as defined in Section 1305x, Chapter 7 of Title 42, United States Code.

(j) "Home health agency" shall have the same meaning as "home health agency" as defined in Section 1305x, Chapter 7 of Title 42, United States Code.

(k) "Copayment" means the portion of a charge that is covered by a plan and not payable by the plan and which is thus the obligation of the covered individual to pay.

(l) "Resident employer" means any person, partnership, association, trust, estate, corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy or receiver or trustee, thereof, or the legal representative of a deceased person, including the state of Connecticut and each municipality therein, which has in its employ one or more individuals during any calendar year, commencing January 1, 1976. For purposes of this chapter, the term "resident employer" shall refer only to an employer with a majority of employees employed within the state of Connecticut.

(m) "Eligible employee" means, with respect to any employer, an employee who either is considered a fulltime employee, or who is expected to work at least twenty hours a week for at least twenty-six weeks during the next twelve months or who has actually worked at least twenty hours a week for at least twenty-six weeks in any continuous twelve month period.

(n) "Alcoholism treatment facility" shall have the same meaning as in section 38-262b.

(o) "Totally disabled" means with respect to an employee, the inability of the employee because of an injury or disease to perform the duties of any occupation for which he is suited by reason of education, training or experience, and, with respect to a dependent, the inability of the dependent because of an injury or disease to engage in substantially all of the normal activities of persons of like age and sex in good health.

(p) "Deductible" means the amount of covered expenses which must be accumulated during each calendar year before benefits become payable as additional covered expenses incurred.

(q) For purposes of this chapter, "disease or injury" shall include pregnancy and resulting childbirth or miscarriage.

(r) "Complications of pregnancy" means (1) conditions requiring hospital stays, when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (2) non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible. (1975, P.A. 75-616, § 1, eff. April 1, 1976; 1976, P.A. 76-399, § 2, eff. June 9, 1976; 1977, P.A. 77-614, § 163, eff. Jan. 1, 1978.)

#### 1976 Amendment

Introductory paragraph: 1976, P.A. 76-399, § 2, substituted "sections 38-371 to 38-381" for "this act".

Subsection (a): 1976, P.A. 76-399, § 2, substituted, in the second sentence, "sections 38-371 to 38-381" for "this act".

Subsection (d): 1976, P.A. 76-399, § 2, amended the second sentence by substituting "sections 38-371 to 38-381" for "this act"; and by substituting "June 9, 1976" for "the effective date of this act".

Subsection (b): 1976, P.A. 76-399, § 2, substituted, in the second sentence, "sections 38-371 to 38-381" for "this act".

Subsections (e) to (r): Added by 1976, P.A. 76-399, § 2.

#### 1977 Amendment

1977, P.A. 77-614, § 163, eff. Jan. 1, 1978, provides for insertion of the words "within the department of business regulation" following "insurance commissioner".

#### Library References

Words and Phrases (Perm. Ed.)

### § 38-372. Applicability of chapter. Individual and group comprehensive health care plans

(a)(1) Every carrier offering individual health insurance in this state shall, as a condition of transacting such health insurance, make an individual comprehensive health care plan, described in section 38-375, available to every resident of this state who is not eligible for Medicare. An individual shall have a choice of the low option or middle option or high option deductible described in subsection (b) of section 38-373. Individual comprehensive health care plans may be made available through participation in the Health Reinsurance Association in accordance with section 38-376, or a residual market association, in accordance with section 38-377. The premium charged for such a plan which is not insured by or through the Health Reinsurance Association or any other residual market association may not exceed the premium which would be applicable through participation in such associations. The premium charged for such a plan insured by or through the Health Reinsurance Association shall be precisely the premium established for that particular classification under the Health Reinsurance Association.

(2) Every self-insurer whose plan covers three or more employees shall make an individual comprehensive health care plan, described in section 38-375, available under a conversion privilege to every person covered by the plan who is a resident of this state, who is not eligible for Medicare and whose coverage under the self-insured plan ceases as a result of layoff, death or termination of employment. An individual shall have the choice of the low option or middle option or high option deductible described in subsection

(b) of section 38-373. The individual comprehensive health care plans may be provided through a carrier or through participation in the Health Reinsurance Association in accordance with section 38-376. The premium charged for such a plan which is not insured by or through the Health Reinsurance Association may not exceed the premium established for that particular classification under the Health Reinsurance Association. The premium charged for such a plan which is insured by or through the Health Reinsurance Association shall be precisely the premium established for that particular classification under the Health Reinsurance Association.

(b) Every carrier offering group health insurance in this state shall, as a condition of transacting such health insurance, make a group comprehensive health care plan, as described in section 38-374, available to every resident employer of three or more eligible employees. An employer shall have the choice of the low option or middle option or high option deductible described in subsection (b) of section 38-373. Group comprehensive health care plans may be made available to resident employers of between three and twenty-five eligible employees through participation in the Health Reinsurance Association, in accordance with section 38-376 or the residual market association, in accordance with section 38-377. The premium charged for such a plan on groups of between three and twenty-five eligible employees which is not insured by or through the Health Reinsurance Association or a residual market association may not exceed the premium which would be applicable through participation in such associations. The premium charged for such a plan which is insured by or through the Health Reinsurance Association must be precisely the premium established for that particular classification under the Health Reinsurance Association.

(c) Except as provided in subdivision (c) of section 38-378, nothing in sections 38-371 to 38-381 shall preclude the right of carriers to transact other kinds of insurance for which they are authorized, nor preclude the right of carriers to transact any other lawful kind of health insurance.

(d) Nothing in sections 38-371 to 38-381 shall require a carrier to make available coverage under a group or individual comprehensive health care plan to any person or group who is already covered under such a plan. (1975, P.A. 75-616, § 2, eff. April 1, 1976.)

#### Library References

Insurance § 467.3, 467.4, 467.5.  
C.J.S. Insurance § 753 et seq., 893, 896.

### § 38-373. Minimum standard benefits of comprehensive health care plans. Optional and excludible benefits. Carrier subrogation rights

All individual and all group comprehensive health care plans shall include minimum standard benefits as described in this section.

(a) Except as provided in subsections (b) and (c), minimum standard benefits shall be benefits, including coverage for catastrophic illness, with a lifetime maximum of one million dollars per individual, for reasonable charges or, when applicable, the allowance agreed upon between a provider and a carrier for charges actually incurred, for the following health care services, rendered to an individual covered by such plan for the diagnosis or treatment of nonoccupational disease or injury: (1) hospital services; (2) professional services which are rendered by a physician or, at his direction, by a registered nurse, other than services for mental or dental conditions; (3) the diagnosis or treatment of mental conditions, as defined by the commissioner, rendered during the year by one or more physicians or other than an inpatient basis or, at their direction, by their staffs of registered nurses, up to a yearly maximum benefit of one thousand dollars; (4) legend drugs requiring a physician's prescription; (5) services of a skilled nursing fa-

illity for not more than one hundred twenty days in a calendar year, provided such services commence within fourteen days following a confinement of at least three consecutive days in a hospital for the same condition; (6) home health agency services, as defined by the commissioner, up to a maximum of one hundred eighty visits in a calendar year, provided such services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, provided further, in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, such home health agency services may commence irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such seven-day period, and the yearly benefit for medical social services, as hereinafter defined, shall not exceed two hundred dollars. "Medical social services" means services rendered, under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (a) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; (b) appropriate action and utilization of community resources to assist in resolving such problems; (c) participation in the development of treatment for such covered person; (7) use of radium or other radioactive materials; (8) oxygen; (9) anesthetics; (10) non-dental prosthesis; (11) rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed; (12) diagnostic x-rays and laboratory tests as defined by the commissioner; (13) oral surgery for: (A) Excision of partially or completely unerupted impacted teeth, or (B) excision of a tooth root without the extraction of the entire tooth; (14) services of a licensed physical therapist, rendered under the direction of a physician; (15) transportation by a local professional ambulance to the nearest health care institution qualified to treat the illness or injury; (16) certain other services which are medically necessary in the treatment or diagnosis of an illness or injury as may be designated or approved by the insurance commissioner within the department of business regulation; (17) confinement in a facility established primarily for the treatment of alcoholism and licensed for such care by the state, or in a part of a hospital used primarily for such treatment, shall be a covered expense for a period of at least forty-five days within any calendar year.

(b) Minimum standard benefits may include one or more of the following provisions: (1) Subject to the provisions of subdivision (3) such plan may require deductibles. The "low option deductible" shall be two hundred dollars per person, the "middle option deductible" shall be five hundred dollars per person, and the "high option deductible" shall be seven hundred fifty dollars per person. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall be applied to that individual's deductible in the following calendar year. The two hundred dollar maximum, the five hundred dollar maximum and the seven hundred fifty dollar maximum may be adjusted yearly to correspond with the change in the medical care component of the consumer price index, as adjusted by the commissioner. The base year for such computation shall be the first full year of operation of such plan. (2) Subject to the provisions of subdivision (3), such plan shall require a maximum copayment of twenty per cent for charges for all types of health care in excess of the deductible and fifty per cent for services listed in subdivision (3) of subsection (a) in excess of the deductible. (3) The sum of the deductible and copayments required in any calendar year under any option may not exceed a maximum limit of one thousand dollars per covered individual, or two thousand dollars per covered family; provided, covered expenses incurred after the applicable maximum limit has been

reached shall be paid at the rate of one hundred per cent, except that expenses incurred for treatment of mental and nervous conditions may be paid at the rate of fifty per cent as specified in subdivision (3) of subsection (a). The one thousand dollar and two thousand dollar maximums shall be adjusted yearly to correspond with the change in the medical care component of the consumer price index as adjusted by the commissioner. (4) The plan shall limit benefits with respect to each pregnancy, other than a pregnancy involving complications of pregnancy, to a maximum of two hundred fifty dollars. (5) The plan may limit lifetime benefits to a maximum of not less than one million dollars per covered individual. (6) No pre-existing condition exclusion shall exclude coverage of any pre-existing condition unless: (A) The condition first manifested itself within the period of six months immediately prior to the effective date of coverage in such a manner as would cause a reasonably prudent person to seek diagnosis, care or treatment; (B) medical advice or treatment was recommended or received within the period of six months immediately prior to the effective date of coverage, or (C) the condition is pregnancy existing on the effective date of coverage. No policy shall exclude coverage for a loss due to pre-existing conditions for a period greater than twelve months following the effective date of coverage. Any individual comprehensive health care plan issued as a result of conversion from group health insurance or from a self insured group shall credit the time covered under such group health insurance toward any such exclusion.

(c) Plans providing minimum standard benefits need not provide benefits for the following: (1) Any charge for any care for any injury or disease either (A) arising out of and in the course of an employment subject to a workmen's compensation or similar law or (B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance; (2) any charge for treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered; (3) any charge for travel, other than transportation by local professional ambulance to the nearest health care institution qualified to treat the illness or injury; (4) any charge for private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room; (5) any charge by health care institutions to the extent that it is determined by the carrier that the charge exceeds the rates approved by the commission on hospital and health care; (6) any charge for services or articles to the extent that it exceeds the reasonable charge in the locality for the service; (7) any charge for services or articles which are determined not to be medically necessary; (8) any charge for services or articles the provisions of which is not within the scope of the license or certificate of the institution or individual rendering such services or articles; (9) any charge for services or articles furnished, paid for or reimbursed directly by or under any law of a government, except as otherwise provided herein; (10) any charge for services or articles for custodial care or designed primarily to assist an individual in meeting his activities of daily living; (11) any charge for services which would not have been made if no insurance existed or for which the covered individual is not legally obligated to pay; (12) any charge for eyeglasses, contact lenses or hearing aids or the fitting thereof; (13) any charge for dental care not specifically covered by this chapter; and (14) any charge for services of a registered nurse who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse.

(d) Whenever a covered individual who receives benefits for an injury has a right of recovery against any person or organization, a carrier that has paid such benefits to or for the insured person shall be subrogated to all such rights of recovery to the extent of its payments.

(e) The minimum standard benefits of any individual or group comprehensive health care plan may be satisfied by catastrophic coverage offered in conjunction with basic hospital or medical-surgical plans on an expense incurred or service basis as approved by the commissioner as providing at least equivalent benefits.

(1975, P.A. 75-616, § 3, eff. April 1, 1976; 1976, P.A. 76-399, § 3, eff. June 9, 1976; 1977, P.A. 77-614, § 163, eff. Jan. 1, 1979; 1978, P.A. 78-76, § 4.)

1976 Amendment

Subsection (a): 1976, P.A. 76-399, § 3, added subd. (17).

Subsection (b): 1976, P.A. 76-399, § 3, redesignated former subds. (4) and (5) as subds. (5) and (6); inserted subd. (4); and added to subd. (6), par. (C).

Subsection (c): 1976, P.A. 76-399, § 3, substituted, in subd. (13), "sections 38-371 to 38-381" for "this act" following "not specifically covered by".

1977 Amendment

1977, P.A. 77-614, § 163, eff. Jan. 1, 1979, provides for insertion of the words

"within the department of business regulation" following "insurance commissioner".

1978 Amendment

1978, P.A. 78-76, § 4, amended subsec. (c)(6) by adding the proviso following "days for the same condition", and by adding a second sentence defining "Medical social services".

Library References

Insurance 467.5.  
C.J.S. Insurance § 893 et seq.

§ 38-374. Additional requirements and eligibility under group comprehensive health care plans. Insurance commissioner's authority to coordinate benefits

A group comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38-373, including the choice of the low option, middle option or high option deductible, and shall also conform in substance to the requirements of this section.

(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee; and (3) dependent unmarried children, who are under the age of nineteen or are full-time students under the age of twenty-three at an accredited institution of higher learning.

(b) The plan shall provide the option to continue coverage under each of the following circumstances until eligible for other group insurance: (1) Upon layoff or leave of absence, or termination of employment, other than as a result of death of the employee, continuation of coverage for such employee and his covered dependents to the end of the thirty-ninth week following the day on which the employee lost eligibility to participate in the group; (2) upon the death of the employee, continuation of coverage for the covered dependents of such employee to the end of the thirty-ninth week following the day on which the employee lost eligibility to participate in the group; (3) during an employee's absence due to illness or injury, continuation of coverage for such employee and his covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence; (4) upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination, shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted therefor within one year of the termination of the plan; (5) the coverage of any covered individual shall terminate: (A) As to a child, at the end of the month following the month in which the child marries, ceases to be dependent on the employee or attains the age of nineteen, whichever occurs first, except that if the child is a fulltime student at an accredited institution, the coverage may be continued while the child remains unmarried and a fulltime student, but not beyond the month following the month in which the child attains the age of twenty-three. If on the date

specified for termination of coverage on a dependent child, the child is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter: (B) as to the employee's spouse, at the end of the month following the month in which a divorce, annulment or legal separation is obtained; and (C) as to the employee or dependent as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act; (6) any continuation of coverage required by this section except subdivision (4) of subsection (b) may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium he would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay the entire premium at the group rate if coverage is continued in accordance with subdivision (1) of subsection (b) above, provided the employer shall not be legally obligated by this act to pay such premium if not paid timely by the employee.

(c) The commissioner shall promulgate regulations concerning coordination of benefits between the plan and other health insurance plans.

(d) The plan shall make available to Connecticut residents, in addition to any other conversion privilege available, a conversion privilege under which coverage shall be available immediately upon termination of coverage under the group plan. The terms and benefits offered under the conversion benefits shall be at least equal to the terms and benefits of an individual comprehensive health care plan.

(1975, P.A. 75-616, § 4, eff. April 1, 1976; 1976, P.A. 76-399, § 1, eff. June 9, 1976.)

1976 Amendment

Introductory paragraph: 1976, P.A. 76-399, § 1, substituted "section 38-373" for "section 3 of this act".

Subsection (b): 1976, P.A. 76-399, § 1, substituted "thirty-ninth week following the day on which the employee lost eligibility to participate in the group"

for "ninetieth day following the day on which such layoff, leave of absence or termination commenced" in subd. (1) and for "ninetieth day following the day on which death occurred" in subd. (2).

Library References

Insurance 467.5.  
C.J.S. Insurance § 893 et seq.

§ 38-375. Additional requirements for individual comprehensive health care plans. Carrier obligations concerning termination of coverage

An individual comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38-373, including the choice of the low option, middle option or high option deductible, and shall also conform in substance to the requirements of this section. Each individual comprehensive health care plan shall contain provisions:

(1) Which obligate the carrier to continue the contract until the earlier of (A) the date on which the individual in whose name the contract was issued first becomes eligible for coverage under Title XVIII of the Social Security Act or under a group comprehensive health care plan or,

(B) the plan anniversary date at least sixty days prior to which the carrier has mailed to the individual at his last address shown on the carrier's records written notice of its decision not to continue coverage on a class basis only.

The carrier may reserve the right to adjust premiums by classes in accordance with its experience for policies or contracts not written by or through the Health Reinsurance Association, provided such premium may not exceed the premium established for that particular class by the Health Reinsurance Association;

(2) which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within such period as shall be specified in the contract, to continue the same coverage until such time as he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived; and

(3) under which the benefits payable shall be excess to all other sources of health insurance benefits, including benefits provided pursuant to any state or federal law other than Medicaid. (1975, P.A. 75-016, § 5, eff. April 1, 1976.)

**Library References**

Insurance § 467.4.

C.J.S. Insurance § 893, 896.

**§ 38-376. Health Reinsurance Association. Classes of risk. Audits. Insurance commissioner's powers**

There is hereby created a nonprofit legal entity to be known as the Health Reinsurance Association. All insurers and self insurers doing business in the state, as a condition to their authority to transact the applicable kinds of health insurance defined in section 38-371, shall be members of the association. The association shall perform its functions under a plan of operation established and approved under subdivision (a), and shall exercise its powers through a board of directors established under this section.

(a)(1) The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the net health insurance premium derived from this state in the previous calendar year. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the monies of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

(2) The board shall submit to the commissioner, a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this act must be made available. The commissioner shall, after notice and hearing, approve the plan of operation provided such plan is determined to be suitable to assure the fair, reasonable and equitable administration of the association, and provides for the sharing of association gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or if at any time thereafter the board fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the commis-

sioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall, in addition to requirements enumerated in sections 38-371 to 38-381:

(A) Establish procedures for the handling and accounting of assets and monies of the association;

(B) establish regular times and places for meetings of the board of directors;

(C) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;

(D) establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner;

(E) establish procedures to amend, subject to the approval of the commissioner, the plan of operations;

(F) establish procedures for the selection of an administering carrier and set forth the powers and duties of the administering carrier;

(G) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(H) establish procedures for the advertisement on behalf of all participating carriers of the general availability of the comprehensive coverage under sections 38-371 to 38-381.

(b) The association shall have the general powers and authority granted under the laws of this state to carriers to transact the kinds of insurance defined under section 38-371, and in addition thereto, the specific authority to:

(1) Enter into contracts necessary or proper to carry out the provisions and purposes of sections 38-371 to 38-381;

(2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating members;

(3) take such legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association;

(4) establish, with respect to health insurance provided by or on behalf of the association, appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the operational expenses of the association;

(5) Administer any type of reinsurance program, for or on behalf of participating members;

(6) Pool risks among participating members;

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by sections 38-371 to 38-381 in its own name or on behalf of participating members;

(8) Administer separate pools, separate accounts or other plans as deemed appropriate for separate members or groups of members;

(9) Operate and administer any combination of plans, pools, reinsurance arrangements or other mechanisms as deemed appropriate to best accomplish the fair and equitable operation of the association;

(10) Set limits on the amounts of reinsurance which may be ceded to the association by its members; and

(11) Appoint from among participating members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(c) Every member shall participate in the association in accordance with the provisions of this subdivision.

(1) A participating member shall determine the particular risks it elects to have written by or through the association. A member shall designate which of the following classes of risks it shall underwrite in the state, from which classes of risk it may elect to reinsure selected risks:

(A) Individual, excluding group conversion;

(B) Individual, including group conversion; and

(C) groups of between three and twenty-five employees or members.

(2) No member or employer shall be permitted to select out individual lives from an employer group to be insured by or through the association. Members electing to administer risks which are insured by or through the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk insured by or through the association cannot be withdrawn by the participating member except in accordance with the rules established by the association.

(3) Rates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. Separate scales of premium rates based on age shall apply for individual risks and group risks. Group rates may be adjusted for area variations in provider costs but individual rates shall not be adjusted for area variations in provider costs. Premium rates shall take into consideration the substantial extra morbidity and administrative expenses for association risks, reimbursement or reasonable expenses incurred for the writing of association risks and the level of rates charged by insurers for groups of ten lives. In no event shall the rate for a given classification or group be less than one hundred twenty-five per cent nor more than one hundred fifty per cent of the average group rate charged for that classification or group with similar characteristics under a policy covering ten lives. All rates shall be promulgated by the association through an actuarial committee consisting of five persons who are members of the American Academy of Actuaries. They shall be filed with the commissioner and may be disapproved within sixty days from the filing thereof if excessive, inadequate, or unfairly discriminatory.

(d)(1) Following the close of each fiscal year, the administering carrier shall determine the net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses for the year. Any net loss shall be assessed to all participating members in proportion to their respective shares of the total health insurance premiums earned in this state during the calendar year, or with paid losses in the year, coinciding with or ending during the fiscal year of the association or on any other equitable basis as may be provided in the plan of operations. For self insured members of the association, health insurance premiums earned shall be established by dividing the amount of paid health losses for the applicable period by eighty-five per cent. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums.

(2) Any net loss to the association represented by the excess of its actual expenses of administering policies issued by the association over the applicable expense allowance shall be separately assessed to those participating members who do not elect to administer their plans. All assessments shall be on an equitable formula established by the board.

(3) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association and the association shall have an annual audit of its operations by an independent certified public accountant. The annual audit shall be filed with the commissioner for his review and the association shall be subject to the provisions of section 38-7.

(e) All policy forms issued by or through the association shall conform in substance to prototype forms developed by the association, shall in all

other respects conform to the requirements of this act, and shall be approved by the commissioner. The commissioner may disapprove any such form if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy.

(f) The association shall not issue nor reissue comprehensive health care plan coverage with respect to any person who is already covered under an individual or group comprehensive health care plan, or who is eligible for Medicare or who is not a resident of this state.

(g) Benefits payable under a comprehensive health care plan insured by or reinsured through the association shall be paid net of all other health insurance benefits paid or payable through any other source, and net of all health insurance coverages provided by or pursuant to any other state or federal law including Title XVIII of the Social Security Act, Medicare, but excluding Medicaid.

(h) There shall be no liability on the part of and no cause of action of any nature shall arise against any carrier or its agents or its employees, the Health Reinsurance Association or its agents or its employees or the residual market mechanism established under the provisions of section 38-377 or its agents or its employees, or the commissioner or his representatives for any action taken by them in the performance of their duties under sections 38-371 to 38-381. This provision shall not apply to the obligations of a carrier, a self-insurer, the Health Reinsurance Association or the residual market mechanism for payment of benefits provided under a comprehensive health care plan.

(1975, P.A. 75-616, § 6, eff. April 1, 1976.)

#### Library References

Insurance 467.4.  
C.J.S. Insurance §§ 893, 896.

### § 38-377. Hospital and medical service corporations. Residual market mechanism. Insurance commissioner's powers concerning such mechanisms

(a) Hospital and medical service corporations may elect to meet the obligations of section 38-372 by participating in the Health Reinsurance Association established in section 38-376, as a full member thereof, or by making comprehensive health care plans available directly through a subscriber contract or combination of contracts or by forming a separate residual market mechanism substantially similar to the association established in section 38-376.

(b) In the event that hospital and medical service corporations choose to form a separate residual market mechanism, the commissioner shall have the same regulatory powers over that residual market mechanism as he has over the Health Reinsurance Association, and such residual market mechanism shall have the same powers and duties as the association. Rating classifications under a residual market mechanism established under this section need not be the same as classifications established under the association, but any rates established by the residual market mechanism shall be approved by the commissioner. The commissioner shall promulgate regulations to carry out the requirements of this section.

(c) If the hospital and medical service corporations do not elect to participate in the Health Reinsurance Association, such hospital and medical service corporations shall be required to make an individual comprehensive health care plan available to every resident of this state who is not eligible for Medicare and whose coverage under a group or individual contract issued by such hospital or medical service corporation has terminated. Such coverage may be made available through a separate residual market mechanism established under this section.

(1975, P.A. 75-616, § 7, eff. April 1, 1976; 1976, P.A. 76-435, § 23, eff. June 9, 1976.)

1976 Amendment

Subsection (c): 1976, P.A. 76-495, § 29, substituted, in the first sentence, "or

individual" for "on" following "whose coverage under a group".

**§ 38-378. Insurance commissioner's powers concerning comprehensive health care plans. Notification to purchasers of policy or contract terms**

In order to provide reasonable simplification of terms and coverages of individual accident and sickness insurance policies and contracts, to facilitate public understanding and comparison, to eliminate provisions which may be misleading or unreasonably confusing in connection with either the purchase of such coverage or with the settlement of claims and to provide for full disclosure in the sale of such coverage:

(a) The commissioner shall issue regulations to establish specific standards for policy provisions used in individual health insurance policies or contracts, but not including group conversion policies or contracts, which shall be in addition to and in accordance with chapter 681 and other applicable laws of this state which may cover the terms of renewability, initial and subsequent conditions of eligibility, non-application of coverage provisions, coverage of dependents, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacements, recurrent conditions, pre-existing conditions, and the definition of the terms hospital, accident, sickness, injury, physician, accidental means, total disability, permanent disability, partial disability, nervous disorders, guaranteed renewable, and noncancelable.

(b) The commissioner shall adopt regulations, in accordance with chapter 54, that specify prohibited policy provisions not otherwise specifically authorized by statute which in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, any person insured under the policy, or any beneficiary.

(c) The commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits under each of the following categories of coverage in individual policies, other than conversion policies issued pursuant to a commercial conversion privilege under a group policy: basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage and specified accident coverage. Specified disease policies, riders and benefits shall be prohibited whether issued on a group or individual basis.

(d) Nothing in this section shall preclude the issuance of any policy which combines two or more of the categories of coverage enumerated in subsection (c), except that specified accident coverage shall not be combined with any other category of coverage. The commissioner shall prescribe the method of identification of policies based upon coverage provided.

(e) No policy shall be delivered or issued for delivery in this state which does not meet the prescribed minimum standards for the categories of coverage listed in subsection (c), provided nothing in this section shall preclude the issuance or delivery of any policy which does not meet such prescribed minimum standards of coverage so long as such policy is clearly identified as not meeting such prescribed standards.

(f) No such policy or contract shall be delivered in this state unless: (1) An outline of coverage described herein accompanies the policy or (2) the outline of coverage described in this section is delivered to the applicant at the time application is made and acknowledgement of receipt of certificate of delivery of such outline is provided the carrier with the application. In the event the policy or contract is issued on a basis other than that applied for, the outline of coverage properly describing the policy shall accompany the policy when it is delivered. The outline of coverage shall include:

(A) A statement identifying the applicable category or categories of coverage provided by the policy in accordance with this section; (B) a description of the principal benefits and coverage provided in the policy; (C) a statement of the exceptions, reductions and limitations contained in the policy or contract; (D) a statement of the renewal provisions including any reservation by the carrier of a right to change premiums; and (E) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(g) Notwithstanding the provisions of chapter 681, if a carrier elects to use a simplified application form, with or without any questions as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy shall cover loss developing after twelve months from any pre-existing condition not specifically excluded from coverage by the terms of the policy and, except as so provided, the policy shall not include wording that would permit a defense based upon pre-existing conditions.

(h) Regulations promulgated pursuant to this section shall specify an effective date applicable to policy and benefit riders delivered or issued for delivery in this state on and after such effective date which shall not be less than one hundred eighty days after the date of adoption or promulgation. (1975, P.A. 75-616, § 8, eff. April 1, 1976; 1976, P.A. 76-309, § 4, eff. June 9, 1976.)

1976 Amendment

Subsection (c): 1976, P.A. 76-399, § 4, amended the second sentence by inserting "Specified disease policies", and by adding "whether issued on a group or individual basis" at the end. ing "riders and benefits" following

**§ 38-379. Application to new or renewed group health policies and contracts. Other regulations**

(a) In order to assure reasonable continuation of coverage and extension of benefits to the citizens of this state, all group health policies or contracts delivered or issued for delivery or renewal in this state on or after April 1, 1976 shall, subject to the provisions of subsection (e), contain those provisions described in subsections (b) and (d) of section 38-374.

(b) The commissioner shall, within one hundred eighty days after April 1, 1976, adopt regulations in accordance with the provisions of chapter 54, covering group coverage discontinuance and replacement.

(c) Nothing in this section shall alter or impair existing group policies or contracts which have been established pursuant to an agreement which resulted from collective bargaining, and the provisions required by this section shall become effective upon the next regular renewal and completion of such collective bargaining agreement. (1975, P.A. 75-616, § 9, eff. April 1, 1976.)

**§ 38-380. Commission on hospitals and health care**

In addition to the powers and duties already granted to it by law, the commission on hospitals and health care shall, within one year of April 1, 1976, adopt regulations designed to allow state professional standard review organizations established under U.S. Public Law 92-603 to extend their review of certain inpatient services to services received by all patients. Such regulations shall be adopted in accordance with the provisions of chapter 54. (1975, P.A. 75-616, § 10, eff. April 1, 1976; 1977, P.A. 77-118.)

Section 4-166 of reg.

1977 Amendment

1977, P.A. 77-118 substituted "allow" for "require" following "adopt regulations designed to", and substituted the

reference to U.S. Public Law "92-603" for "92-403".

§ 38-381. Commissioner of income maintenance. Contract authority concerning medicaid programs

The commissioner of income maintenance may enter into contractual agreements with any carrier or with the Health Reinsurance Association or a residual market mechanism to obtain appropriate administrative services, insurance benefits or any other insurance related services in connection with the state's medicaid program. All terms and provisions of any such contracts shall be mutually acceptable to the parties involved.

(1975, P.A. 75-616, § 11, eff. April 1, 1976; 1977, P.A. 77-614, §§ 521, 608, eff. Jan. 1, 1979; 1977, P.A. 77-614, § 587, eff. June 2, 1977; 1978, P.A. 78-303, § 85, eff. June 6, 1978.)

1977 Amendments

1977, P.A. 77-614, § 608, eff. Jan. 1, 1979, provided for change of term from "welfare commissioner" to "commissioner of income maintenance".

1977, P.A. 77-614, § 587, eff. June 2, 1977, as amended by 1978, P.A. 78-303, §

85, eff. June 6, 1978, authorized technical, grammatical, and punctuation changes with reference to 1977, P.A. 77-614 and the public acts of 1977 and 1978. For text of these provisions, see notes under § 2-56.

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CONSULT GENERAL INDEX POCKET PART

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