

4685.1955 SUPPLEMENTAL BENEFITS.

Subpart 1. **Definitions.** The terms used in this part have the meanings given them.

A. "Supplemental benefit" means an addition to the comprehensive health maintenance services required to be offered under a health maintenance contract which provides coverage for nonemergency, self-referred medical services which is either a comprehensive supplemental benefit or a limited supplemental benefit according to items B and C.

B. "Comprehensive supplemental benefit" means supplemental benefits for at least 80 percent of the usual and customary charges for all covered supplemental benefits, except emergency care, required for a qualified plan as provided by Minnesota Statutes, section 62E.06, or a qualified Medicare supplement plan as provided by Minnesota Statutes, section 62E.07, if it were offered as a separate health insurance policy.

C. "Limited supplemental benefit" means any supplemental benefit which provides coverage at a lower level of benefits than a comprehensive supplemental benefit as described under item B. A limited supplemental benefit may be for a single service or any combination of services.

Subp. 2. **General requirements on provisions of coverage.**

A. Every contract or evidence of coverage for supplemental benefits must clearly state that supplemental benefits are not used to fulfill comprehensive health maintenance services requirements as defined under part 4685.0700.

B. In any supplemental benefit providing coverage for a medical service, reimbursement for that service must include treatments by all credentialed practitioners providing that service within the lawful scope of their practice, unless the certificate of coverage specifically states the practitioners whose services are not covered. Practitioners described in item C cannot be excluded from coverage. For the purposes of this part, "credentialed practitioners" means any practitioner licensed or registered according to Minnesota Statutes, chapter 214.

C. In any supplemental benefit providing reimbursement for any service which is in the lawful scope of practice of a duly licensed osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of Minnesota Statutes, section 62A.15, subdivision 3a, the person entitled to benefits is entitled to access to that service on an equal basis, whether the service is performed by a physician, osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of Minnesota Statutes, section 62A.15, subdivision 3a, licensed under the laws of Minnesota.

D. A health maintenance organization may not deny supplemental benefit coverage of a service which the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have

been covered under the member's supplemental benefits contract by the health maintenance organization had prior authorization or second opinion been obtained.

A health maintenance organization may, however, impose a reasonable assessment on coverage for lack of prior authorization or second opinion for supplemental benefit services. The assessment cannot exceed 20 percent of the usual and customary charges for the service received.

Subp. 3. **Disclosure of comprehensive supplemental benefits.** Every contract or evidence of coverage for comprehensive supplemental benefits must include a detailed explanation of the services available, including:

A. that coverage is available for all benefits provided by the health maintenance organization's health maintenance services, except emergency services;

B. the level of coverage available under the supplemental benefits, including any limitations on benefits;

C. all applicable copayments, deductibles, or maximum lifetime benefits;

D. the procedure for any required preauthorization, including any applicable assessment for failure to obtain preauthorization; and

E. the procedure for filing claims under the supplemental benefits, which must comply with Minnesota Statutes, section 72A.201.

Subp. 4. **Disclosure of limited supplemental benefits.** Every contract or evidence of coverage for limited supplemental benefits must include a detailed explanation of the services available including:

A. A listing of all benefits available through the limited supplemental benefits.

B. A listing of any excluded general grouping of services as listed in Minnesota Statutes, section 62D.02, subdivision 7. Those groupings include preventive health services, outpatient health services, and inpatient hospital and physician services. Emergency care is not permitted as a supplemental benefit.

If less than all of the services in a grouping are covered, specific exclusions within that grouping must be clearly stated.

C. The level of coverage available for each benefit.

D. All applicable copayments, deductibles, or maximum lifetime benefits.

E. The procedure for any required preauthorization, including any applicable assessment for failure to obtain preauthorization.

F. The procedure for filing claims under the limited supplemental benefits, which must comply with Minnesota Statutes, section 72A.201.

Subp. 5. **Consumer information.** All supplemental benefits evidences of coverage and contracts must contain a clear and complete statement of enrollees' rights as consumers. The statement must be in bold print and captioned "Important Consumer Information For Supplemental Benefits" and must include the provisions given in this subpart for either comprehensive or limited supplemental benefits, as appropriate.

If the supplemental benefit is presented as a separate section of a contract or evidence of coverage for comprehensive health maintenance services, the supplemental benefit section must begin with the consumer information statement described in this subpart.

If the supplemental benefit is presented as an integrated part of the comprehensive health maintenance services contract or evidence of coverage, the consumer information statement must appear directly after the "Enrollee Bill Of Rights" and "Consumer Information" sections at the beginning of the contract or evidence of coverage. When the supplemental benefits are integrated into the contract or evidence of coverage, the differences between the supplemental benefit and the comprehensive health maintenance services must be clearly set out in the contract or evidence of coverage.

The statement of consumer information must be in the language of item A or B, as appropriate, or in substantially similar language (to accommodate changes based on a prior authorization requirement, for example) approved in advance by the commissioner:

A. CONSUMER INFORMATION FOR COMPREHENSIVE SUPPLEMENTAL BENEFITS

(1) **COVERED SERVICES:** The comprehensive supplemental benefit of (name of health maintenance organization) covers similar services as the comprehensive health maintenance services, but at a different level of coverage. Copayments, deductibles, and maximum lifetime benefit restrictions may apply. Your contract describes the procedures for receiving coverage through the comprehensive supplemental benefit.

(2) **PROVIDERS:** To receive services through the comprehensive supplemental benefit, you may go to providers of covered services who are not on the provider list supplied by (name of health maintenance organization) and for whom you did not get a referral.

(3) **REFERRALS:** A referral from (name of health maintenance organization) for services covered by the comprehensive supplemental benefit is not required to receive coverage. However, if a referral is requested from (name of health maintenance organization) you may be eligible for the same services, from the same provider at a lower cost to you, as a benefit under your comprehensive health maintenance services. See section (section number) of the evidence of coverage for specific referral details.

(4) **PRIOR AUTHORIZATION:** You are not required to get prior authorization from (name of health maintenance organization) before using supplemental benefits. However, there may be a reduction in the level of benefits available to you if you do not get prior authorization. See section (section number) of your comprehensive supplemental benefit agreement for specific information about prior authorization.

(5) **EXCLUSIONS:** Coverage of supplemental benefits is limited to those services specified in your evidence of coverage. Section (specify number) lists related services which are excluded from coverage and clarifies any limitations imposed on coverage of the services.

(6) **CONTINUATION:** Your comprehensive health maintenance services contract provides for continuation and conversion rights under certain circumstances. If you continue your coverage as an individual under your group contract, the comprehensive supplemental benefits will also continue. If you convert to an individual plan, supplemental benefits may not be available. Your continuation and conversion rights to supplemental benefits are explained fully in your comprehensive supplemental benefits agreement.

(7) **DISCONTINUATION:** Your comprehensive supplemental benefits are an addition to your comprehensive health maintenance coverage. Changes in your contract may result in the discontinuation of one or more of your supplemental benefits. Please read all amendments to your contract carefully.

B. CONSUMER INFORMATION FOR LIMITED SUPPLEMENTAL BENEFITS

(1) **COVERED SERVICES:** The limited supplemental benefit of (name of health maintenance organization) covers selected services, at varying levels of coverage. It does not provide coverage from nonparticipating providers for all services which are covered under a qualified health insurance plan under Minnesota law. Copayments, deductibles, and maximum lifetime benefit restrictions may apply. Your certificate of coverage lists the services available and describes the procedures for receiving coverage through the limited supplemental benefit.

(2) **PROVIDERS:** To receive benefits through the limited supplemental benefit, you may go to providers of covered services who are not on the provider list supplied by (name of health maintenance organization) and for whom you did not get a referral.

(3) **REFERRALS:** A referral from (name of health maintenance organization) for services covered by the limited supplemental benefit is not required to receive coverage. However, if a referral is requested from (name of health maintenance organization) you may be eligible for the same services, from the same provider at a lower cost to you, as a benefit under your comprehensive health maintenance services. See section (section number) of the evidence of coverage for specific referral details.

(4) **PRIOR AUTHORIZATION:** You are not required to get prior authorization from (name of health maintenance organization) before using supplemental benefits. However, there may be a reduction in the level of benefits available to you if you do not get prior authorization. See section (section number) of your limited supplemental benefit agreement for specific information about prior authorization.

(5) **EXCLUSIONS:** Services are not covered by the limited supplemental benefit unless they are listed in the supplemental benefits provisions. Section (specify number) lists related services which are excluded from coverage and clarifies any limitations imposed on coverage of such services.

(6) **CONTINUATION:** Your comprehensive health maintenance services contract provides for continuation and conversion rights under certain circumstances. If you continue your coverage as an individual under your group contract, the limited supplemental benefits will also continue. If you convert to an individual plan, supplemental benefits may not be available. Your continuation and conversion rights to supplemental benefits are explained fully in your limited supplemental benefits agreement.

(7) **DISCONTINUATION:** Your limited supplemental benefits are an addition to your comprehensive health maintenance coverage. Changes in your contract may result in the discontinuation of one or more of your supplemental benefits. Please read all amendments to your contract carefully.

Subp. 6. **Out-of-pocket expenditures.** The out-of-pocket expenses associated with supplemental benefits, including any deductibles, copayments, or assessments shall be included in the total out-of-pocket expenses for the entire package of benefits provided. The total out-of-pocket expenses for a plan, including those associated with supplemental benefits, may not exceed the maximum out-of-pocket expenses allowable for a number three qualified insurance plan as provided by Minnesota Statutes, section 62E.06.

A plan may designate what portion of the maximum out-of-pocket benefits may be used in relation to supplemental benefits, with the remaining amount applicable only to comprehensive health maintenance services. For example, if the maximum out-of-pocket expenses is \$3,000, the health maintenance organization may designate in its contract that the maximum out-of-pocket expenses for supplemental benefits is \$1,000 and the maximum for comprehensive health maintenance services is \$2,000. Every contract and evidence of coverage must include a clear statement describing the maximum out-of-pocket expense limitations and, if applicable, how the maximum expenses are allocated between comprehensive health maintenance services and supplemental benefits. The contract must also include a statement explaining that enrollees must keep track of their own out-of-pocket expenses, provided however, that enrollees may contact the health maintenance organization member services department for assistance in determining the amount paid by the enrollee for specific services received.

Subp. 7. **Annual reports.** A health maintenance organization which offers supplemental benefits shall include in its annual report the following schedules:

A. a schedule analyzing the previous year's estimation of incurred but not reported supplemental benefit claims; and

B. a schedule detailing claim development including historical data.

Subp. 8. **Estimation of incurred but not reported claims.** A health maintenance organization must estimate incurred but not reported supplemental benefit claim liabilities according to generally accepted actuarial methods.

Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but not reported supplemental benefit claims. All such reserves for prior years shall be tested for adequacy and reasonableness by reviewing the health maintenance organization's claim runoff schedules in accordance with generally accepted accounting principles and reported annually in the schedule required under subpart 7, item A.

Subp. 9. **Accrued supplemental benefit claims.** NAIC BLANK FOR HEALTH MAINTENANCE ORGANIZATIONS, REPORT #1-B: Report#1-B: BALANCE SHEET LIABILITIES AND NET WORTH is amended by adding a line for Accrued Supplemental Benefit Claims, and requiring a separate schedule of such claims detailing direct claims adjusted or in the process of adjustment plus incurred but not reported claims.

Statutory Authority: *MS s 62D.05; 62D.20*

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