Department of Commerce

Adopted Rules Relating to the Comprehensive Health Insurance Association

Rules as Adopted

2740.0100 DEFINITIONS.

Subpart 1. to 12. [Unchanged.]

Subp. 13. **Covered expenses.** "Covered expenses" means the usual and customary charges for the services and articles listed in Minnesota Statutes, section 62E.06, or, with respect to qualified plans, the actuarial equivalence thereof, when prescribed for a covered person by a physician and when the expenses are incurred during a period in which the policy or contract is in effect.

Subp. 14. to 28. [Unchanged.]

Subp. 29. **Licensed and tested insurance agent or insurance agent.** "Licensed and tested insurance agent" or "insurance agent" means an insurance agent as defined in Minnesota Statutes, section 60A.02, subdivision 7, and licensed as such by the commissioner.

Subp. 30. and 31. [Unchanged.]

Subp. 32. **Net gains.** "Net gains" means the excess of premiums or contract charges over claims expenses, after the writing carrier's expenses and agent referral fees, not to exceed 15 percent of premiums or contract charges, have been paid as provided in part 2740.4400, subpart 4.

Subp. 33. to 44. [Unchanged.]

Subp. 44a. **Qualified medicare supplement plan.** "Qualified medicare supplement plan" means a plan of health coverage meeting the requirements of Minnesota Statutes, sections 62A.31, 62A.32, 62E.02, subdivision 5, and 62E.07.

Subp. 45. to 52. [Unchanged.]

Subp. 53. **Rejection.** "Rejection," for the purpose of state plan eligibility, means refusal by any association member, or any authorized representative, including any insurance agent,

APPROVED BY THE REVISOR OF STATUTES

acting on behalf of any association member, to issue a qualified plan or a qualified medicare supplement plan to a person who completes an application for coverage under such qualified plan, or a qualified medicare supplement plan, as determined by the board.

Subp. 54. to 56. [Unchanged.]

Subp. 56a. **Self-insurer.** "Self-insurer" means an entity defined by Minnesota Statutes, section 62E.02, subdivision 21, which is a "governmental plan" as defined by United States Code, title 29, section 1002(32) or a "church plan" as defined by United States Code, title 29, section 1002(33)(A) or which is otherwise exempt from or outside of the scope of the provisions of the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001 to 1381, as amended.

Subp. 57. [Unchanged.]

Subp. 58. **Total cost of self-insurance.** "Total cost of self-insurance" includes any direct and indirect administrative expenses incurred that are related to the operation of a plan of self-insurance, plus the sum of any payment made to or on behalf of Minnesota residents for costs or charges for health benefits by a self-insurer under a plan of health coverage, which is not counted as premium by an insurer, except to the extent of such payments made for coverage of the types described in Minnesota Statutes, section 62E.02, subdivision 11, clauses (1) to (8).

Subp. 59. [Unchanged.]

2740.1100 DUTIES OF EMPLOYERS.

Subpart 1. **Duty to make available a qualified plan.** An employer shall be deemed to have made available a qualified plan to its employees as required in Minnesota Statutes, section 62E.03, subdivision 1 when participation under a number 2 or number 3 qualified plan or a health maintenance plan is offered to the employee by a self-insurer or through an insurer or health maintenance organization, without regard to whether the cost of such participation is paid directly or indirectly by the employer or by the employee or by their joint payment.

Subp. 2. [Unchanged.]

Subp. 3. **Frequency of required offer.** Except as provided in subpart 2, an employer shall be deemed to have complied with the requirements of Minnesota Statutes, section 62E.03, subdivision 1 if the employer makes available to the employer's employees a plan of health coverage which is certified as a number 2 or number 3 qualified plan or a health maintenance plan at least once during each accounting period utilized by the employer for Minnesota income tax purposes.

2740.1200 DUTIES OF INSURERS AND FRATERNALS.

Subpart 1. [Unchanged.]

Subp. 2. **Timing of required offer of a qualified plan or qualified medicare supplement plan.** Timing of required offer of a qualified plan or qualified medicare supplement plan is as follows:

A. The offer of each type of qualified plan (that is, a number 1, number 2, and number 3 qualified plan) that is required when an insurer or fraternal is offering an individual policy of accident and health insurance shall occur no later than the date of delivery of such policy to the applicant.

B. to E. [Unchanged.]

Subp. 3. [Unchanged.]

Subp. 4. **Duty to offer major medical coverage.** Each insurer and fraternal shall affirmatively offer, subject to its underwriting standards, coverage of major medical expenses to every applicant for a new unqualified policy at the time of application and annually thereafter to every holder of an unqualified policy of accident and health insurance renewed by the insurer or fraternal as required by Minnesota Statutes, section 62E.04, subdivision 4. "Affirmatively offer" shall mean written advice to the applicant for, or the holder of, an unqualified policy of accident and health insurance, of the availability of coverage for major medical expenses. Such written advice of the availability of the coverage for major medical expenses may be satisfied by a contractual provision in the unqualified policy that gives the insured the contractual right to apply to the insurer or fraternal for a new policy or a

rider on an existing unqualified policy that provides coverage for 80 percent of the covered expenses for services listed in Minnesota Statutes, section 62E.06, subdivision 1 or the actuarial equivalence thereof subject to a $5,000 deductible for out-of-pocket expenses, subject to the insurer's or fraternal's underwriting requirements.

Subp. 5. and 6. [Unchanged.]

Subp. 7. **Exceptions to duties for certain policies and contracts.** Exceptions to duties for certain policies and contracts are as follows:

A. [Unchanged.]

B. The issuance or renewal by an insurer or fraternal on or after June 3, 1977, of a policy or contract that is designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis, shall not be subject to Minnesota Statutes, section 62E.04, except for policies and contracts sold by an insurer to provide payments on a hospital indemnity basis if such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue.

Subp. 8. [Unchanged.]

2740.1600 TERMINATION OF COVERAGE; CONVERSION PRIVILEGES.

Subpart 1. and 2. [Unchanged.]

Subp. 3. **Due notice of cancellation or termination.** An insurer, health maintenance organization, or self-insurer shall be deemed to have provided "due notice of cancellation or termination" as required in Minnesota Statutes, section 62E.16 if the insurer, health maintenance organization, or self-insurer notifies in writing those employees at their respective addresses as provided to the insurer, health maintenance organization, or self-insurer by the employer pursuant to the terms of Minnesota Statutes, section 62E.16.

2740.2100 DEFINITIONS.

Subpart 1. **Accident and health insurance business.** "Accident and health insurance business" means the

issuance or renewal of any accident and health insurance policy as defined in Minnesota Statutes, section 62E.02, subdivision 11.

A. [Unchanged.]

B. Such business shall not include the issuance or renewal of policies or contracts providing coverage that is:

(1) to (8) [Unchanged.]

(9) limited to accident-only coverage issued by an insurance agent and that provides reasonable benefits in relation to the cost of covered services.

Subp. 2. and 3. [Unchanged.]

Subp. 4. **Self-insurance business.** "Self-insurance business" means the provision, directly or indirectly, of a plan of health coverage by a self-insurer. "Self-insurance business" does not include the direct provision of health care services to employees at no charge to them by an employer engaged in the business of providing health care services to the public, nor does it include provision of benefits that, if provided by an insurer doing accident and health insurance business, would be excluded under subpart 1, item B. "Directly or indirectly" for the purposes of parts 2740.2100 to 2740.5500 means that the self-insurer funds the plan of health coverage in any amount or collects any employee contributions which are used to pay for the plan of health coverage.

2740.2400 ASSESSMENTS.

Contributing members will be assessed for their proportionate share of the operating and administrative expenses of the association, incurred or estimated to be incurred, together with losses, if any, incurred by the association as a result of operation of the state plan. The total amount of operating and administrative expenses and losses:

A. [Unchanged.]

B. may, at the recommendation of the board, subject to the approval of the commissioner, consist of a reasonable estimate of the operating and administrative expenses of the association for the succeeding fiscal year, which amount shall be adjusted at the end of the succeeding fiscal year to the

amount of actual operating and administrative expenses, and contributing members shall be entitled to credit for any excess or shall be assessed for any deficit in these expenses in future assessments.

2740.2500 LEVY OF ASSESSMENTS.

Subpart 1. **Annual.** The association shall make an annual determination of each contributing member's liability, if any, and may levy assessments following each fiscal year end. The fiscal year ends on December 31 unless the association establishes a different fiscal year end. Assessments are due and payable 30 days after receipt of a written assessment notice.

Subp. 2. **Interim.** The association may also, upon approval of the commissioner, levy interim assessments when deemed necessary to assure the financial capability of the association to meet the incurred or estimated operating and administrative expenses of the association and losses resulting from the state plan. Interim assessments shall be due and payable within 30 days of receipt by a contributing member of a written interim assessment notice.

Subp. 3. **Member share.** The association shall levy each contributing member's share of the total assessment based on the ratio of: the contributing member's total premium for accident and health insurance business as defined in part 2740.2100, subparts 1 and 2, received from or on behalf of residents of Minnesota, as determined by the commissioner; to the total premium for accident and health insurance business for all contributing members.

Subp. 4. **Costs and charges.** The costs and charges referred to in the ratio in subpart 3 shall, to the extent possible, be determined by reference to a form issued by the association or the commissioner which all contributing members shall submit to the commissioner annually for the preceding calendar year.

A. [Unchanged.]

B. The commissioner shall have the authority to audit the accounts and records of any contributing member for the

purpose of obtaining information necessary to levy an assessment.

Subp. 5. **Discretionary waiver.** The board may, in its discretion, decline to levy assessments against contributing members that owe $10 or less in a given year.

2740.2600 FAILURE TO PAY ASSESSMENTS.

Any contributing members that fail to pay annual or interim assessments when such assessments become payable will be reported by the association to the commissioner for appropriate action within the discretion of the commissioner.

2740.2900 DETERMINATION OF MEMBER'S VOTING RIGHTS.

Subpart 1. [Unchanged.]

Subp. 2. **Weighted vote.** A member's vote shall be a weighted vote based on the member's total cost of self-insurance, accident and health insurance premiums, subscriber contract charges, or health maintenance contract charges derived from or on behalf of residents of Minnesota in the previous calendar year, as determined by the commissioner. To the extent possible, this figure shall be determined by reference to the annual reporting form submitted by contributing members to the commissioner in accordance with part 2740.2500, subpart 4, and similar forms showing all other members' total accident and health insurance premiums, subscriber contract charges (defined as charges for business specified in part 2740.2100, subparts 1 and 2) received from or on behalf of residents of Minnesota, or total cost of self-insurance, as defined in part 2740.0100, subpart 58, as determined by the commissioner.

If the necessary information is not available to the commissioner on the form described in this subpart at the time that voting rights must be determined, the commissioner may estimate the member's weighted vote based on other information available to the commissioner.

Subp. 3. **Voting procedures.** Members are entitled to vote in person, by proxy, or by mail as determined by the board.

When a member elects to vote in person at a members'

meeting, the representative casting the vote shall present credentials as required pursuant to the bylaws or operating rules of the association.

When a member elects to vote by proxy, the proxy statement as approved by the board shall be returned on or before the date indicated in the meeting notice sent to the members.

Voting by mail may be permitted as authorized by the bylaws or operating rules of the association, and the meeting notice to members shall so indicate.

2740.3100 MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLANS.

Subpart 1. [Unchanged.]

Subp. 2. **Benefits of number 1 and number 2 qualified plan.** Benefits shall meet or exceed the requirements of Minnesota Statutes, section 62E.06 or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables in parts 2740.9905 to 2740.9986, except where substitution of an actuarially equivalent benefit is not permissible under the act.

A. [Unchanged.]

B. Coverage shall include an annual (calendar year) limitation of not more than $3,000 per covered person on total out-of-pocket expenses, which out-of-pocket expenses shall include the deductible under the state plan policy or contract, and which out-of-pocket expense limitation is not subject to substitution of an actuarially equivalent benefit.

C. Coverage shall be subject to a maximum lifetime benefit of not less than $250,000 per covered person, less any amount paid to or on behalf of the covered person under any other qualified plan of the state plan. This benefit is not subject to substitution of an actuarially equivalent benefit.

Subp. 3. **Benefits of qualified medicare supplement plan.** Benefits of a qualified medicare supplement plan shall meet or exceed the following minimum standards.

A. The plan shall provide benefits to covered persons by supplementing medicare through provision of:

(1) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare to at least 50 percent of the deductible and copayment required under medicare for the first 60 days of any medicare benefit period;

(2) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period;

(3) coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days to the extent not covered by medicare;

(4) upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of at least 50 <u>100</u> percent of the medicare calendar year part B deductible.

B. The plan shall provide 80 percent of the covered charges for expenses as provided in Minnesota Statutes, section 62E.06, which charges are not paid or payable under medicare or would not have been paid or payable had the covered person who is or was entitled or eligible to enroll in medicare been so enrolled or which charges are not paid or payable under item A.

C. Coverage shall include an annual limitation of $1,000 total out-of-pocket expenses per covered person for covered charges, provided that an annual deductible of not more than $200 is permissible for those covered charges not paid or payable under medicare or otherwise included in item A or B.

D. Coverage shall be subject to a maximum lifetime benefit of not less than $100,000 per covered person, less any amount paid to or on behalf of the covered person under any other qualified medicare supplement plan of the state plan.

E. The minimum coverage of a qualified medicare

supplement plan required by this subpart is not subject to substitution of actuarially equivalent benefits.

Subp. 4. and 5. [Unchanged.]

2740.3600 ENROLLMENT.

Subp. 1. [Unchanged.]

Subp. 2. **Eligible person.** "Eligible person," as used in subpart 1, means a resident of Minnesota who submits or on whose behalf is submitted a complete certificate of eligibility and enrollment form to the association or its writing carrier and who is not already covered by another state plan policy or contract.

A. A complete certificate of eligibility and enrollment form may provide:

(1) name, address, age, and length of time as a resident of Minnesota;

(2) [Unchanged.]

(3) evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, by one association member, or by an authorized representative, including an insurance agent, acting on behalf of an association member, within six months of the date of application. "Substantially reduce coverage from that received by a person who is considered a standard risk" includes any restriction on coverage as a result of an illness, condition, or risk which the association deems substantial, any increase in rates for an applicant based on an illness, condition, or risk, which the association deems substantial, and any preexisting conditions limitation which the association deems substantial.

B. In lieu of evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, as required by item A, subitem (3), a complete certificate of eligibility and enrollment form may provide evidence which

meets the requirements of an operating rule adopted by the association of a proposed covered person having been treated within three years of the date of the certificate of eligibility and enrollment form for one or more conditions listed in the operating rule.

C. Before a person is determined to be an eligible person, the board may require that any items listed in items A and B or, if acting pursuant to provisions of the association's operating rules, other necessary information be submitted to the association or its writing carrier and may also investigate the authenticity of information submitted as a part of the certificate of eligiblity.

D. If a covered person, under a qualified plan of the state plan, upon reaching age 65, or becoming enrolled in medicare, wishes to purchase a state plan qualified medicare supplement plan, the requirement that the person obtain one rejection, restrictive rider, rate-up, or preexisting conditions limitation on a qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, from one member of the association, or from an authorized representative, including an insurance agent acting on behalf of an association member, within the preceding six months may be waived by the board if acting pursuant to provisions of the association's operating rules.

E. A person who is age 65 or older shall be eligible for coverage only under the state plan's qualified medicare supplement plan and when an insured person under a qualified plan reaches age 65, the board may, if acting pursuant to provisions of the association's operating rules, terminate or refuse to renew coverage under the qualified plan. A person under age 65 who is otherwise eligible for coverage under the state plan and is enrolled in medicare shall be permitted to purchase a qualified plan 1 or 2 or the qualified medicare supplement plan of the state plan.

F. An applicant or any person proposed to be covered

under a qualified plan of the state plan who has previously been covered under one or more qualified plans of the state plan and who has exhausted the $250,000 maximum lifetime benefit shall not be an eligible person for coverage under a qualified plan of the state plan; an applicant or any person proposed to be covered under a qualified medicare supplement plan of the state plan who has previously been covered under one or more qualified medicare supplement plans of the state plan and who has exhausted the $100,000 maximum lifetime benefit shall not be an eligible person for coverage under a qualified medicare supplement plan of the state plan.

G. When a covered person under the state plan no longer meets one or more of the requirements for eligibility for coverage under the state plan, the board may, if acting pursuant to the association's operating rules, terminate or refuse to renew coverage under the state plan.

2740.3700 ASSOCIATION'S RESPONSE.

Subpart 1. **Time limitation.** Within 30 days of receipt of a complete certificate of eligibility and enrollment form pursuant to part 2740.3600, subpart 2, items A, B, and C, the association or the writing carrier shall accept the certificate of eligibility or shall reject the certificate of eligibility for failure to meet the eligibility requirements.

Subp. 2. **Acceptance.** If the association or its writing carrier accepts the certificate of eligibility, it shall forward a notice of acceptance, billing information, and a policy or contract or certificate that shall evidence coverage under the state plan.

A. [Unchanged.]

B. When the state plan premium is received by the association or its writing carrier for the first billing period and accepted in accordance with this part, the coverage shall be effective retroactive to the date of receipt by the association or its writing carrier of the completed certificate of eligibility pursuant to part 2740.3600, subpart 2, items A, B, and C unless otherwise requested by the insured person and

approved by the board.

Subp. 3. **Nonacceptance.** If the association does not accept the certificate of eligibility, the applicant shall be informed of the reason for the rejection and shall have the opportunity to submit additional information to substantiate eligibility for coverage under the state plan and to request reconsideration of the decision. The board may establish a review mechanism for reviewing requests for reconsideration of rejected certificates of eligibility. The association shall give notice of a final determination of ineligibility to the applicant stating the reasons therefor and advising the applicant of the right to appeal to the commissioner within a reasonable period of time.

2740.3900 DISSEMINATION OF INFORMATION CONCERNING STATE PLAN.

Subpart 1. **Plan.** The association shall develop a plan for use by the association, upon approval by the commissioner, to publicize the existence of the state plan and the eligibility requirements and procedures for enrollment, and to maintain public awareness of and participation in the state plan.

Subp. 2. **Forms and instructions.** The association shall prepare and make available certificate of eligibility forms and enrollment instruction forms to members, insurance agents and brokers, and to the general public in Minnesota.

Subp. 3. **Referral fee.** The association shall require the writing carrier to pay a referral fee of $50 for any certificate of eligibility accepted by the association or its writing carrier if the referring agent is licensed by the commissioner as an insurance agent and if the referring agent's signature appears as the agent on the accepted certificate of eligibility. The referral fee shall be paid from the premium received for the state plan. Referring agents shall not be authorized to interpret, amend, or alter the terms of the state plan policy or contract, nor shall referring agents be authorized to bind the association in any way. Referring agents shall not be agents of the association for any purpose, and the association shall not bear responsibility for acts of referring

agents.

2740.4400 OPERATIONS OF WRITING CARRIER.

Subpart 1. **Administrative and claims payment functions.** The writing carrier shall perform all administrative and claims payment functions relating to the state plan.

A. [Unchanged.]

B. The writing carrier shall perform all necessary functions to assure timely payment of benefits to covered persons under the state plan.

(1) to (3) [Unchanged.]

(4) The writing carrier shall exercise reasonable efforts to advise covered persons, within 60 business days of receipt of a properly completed and executed proof of loss, whether the submitted claim was accepted or rejected by the writing carrier, unless sooner settled.

(5) The writing carrier may establish an appeals procedure approved by the board to review claims that are denied in whole or in part. When a claim or any portion thereof is denied, the writing carrier shall inform the covered person of the existence of the procedure, including the right to appeal to the commissioner within a reasonable period of time.

Subp. 2. [Unchanged.]

Subp. 3. **Claims expenses.** The writing carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the state plan. If the writing carrier's payments for claims expenses exceed the portion of the state plan premiums allocated by the board for payment of claims expenses, the association shall provide to the writing carrier additional funds for payment of claims expenses. Not less than 85 percent of the state plan premium, as determined by the board, shall be used to pay claims expenses, and not more than 15 percent of the state plan premium shall be used to pay agent referral fees (authorized by Minnesota Statutes, section 62E.15, subdivision 3) and to pay the writing carrier's direct and indirect expenses, as defined and authorized in Minnesota Statutes, section 62E.13, subdivision 7 and described in subpart

5.

Subp. 4. **Direct and indirect expense reimbursement.** The writing carrier shall be paid from time to time as provided in the association's contract with the writing carrier for its direct and indirect expenses incurred in the performance of its services from the state plan premiums received in an amount not to exceed the lesser of:

A. 15 percent of the state plan premium, less agent referral fees payable under part 2740.3900, subpart 3;

B. and C. [Unchanged.]

Subp. 5. **Direct and indirect expenses.** Direct and indirect expenses shall include that portion of the writing carrier's actual administrative, printing, claims administration, management, building overhead expenses, and other actual operating and administrative expenses approved by the board as allocable to the administration of the state plan.

Subp. 6. and 7. [Unchanged.]

2740.5200 REINSURANCE PLAN.

Subpart 1. [Unchanged.]

Subp. 2. **Application and acceptance.** Insurer or fraternal members wishing to participate in the pool shall apply to the association for participation in the pool, specifying the categories of coverage that the member desires to reinsure.

Each member entering into a reinsurance pooling agreement for a particular category or categories of coverage shall offer to place in the pool all policies and contracts that it issues in the category or categories listed in part 2740.5100 that it wishes to reinsure.

Only policies and contracts acceptable to the association or its reinsurance administrator may be accepted for reinsurance. The association is under no obligation to accept any but standard risks in the reinsurance plan.

Subp. 3. to 5. [Unchanged.]

2740.9904 PURPOSE.

Minnesota Statutes, section 62E.02, defines "qualified

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

plans" as health benefit plans that provide the benefits required in Minnesota Statutes, section 62E.06 or "the actuarial equivalent of those benefits." Minnesota Statutes, section 62E.06 describes three qualified plans. These statutes require all plans of health coverage subject to Minnesota Statutes, section 62E.06 to be labeled as qualified or non-qualified. The commissioner may be requested to determine whether a plan is qualified and may take up to 90 days to make that determination. Minnesota Statutes, section 62E.02 defines a qualified medicare supplement plan as one which has been certified by the commissioner as providing the minimum benefits required by Minnesota Statutes, section 62E.07. Since the definition does not allow the option of an actuarial equivalent plan, the current rules do not include actuarial equivalent tables for medicare supplement policies.

2740.9909 COMPOSITE POINT VALUES FOR QUALIFIED PLAN NUMBER THREE.

The composite point values for a qualified plan number three for 1984 are as shown herein.

Composite Point Values for Minnesota Qualified Plan No. 3

Points	Benefit
363	Hospital room and board, unlimited days, semi-private.
480	Hospital extras (i.e., hospital services, hospital miscellaneous, hospital special services, or ancillary services) including anesthesia.
243	Surgery, including administration of anesthesia, assistant surgeon and oral surgery but no tooth repair or extractions.
215	Home and office physician care, unlimited.
51	Physician care in hospital, unlimited.
63	Obstetrics, unlimited.
110	Hospital maternity, unlimited.
105	X rays and laboratory tests, outpatient and out of hospital.
100	Prescription drugs and medicine, outpatient and out of hospital.
15	Radioactive therapy, outpatient and out of hospital.
16	Nursing or convalescent facility.
8	Home health agency care.
10	Physical therapy.
4	Oxygen.
5	Prostheses.
5	Durable medical equipment rental or purchase.
2	Second opinion surgery.
2	Private duty nursing.
3	Ambulance.
-12	Adjustment for major medical maximum.
1788	Total reasonable and customary medical services
-245	$150 deductible.

-309 20 percent coinsurance.

1234 Total after deductions for deductible and coinsurance

-49 Coordination of benefits.
-31 Nonduplication with no-fault.
30 3,000 annual "out-of-pocket" expense limit.
8 Well baby care.
0 Emergency accident.
0 Supplement accident.
0 Student dependents.

1192 Grand Total

2740.9914 DETERMINATION OF AVERAGE SEMI-PRIVATE HOSPITAL ROOM AND BOARD LEVEL OF SURGICAL CHARGES.

Subpart 1. ~~Why develop values annually.~~ ~~Many companies issue policies with scheduled benefits. Due to inflation the value of scheduled benefits declines each year in relation to reasonable and customary charges. It would be best if the test of actuarial equivalence would automatically adjust for inflation and thus would more accurately value these types of benefits.~~

~~Subp. 2.~~ **When values determined.** In December of each year, the commissioner will publish the following values:

A. the average semi-private hospital room and board (ASP value);

B. the value of surgical charges (SURG value);

C. the ratios of the average semi-private hospital room and board for the year to that in 1984 (ASP factor);

D. the ratio of the value of surgical charges for the year to that in 1984 (SURG factor); and

E. the composite ratio of medical care for the year to that in 1984 (COMP factor).

The commissioner may appoint a service agency to calculate these values on a consistent basis each year.

Subp. ~~3.~~ 2. **How values determined.** Values will be determined as follows:

A. The ASP value will be the weighted bed average of semi-private room and board charges for acute hospitals in Minnesota. The information will be derived from each hospital's latest room and board charge filed with the commissioner or the service agency. A semi-private room will be defined as a room

with two beds.

B. The SURG value will be the sum of the product of the average charge, filed with the commissioner or the service agency, for each of the surgical operations shown below times the factor shown for that operation. The surgical operations and their factors are shown in part 2740.9919.

C. The ASP factor will be the ASP value to be published for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

D. The SURG factor is the ratio of the SURG value for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

E. The COMP factor is the composite factor for medical care. This equals 54 percent times the ASP factor for the year plus 46 percent times the SURG factor for the year.

2740.9919 TABLE OF SURGICAL FACTORS TO DEVELOP SURG VALUE.

CPT4 Code	Surgical Factor	Description
SKIN		
10060	.7710	Abscess, incision, and drainage, simple
11400	2.0161	Benign lesion removal of (up to 0.5 cm.)
11750	.4368	Nail, permanent removal of
12011	1.9732	Simple wound, simple repair (up to 2.5 cm.)
17100	4.6520	Benign skin lesion, destruction of
MUSCULOSKELETAL		
20610	1.9226	Major joint or bursa, injection or aspiration of
27130	.1565	Total hip joint replacement, simple
29425	1.0286	Application walking cast
CARDIOVASCULAR		
33512	.1111	Coronary bypass, three arteries
93547	.2166	Left heart catheterization with coronary angiogram
DIGESTIVE SYSTEM		
43235	.4514	Gastroscopy, diagnostic
43844	.0569	Stomach bypass for morbid obesity
44950	.2618	Appendectomy
45300	2.7170	Proctosigmoidoscopy, diagnostic
47600	.3765	Gallbladder, removal of
49505	.3086	Inquinal hernia repair, unilateral
URINARY SYSTEM		
52601	.1579	Prostate resection (TUR), complete
53670	3.5273	Urinary bladder catheterization
MALE GENITAL		
54150	.8509	Circumcision by clamp, newborn
FEMALE GENITAL		
58120	.8470	Uterus, dilation and curettage (D & C),

		nonobstetrical
58150	.4792	Uterus, removal of
58980	.9455	Laparoscopy, diagnostic
NERVOUS SYSTEM		
63030	.0694	Laminotomy herniated disc, lumbar
64721	.1988	Carpal tunnel symdrome repair
EYE		
66980	.2003	Cataract removal, intraocular lens insertion
EAR		
69437	.3934	Tympanostomy with ventilating tube insertion

2740.9924 HOW TO USE THE LIST.

Subpart 1. **Basic and comprehensive major medical plans.** The list is used in the following manner:

A. Determine the ASP value, SURG value, ASP factor, SURG factor, and COMP factor for the calendar year. This is published annually by the commissioner.

B. List the plan benefits, ignoring deductibles, coinsurance, well baby care, emergency accident, supplemental accident, and student dependents. Include the plan maximum in the plan benefits.

C. For each benefit, find the appropriate table of equivalent points for basic and major medical plans.

D. Extract the appropriate point value for the benefit from the table, interpolating as necessary or indicated, and place it opposite the listed benefit. Ignore benefits for which no table exists.

E. Total the points for these benefits.

F. List deductible and coinsurance if the plan is a comprehensive major medical plan.

G. Determine the appropriate point values for deductible, interpolating as necessary, and place the value in the list of points. Calculate the coinsurance points and place the values in the list of points.

H. Determine the total points after the deduction for deductible and coinsurance.

I. Determine the deduction for coordination and nonduplication of benefits.

J. Determine the number of points for the limit on "out-of-pocket" expenses, well baby care, emergency accident,

supplemental accident, and student dependents.

K. Calculate the grand total.

L. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

Subp. 2. **Superimposed major medical plans.** The following govern superimposed major medical plans:

A. Follow steps outlined in subpart 1, items A to D for basic health plan benefits.

B. Total the points for the basic plan.

C. Utilize part 2740.9964, subparts 23, 24, and 25 to determine the point value of a Minnesota qualified plan superimposed over the basic plan with the deductible and benefit period of the plan at hand, interpolating as necessary. Put the points in the point column.

D. Compare the benefits in the superimposed major medical plan with the benefit structure of a Minnesota qualified plan:

(1) $250,000 lifetime maximum.

(2) 80/20 coinsurance.

(3) $3,000 annual per person out-of-pocket maximum.

(4) Eligible expenses are usual and customary expenses for:

(a) hospital services;

(b) physician care;

(c) prescription drugs;

(d) nursing home care of up to 120 days in one year, commencing within 14 days of hospitalization of at least three days;

(e) home health care;

(f) radium and radioactive therapy;

(g) oxygen;

(h) anesthetics;

(i) prostheses;

(j) rental or purchase of durable medical equipment;

(k) diagnostic x rays and laboratory tests;

(l) oral surgery on impacted teeth, on tooth roots, or on gums and tissues of the mouth when not performed in connection with tooth extraction;

(m) physical therapy;

(n) maternity same as any illness;

(o) Minnesota statutorily-mandated benefits; and

(p) coordination of benefits.

E. Consult the tables for point adjustments (usually negative for Minnesota qualified plan benefits not in the superimposed major medical plan being tested). Put the adjustments in the point column.

F. Calculate the total by adding the points for the basic plan (item B), the superimposed major medical plan (item C), and the adjustments (item E).

G. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

2740.9929 BENEFIT VARIATIONS NOT COVERED BY TABLES.

Only those plan variations that are most common are recognized. For instance, comprehensive plan coinsurance was assumed normally not to exceed 20 percent. Therefore, no points are shown for 25 percent. However, points for such missing benefit variations can be extrapolated or estimated.

2740.9934 USE OF TABLES.

Subpart 1. **Certification of plans.** Any insurer, self-insurer, or policyholder may use the test for actuarial equivalence as a guide. To obtain certification of any plan of health benefits as qualified, it must be submitted to the commissioner.

Subp. 2. **Filing with commissioner.** The following ~~should~~ must be sent to the commissioner:

A. The plan document if an uninsured plan or the policy form if an insured plan.

B. A statement of the grand total from part 2740.9924.

C. A certification that the plan is qualified as either a plan 1, 2, or 3, or is nonqualified, by using the test of actuarial equivalence in part 2740.9949. The certification must be by a principal or officer, or by a member of the Academy of Actuaries.

D. If the plan is not a qualified plan by using the test of actuarial equivalence, and the insurer or self-insurer desires to have it certified as a qualified plan, a statement of the specific reasons for the desired qualification.

Subp. 3. Certification by commissioner. If the documents required by subpart 2 are filed and the plan is a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be deemed certified as filed. If the documents required by subpart 2 are filed and the plan is not a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be qualified ~~if, and when, the commissioner certifies it as a qualified plan~~ upon certification by the commissioner.

2740.9939 UPDATE OF TABLES.

Periodically, the tables may be revised as health care costs change. ~~The commissioner may revalue the actuarial equivalence of any plan or policy at any time deemed appropriate.~~ Also, as health care costs change, a plan may automatically lose or change its qualification. Annual revaluation of plans is required. When a plan is revalued and its qualification status changes, the filing procedures in part 2740.9934 will be followed.

2740.9944 MISUSE OF TABLES.

The tables of equivalent points are not intended for any other use, especially not for premium calculations. They represent a composite of data and were adjusted to be useable for testing actuarial equivalence. No other use is contemplated.

2740.9949 TEST FOR ACTUARIAL EQUIVALENCE FOR PLANS OTHER THAN MEDICARE SUPPLEMENT PLANS.

Subpart 1. Table for 1984.

If the Grand Total of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualified Plan No.
1192 + points	3
911 + points	2
767 + points	1
Less than 767 points	Nonqualified

Subp. 2. **Effect of inflation.** Each year the number of points required for each qualified plan will increase due to the effects of inflation on the benefits. Particular care ~~should~~ must be taken to revalue any policy form which contains scheduled benefits or other policy forms which have different deductible or coinsurance provisions.

2740.9954 WORKSHEET FOR OTHER THAN MEDICARE SUPPLEMENT PLANS.

Comprehensive Health Insurance

Test for Actuarial Equivalence

Other than Medicare Supplement Plans

Subparts of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board			
2.	Hospital extras			
3.	Surgery			
4.	Physician care-home, office			
5.	Physician care-hospital			
6.	Maternity			
7.	Diagnostic X-ray and lab			
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convales-cent facility			
11.	Home health care			
12.	Physical therapy			
12.	Oxygen			
12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty nursing			
12.	Ambulance			
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			
	Subtotal reasonable and customary			

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

	medical services	
16.	Deductible	
16.	Coinsurance	
	Subtotal net of deductible and coinsurance	
17.	Adjust (Comb. medical/dental deductible)	
18.	COB/No-Fault	
19.	Limit on "out-of-pocket" expenses	
20.	Well baby care	
21.	Emergency and supplemental accident	
22.	Student dependents	
23.-25.	Superimposed major medical	
	Grand Total	
	Combined Basic and Superimposed	XXX XXX

Equivalent to Minnesota qualified plan number___ nonqualified___
Date_____ By_____

2740.9959 LOCATION OF TABLES OF EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS.

Subparts of part 2740.9964	Other than Medicare Supplement Plans Name
1.	Hospital room and board
2.	Hospital extras
3.	Surgery
4.	Home and office physician care
5.	In-hospital physician care
6.	Maternity
7.	Diagnostic X-ray and laboratory
8.	Drugs and medicine
9.	Radioactive therapy
10.	Nursing or convalescent - home care
11.	Home health care agency service
12.	Physical therapy
12.	Oxygen
12.	Prostheses
12.	Durable medical equipment
12.	Second opinion surgery
12.	Private duty nursing
12.	Ambulance
13.	Hospital room and board in full
14.	All hospital charges in full
15.	Major medical maximums
16.	Coinsurance and deductibles
17.	Combined dental and health insurance deductible
18.	Coordination and nonduplication of benefits
19.	Limit on "out-of-pocket" expenses
20.	Well baby care
21.	Emergency and supplement accident
22.	Student dependents
23.	Superimposed major medical
24.	Superimposed major medical
25.	Superimposed major medical

2740.9964 EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS; NOT TO BE USED FOR MEDICARE SUPPLEMENT PLANS.

Subpart 1. **Hospital room and board.**

Maximum Days	Room & Board
31	327
70	347
120	351
365	359
Unlimited	363

A. Room and board is defined to include a semi-private room, or charges for a private room if prescribed as medically necessary by a physician. If the policy does not pay the additional charges for a private room, then deduct three points from hospital room and board.

B. If the policy pays the private room charge even though not medically necessary, then add ten points if average charge per day is four percent greater than the average semi-private room and board charge.

C. If the policy pays the hospital room and board charge up to a maximum daily benefit which is less than the average semi-private room and board charge in the area, then multiply the points for the semi-private room and board at the indicated maximum days by the ratio of the scheduled amount to the ASP value in the area for the year.

Subp. 2. **Hospital extras.** Hospital extras such as hospital services, special hospital services, ancillary services, and hospital therapeutics.

Maximum Amount*	Anesthesia** Included	Not Included
$ 500	130	130
1,000	217	216
2,000	317	312
5,000	413	401
10,000	454	433
15,000	469	444
Unlimited	480	451

*Before entering this table, divide the maximum amount in the policy by the ASP factor for the year.

**Anesthesia does not include the administration of anesthesia.

This is for miscellaneous hospital services and includes the cost for inpatient hospital care, the cost for outpatient hospital treatment and the excess cost of intensive care unit or

coronary care unit over the average semi-private room and board.

Subp. 3. **Surgery.**

Limit	Administration of Anesthesia Included	Not Included
Prevailing Fee with Assistant Surgeon	243	206
Prevailing Fee without Assistant Surgeon	244	187

If the policy pays the reasonable and customary charges up to a maximum in a schedule, then multiply the points for the prevailing fee by the ratio of the value of the schedule used in the policy to the SURG value for the year.

Subp. 4. **Home and office physician care.**

Annual Maximum*	First Visit Accident First Visit Sickness	Third Visit Sickness
$ 200	111	63
500	141	72
1,000	165	93
Unlimited	215	118

*Before entering this table, divide the annual maximum in the policy by SURG factor for the year.

Subp. 5. **In-hospital physician care.**

Maximum Number of Visits	Prevailing Fee
31	46
70	49
120	49
365	50
Unlimited	51

A. This benefit pays the reasonable and customary charge to the physician (other than the surgeon, assistant surgeon, or anesthetist) while confined in the hospital for medical or surgical reasons.

B. If the policy pays the greater of this benefit or the surgical benefit, then reduce these points by 30 percent.

C. A number of policies pay a limited amount per visit (limited to one visit per day) which is less than or equal to the cost for a routine follow-up visit in the hospital. If it is equal to the cost for a routine follow-up visit (assumed to be $24.20*/day in 1984), then deduct 14 points from the above points. If it is less than that, then use a proportional part

of the points determined as if the maximum was equal to the cost for a routine follow-up visit.

*Multiply the indicated value by the SURG factor for the year.

Subp. 6. **Maternity.**

A. complications only:

limited to some specified list	20
any complications	25

B. full maternity (including complications):

Maximum Limit*	Deductible	Flat Maternity	Obstetrics	Hospital Maternity
$ 300	None	-	23	28
600	None	49	44	55
1,000	None	81	59	80
2,000	None	149	-	-
Unlimited	None	173	63	110

*Before entering this table, divide maximum limit in the policy by the ASP factor for the year.

Subp. 7. **X rays and laboratory tests (out of hospital).**

Maximum*	Scheduled (Any Scheduled)	Unscheduled
$100	56	70
200	67	89
500	74	101
Unlimited	77	105

*Before entering this table, divide the maximum in the policy by the ASP factor for the year.

Subp. 8. **Prescription drugs and medicine (out of hospital).**

Deductible* Per Prescription	
$4.00	69
2.00	86
None	100

*Before entering this table, divide the deductible per prescription by the SURG factor for the year.

Subp. 9. **Radioactive therapy (out of hospital).**

Scheduled (Any Schedule)	10
Unscheduled	15

Subp. 10. **Nursing or convalescent home care (within 14 days of hospital confinement of at least three days).**

Maximum Days

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

120 or More	16
Less than 120	0

Subp. 11. **Home health care agency services.**

Maximum Visits/Year	
180 or More	8
Less than 180	0

Subp. 12. **Miscellaneous.**

A. physical therapy (out of hospital), 10;

B. oxygen (out of hospital), 4;

C. prostheses (out of hospital), 5;

D. durable medical equipment rental or purchase (out of hospital), 5;

E. second opinion surgery, 2;

F. private duty nursing (in hospital only), 2; and

G. ambulance, 3.

Subp. 13. **Hospital room and board in full to indicated limit (basic and comprehensive major medical plans).** Add these points to the points in subpart 1 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

	Plan Deductible*	Limit*			
Plan	On All Benefits	$1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0 - 300	58	60	66	79
Comprehensive	301 - 600	61	63	69	82
Comprehensive	601 - 900	66	68	74	87
Comprehensive	901 - 1200	74	76	82	95

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the policyholder pays 20 percent after the deductible. If the policyholder pays a different percentage, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that hospital room and board will be paid at 100 percent and that the deductible will not be applied to it. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining

deductible will not be applied but the coinsurance will be applied, to the hospital room and board benefits.

Subp. 14. **All hospital charges in full to indicated limit (basic and comprehensive major medical plans).** Add these points to the total points in subparts 1 and 2 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

Plan	Plan Deductible* On All Benefits	LIMIT* $1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0- 300	70	110	121	177
Comprehensive	301- 600	171	151	162	218
Comprehensive	601- 900	198	238	249	305
Comprehensive	901-1200	343	383	394	450

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is 1800. If the percentage being paid by the insured is not 20 percent, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that the hospital room and board and hospital services will be paid at 100 percent and that the deductible will not be applied to them. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining deductible will not be applied but the coinsurance will be applied, to either hospital room and board or hospital services benefits.

Subp. 15. **Major medical maximum (comprehensive and superimposed plans).**

Maximum*	Add (+) or Subtract (-)
$ 100,000	-27
250,000	-12
500,000	- 7
1,000,000	- 2

* Before entering the table, divide the maximum in the policy by

the COMP factor for the year.

The smallest maximum in a qualified plan is $250,000. The $100,000 maximum as provided ~~should~~ must be used in future years to help determine the reduction for a $250,000 plan.

Subp. 16. **Coinsurance and deductibles (comprehensive major medical plans).**

A. This table assumes that the point values for all medical services and supplies are approximately 1800 points before deduction for the maximum on total benefits. If the total points are significantly greater or smaller, then the point values must be adjusted.

Deductible*	Deducted Points
$ 0	0
50	85
100	170
150	245
200	310
500	622
1,000	820

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

B. To determine the deduction for the coinsurance, subtract the points deducted for the deductible from the total point value for the benefits and then multiply the result by the coinsurance percentage.

Subp. 17. **Combined dental and health insurance deductible (comprehensive major medical plans).**

Deductible*	Added Points
$ 50	75
100	60
150	43
200	38
500	35
1,000	15

* Before entering this table, divide the deductible in the policy by the COMP factor for the year.

Subp. 18. **Coordination and nonduplication of benefits (all plans).**

A. The following percentage of points after deduction for deductible and coinsurance ~~should~~ must be subtracted if the policy coordinates benefits with other plans and its pricing assumes that a number of insured will have other policies in

force.

(1) with other health plans, 4.0 percent;

(2) with no fault, 2.5 percent;

(3) with both subitems (1) and (2), 6.5 percent; and

(4) with neither, 0.

B. The percentage ~~should~~ must be applied to the total points after deduction for deductible and coinsurance.

Subp. 19. Limit on "out-of-pocket" expenses (maximum copayment and deductible per benefit year) -- comprehensive and superimposed major medical plans.

Maximum Claim When Out-of-Pocket is reached*	Points
$ 500	236
1,000	196
2,000	158
3,000	130
4,000	110
11,000	45
13,000	36
14,400	30

*Before entering this table, divide the maximum claim when out-of-pocket limit by the COMP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is about 1800. If the percentage of claims being paid by the insured is other than 20 percent, multiply the number of points above by the ratio of the coinsurance being paid by the insured to 20 percent.

B. The above table assumes that the amounts paid by the policyholder for deductible and coinsurance are included in determining the out-of-pocket limitation.

Subp. 20. Well baby care.

Deductible*	Points
$ 0	17
150	8
500	2
1,000	0

*Before entering this table, multiply the deductible in the

policy by the COMP factor for the year.

The above benefit assumes that the deductible and coinsurance are applied to the costs of the newborn.

Subp. 21. **Emergency and supplemental accident (basic plans only).**

Maximum*	Emergency	Supplemental
$ 50	10	--
100	15	20
300	--	30
500	--	35
1,000	--	40
Unlimited	20	--

*Before entering this table, divide the maximum in the policy by the SURG factor for the year.

Subp. 22. **Student dependents.**

Student Extension Beyond Age 19	
None	0
To age 21	2
To age 23	4
To age 25	5

Subp. 23. **Superimposed major medical plans--over basic health plans with less than 500 points.**

A. Calculate point value of a comprehensive major medical plan by using deductible* $200 greater than actual.

B. Add basic health plan points.

* Before entering the table, divide the deductible in the policy by the COMP factor for the year before adding $200. Do not make any further adjustments to the deductible.

Subp. 24. **Superimposed major medical plans--80/20 coinsurance--over basic health plans with 500-799 points.**

	Calendar Year Plan		~~Two~~ year benefit period plan	
Deductible*	Individual	2 x family	Individual	2 x family
a. Corridor				
$ 100	740	780	745	765
200	665	705	680	700
300	615	655	630	650
500	543	582	558	578
1,000	385	425	400	420
b. Integrated				
$1,000	615	635	650	670
2,000	515	525	535	545

Note: Points assume major medical contains Minnesota

qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

Subp. 25. **Superimposed major medical plans--80/20 coinsurance--over basic health plans with 800 or more points.**

	Add to Basic Plan Points			
	Calendar Year Plan		Two year benefit period plan	
Deductible*	Individual	2 x family	Individual	2 x family
a. Corridor				
$ 100	515	545	525	535
200	445	475	455	465
300	405	435	415	425
500	339	369	349	359
1,000	215	245	225	235
b. Integrated				
$1,000	505	525	530	550
2,000	405	415	420	430

Note: Points assume major medical contains Minnesota qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

2740.9979 BASIC BACKGROUND FOR EXAMPLES.

Subpart 1. **Inflation assumptions for 1985.** The examples which follow assume that the actuarial equivalence of a series of plans is being calculated for calendar year 1985. Inflation was assumed to be 15.5 percent and 8.0 percent for hospital related and all other services, respectively.

Subp. 2. **Values published by commissioner for 1985.**

ASP value for 1984	190*
ASP value for current year (1985*)	220*
SURG value for 1984	4,000.00
SURG value for current year (1985*)	4,320.00*
ASP factor for 1985*	1.155*
SURG factor for 1985*	1.080*
COMP factor for 1985*	1.121*

*Estimated. Please substitute the actual values.

Subp. 3. **Point values for qualified plans in 1985.** The following are the revised point values used to determine plans which are actuarially equivalent to qualified plans 1, 2, and 3

for 1985.

Qualified Plan Number	If plan has the indicated number of points then plan is actuarially equivalent to the qualified plan in: 1984	1985
3	1192 + points	1216 + points
2	911 + points	957 + points
1	767 + points	847 + points
Nonqualified	Less than 767	Less than 847

2740.9991 EXAMPLE I.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Surgery	Includes Assistant Surgeon and Administration of Anesthesia
Deductible:	$100
Coinsurance:	80/20
Maximum:	$250,000
Maternity:	Any complications
Student dependents:	To age 23
Limits on specified benefits	Outpatient mental limited to Minnesota
Required benefits	--
Excluded care	Home health care
Out-of-pocket limit	$3,000 per year
Coordination of benefits	Yes, but no COB for no-fault.

B. Answer (calculated January 1, 1985): test result is 1186 points. This plan is a Minnesota qualified plan number 2.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subparts of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Comprehensive
1.	Hospital room and board			363
2.	Hospital extras			480
3.	Surgery			243
4.	Physician care-home, office			215
5.	Physician care-hospital			51
6.	Maternity			25
7.	Diagnostic X-ray and lab			105
8.	Drugs and medicine			100
9.	Radioactive therapy			15
10.	Nursing/convalescent facility			16
11.	Home health care			0

12.	Physical therapy		10
12.	Oxygen		4
12.	Prostheses		5
12.	Durable medical equipment		5
12.	Second opinion surgery		2
12.	Private duty nursing		2
12.	Ambulance		3
13.	Hospital room and board in full		
14.	All hospital expenses in full		
15.	Major medical maximums		-12
	Subtotal reas. and cust. med. services		1632
16.	Deductible		-138
16.	Coinsurance		-299
	Subtotal net of ded. and coin.		1195
17.	Adjust (comb. medical/dental ded)		
18.	COB/No-fault		-48
19.	Limit on "out-of-pocket expenses"		35
20.	Well baby care		
21.	Emergency and supplemental accident		
22.	Student dependents		4
23.-25.	Superimposed major medical		
	Grand Total		1186
	Combined basic and superimposed	XXX	XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) The maximum in the policy ($250,000) divided by the COMP factor (1.121) is $223,015. This is 82.01 percent of the difference between the $100,000 and $250,000 maximums in part 2740.9964, subpart 15. The points would be minus 27 plus .8201 times 15 or -14.70 points.

(2) The deductible in the policy ($100) divided by the COMP factor (1.121) is 89.21. This is 78.41 percent of the difference between the $50 and $100 deductibles in part 2740.9964, subpart 16. Points deducted for the deductible would be 85 plus .7841 times 85 or 151.65. Since the total points in the policy before the deductible is significantly less than 1800, multiply 151.65 by (1632/1800). The result is 137.50.

(3) The out-of-pocket maximum is $3,000. The maximum claim when the out-of-pocket is reached is $14,600. This divided by the COMP factor (1.121) is 13,024. This is

10.29 percent of the difference between the $13,000 and $14,400 maximum claim when out-of-pocket is reached. The adjustment for the out-of-pocket limit is 36 minus .1029 times 6 or 35.38.

2740.9992 EXAMPLE II.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital:	$170 per day, 365 days; 80 percent of misc. extras, the cost of anesthesia is included. The policy does not pay for private room even if medically necessary.
Surgery:	$3,000 maximum surgical schedule. Add 15 percent for the administration of anesthesia.
In hospital physicians calls:	$25 per day - 365 day maximum
Maternity:	Any complications
X-ray and lab tests (out of hospital):	$500 maximum - unscheduled

B. Answer (calculated January 1, 1985): test result is 1004 points. This plan is a Minnesota qualified plan number two.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subpart of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board	275		
2.	Hospital extras (80 percent)	384		
3.	Surgery	189		
4.	Physician care - home, office			
5.	Physician care - hospital	33		
6.	Maternity	25		
7.	Diagnostic X-ray and lab	98		
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility			
11.	Home health care			
12.	Physical therapy			
12.	Oxygen			

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty nursing			
12.	Ambulance			
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			
	Subtotal reas. and cust. med. services			
16.	Deductible			
16.	Coinsurance			
	Subtotal net of ded. and coin.			
17.	Adjust (comb. medical/dental ded)			
18.	COB/No-fault			
19.	Limit on "out-of-pocket expenses"			
20.	Well baby care			
21.	Emergency and supplemental accident			
22.	Student dependents			
23.-25.	Superimposed major medical			
	Grand Total	1004		
	Combined basic and superimposed		XXX	XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) Policy does not pay extra for private room even if medically necessary. Deduct three points from the 359. Since the ASP value in 1985 is 220, the number of points will be 356 times the ratio of 170 to 220 or 275.09 points.

(2) The surgical table was evaluated as 3,680.02 points. The points not including administration of anesthesia is 206 times the ratio of 3680.02 to 4620.00 or 164.09 points. For administration of anesthesia, the points are 164 times .15 or 24.6 points.

(3) Since the maximum per diem cost of in-hospital physicians calls is less than the cost for routine follow-up (24.20 times 1.08 or 26.14), subtract 14 points from the number of points for prevailing fee with 365-day maximum. The result is 35 points. Multiply the 35 points by the ratio of $25 to 26.14 or 33.47 points.

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

(4) Since the ASP factor is 1.15, the $200 and $500 maximum shown in part 2740.9964, subpart 7 is now 230 and 575 respectively. Thus the $500 maximum is 78.26 percent of the way between the two maximums. Therefore the point value equals 89 plus .7826 times (101-89) or 98.39 points.

2740.9993 EXAMPLE III.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital:	$80 per day, 120 days, $2,000 extras.
Surgery:	$1,500 maximum surgical schedule, add ten percent for administration of anesthesia.
Coordination of benefits	Yes, does not include no-fault
Superimposed major medical:	
Deductible:	$200 corridor per calendar year
Coinsurance:	80/20
Maximum:	$250,000
Maternity:	Any complications
Student dependents:	No
Out-of-pocket limit:	$3,000
Excluded care:	Home health care and skilled nursing care
Limits on specified benefits:	
1. Room and board	$200 less basic benefits. Unlimited days
Coordination of benefits	Yes, does not include no-fault

B. Answer (calculated January 1, 1985): test result is 1147 points. This plan is a Minnesota qualified plan number two.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

Subpart of part 2740.9964	Benefit	Basic	Major medical Superimposed	Major medical Comprehensive
1.	Hospital room and board	128	-26	
2.	Hospital extras	290		
3.	Surgery	114		
4.	Physician care - home, office			
5.	Physician care - hospital			
6.	Maternity			
7.	Diagnostic X-ray and lab			

8.	Drugs and medicine				
9.	Radioactive therapy				
10.	Nursing/convalescent facility		-13		
11.	Home health care		-6		
12.	Physical therapy				
12.	Oxygen				
12.	Prostheses				
12.	Durable medical equipment				
12.	Second opinion surgery				
12.	Private duty nursing				
12.	Ambulance				
13.	Hospital room and board in full				
14.	All hospital expenses in full				
15.	Major medical maximums				
	Subtotal reas. and cust. med. serv.	532			
16.	Deductible				
16.	Coinsurance				
	Subtotal net of ded. and coin.				
17.	Adjust (comb. medical/dental ded)				
18.	COB/no-fault	21			
19.	Limit on "out-of-pocket expenses"				
20.	Well baby care				
21.	Emergency and supplemental accident				
22.	Student dependents				
23.-25.	Superimposed major medical		681		
	Grand Total	511	636		
	Combined basic and superimposed	1147	XXX		XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) Since the room and board limit is less than the ASP factor, the number of points will equal 351 times the ratio of 80 to 220.

(2) The $2,000 maximum divided by 1.155 is 1731.60. This is 73.16 percent of the difference between the $1,000 and $2,000 maximums in the table. The points would be 217 plus .7316 times (317 - 217) or 290.16 points.

(3) The surgical schedule is the same as in example II in part 2740.9992 value. The value of the table is 1840.1 for the $1,500 maximum. The points excluding administration of anesthesia is 243 times 1840.1 divided by

4320.00 or 103.51 points. The administration of anesthesia would add 10.35 points.

(4) The $200 corridor deductible would be adjusted before entering part 2740.9964, subpart 24. The adjusted deductible would be 200 divided by 1.121 or 178.41. Since this is 78.41 percent of the way between the $100 and $200 deductibles, the points would be 740 minus .7841 times (740-665) or 681.19 points.

(5) Home health care and skilled nursing home care are excluded. Therefore we should deduct 80 percent of their points shown in part 2740.9964, subparts 10 and 11.

(6) Hospital room and board is limited to $200 per day less what the basic benefit pays. The adjustment should equal .8 (363 times 20 divided by 220) or 26.4 points.

REPEALER. Minnesota Rules, parts 2740.2300; 2740.9905; 2740.9910; 2740.9915; 2740.9920; 2740.9925; 2740.9930; 2740.9935; 2740.9940; 2740.9945; 2740.9950; 2740.9955; 2740.9960; 2740.9965; 2740.9970; 2740.9981; 2740.9982; 2740.9983; 2740.9984; 2740.9985; and 2740.9986 are repealed.