CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES.

Subdivision 1. **Scope.** The provisions of this section apply (a) to all group policies or subscriber contracts which provide benefits for at least 100 certificate holders who are residents of this state or groups of which more than 90 percent are residents of this state and are issued, delivered, or renewed by accident and health insurance companies regulated under this chapter, or by nonprofit health service plan corporations regulated under chapter 62C and (b), unless waived by the commissioner to the extent applicable to holders who are both nonresidents and employed outside this state, to all group policies or subscriber contracts which are issued, delivered, or renewed within this state by accident and health insurance companies regulated under this chapter, or by nonprofit health service plan corporations regulated under chapter 62C.

Subd. 2. **Minimum benefits.** All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage, to at least the extent of 80 percent of the first $750 of the cost of the usual and customary charges incurred over a 12-month period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient in a hospital, if the services are furnished by (1) a licensed or accredited hospital, (2) a community mental health center or mental health clinic approved or licensed by the commissioner of public welfare or other authorized state agency, or (3) a licensed consulting psychologist licensed under the provisions of sections 148.87 to 148.98, or a psychiatrist licensed under chapter 147.

History: *1981 c 265 s 1; 1Sp1981 c 4 art 1 s 49*

62A.154 BENEFITS FOR DES RELATED CONDITIONS.

Subdivision 1. **Definitions.** For the purposes of this section, the terms defined in this section have the meanings given them.

(a) "Covered person" means a natural person who is covered under a policy.

(b) "Insurer" means an insurer providing health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, a nonprofit health services plan corporation regulated under chapter 62C, a health maintenance organization regulated under chapter 62D or a fraternal beneficiary association regulated under chapter 64A.

(c) "Policy" means a policy or plan of health, medical, hospitalization or accident and sickness insurance, a health maintenance contract, or a health benefit certificate provided by an insurer which provides coverage of, or reimbursement for, hospital, medical, or surgical expenses on a group or individual basis, but does not include a policy designed primarily to provide coverage payable on a per diem,

fixed indemnity or nonexpense incurred basis, or a policy that provides only accident coverage.

Subd. 2. **Required coverage.** No policy shall be issued or renewed in this state after August 1, 1981 if it provides an exclusion, reduction, or other limitation as to coverage, deductible, coinsurance or copayment applicable solely to conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol, unless the covered person has been diagnosed as having diethylstilbestrol-related cancer prior to the date on which coverage for that person begins. In the absence of credible evidence of a higher morbidity rate due to exposure to diethylstilbestrol, no insurer shall surcharge or in any other manner increase the premium. If there is credible evidence of a higher morbidity rate due to exposure to diethylstilbestrol, no insurer shall surcharge or in any other manner increase the premium without the prior approval of the commissioner.

Subd. 3. **Refusal to issue or renew.** No insurer shall refuse to issue or renew a policy, or to provide coverage under a policy, in this state after August 1, 1981 solely because of conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol, unless the covered person has been diagnosed as having diethylstilbestrol-related cancer prior to the date on which an initial premium payment is received by the insurer.

History: *1981 c 350 s 1*

62A.21 CONVERSION PRIVILEGES FOR INSURED FORMER SPOUSES AND CHILDREN.

[For text of subd 1, see M.S.1980]

Subd. 2. [Repealed, 1981 c 329 s 4]

Subd. 2a. Every group policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's former spouse and children upon entry of a valid decree of dissolution of marriage, if the decree requires the insured to provide continued coverage for those persons. The coverage may be continued until the earlier of the following dates:

(a) The date of remarriage of either the insured or the insured's former spouse; or

(b) The date coverage would otherwise terminate under the group policy.

Any required premium contributions for the coverage shall be paid by the insured to the group policyholder for remittance to the insurer.

Subd. 2b. Every group policy described in subdivision 1 shall contain a provision allowing a former spouse of an insured, without providing evidence of insurability, to obtain from the insurer at the expiration of any continuation of coverage required under subdivision 2a, or upon termination of coverage by reason of an entry of a valid decree of dissolution which does not require the insured to provide continued coverage for the former spouse, conversion coverage providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the insurer within 30 days following the expiration of the continued coverage and upon payment of the appropriate premium. A policy providing reduced benefits at a reduced premium rate may be accepted by the former spouse in lieu of the optional coverage otherwise required by this subdivision. The individual policy shall be renewable

at the option of the former spouse as long as the former spouse is not covered under another qualified plan as defined in section 62E.02, subdivision 4, up to age 65 or to the day before the date of eligibility for coverage under Title XVIII of the Social Security Act, as amended. Any revisions in the table of rate for the individual policy shall apply to the former spouse's original age at entry, and shall apply equally to all similar policies issued by the insurer.

Subd. 3. Subdivision 1 applies to every policy of accident and health insurance which is delivered, issued for delivery, renewed or amended on or after July 19, 1977.

Subdivisions 2a and 2b apply to every policy of accident and health insurance which is delivered, issued for delivery, renewed, or amended on or after August 1, 1981.

History: *1981 c 329 s 1-3*

62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.

Subdivision 1. **Policy requirements.** No individual or group policy, certificate, subscriber contract or other evidence of accident and health insurance issued or delivered in this state shall be sold or issued to an individual age 65 or older covered by medicare unless the following requirements are met:

(a) The policy must provide a minimum of the coverage set out in subdivision 2;

(b) The policy must cover pre-existing conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage;

(c) The policy must contain a provision that the plan will not be canceled or nonrenewed on the grounds of the deterioration of health of the insured; and

(d) An outline of coverage as provided in section 62A.39 must be delivered at the time of application and prior to payment of any premium.

The requirements of sections 62A.31 to 62A.42 shall not apply to disability income protection insurance policies or group policies of accident and health insurance which do not purport to supplement medicare issued to any of the following groups:

(a) A policy issued to an employer or employers or to the trustee of a fund established by an employer where only employees or retirees, and dependents of employees or retirees, are eligible for coverage.

(b) A policy issued to a labor union or similar employee organization.

(c) A policy issued to an association, a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 100 persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have a constitution and by-laws which provide that (1) the association or associations hold regular meetings not less frequently than annually to further purposes of the members, (2) except for credit unions, the association or associations collect dues or solicit contributions from members, and (3) the members have voting privileges and representation on the governing board and committees.

Subd. 2. **General coverage.** For a policy to meet the requirements of this section it must contain (1) a designation specifying whether the policy is a medicare supplement 1+, 1, 2, or 3, (2) a caption stating that the commissioner

has established four categories of medicare supplement insurance and minimum standards for each, with medicare supplement 1+ being the most comprehensive and medicare supplement 3 being the least comprehensive, and (3) the policy must provide the minimum coverage prescribed in sections 62A.32 to 62A.35 for the supplement specified.

History: *1981 c 318 s 1*

62A.32 MEDICARE SUPPLEMENT 1+; COVERAGE.

Medicare supplement 1+ must have a level of coverage so that it will be certified as a qualified plan pursuant to chapter 62E, and will provide:

(a) 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 co-payment required under medicare for the first 60 days of any medicare benefit period;

(b) 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;

(c) 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;

(d) 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;

(e) Coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of at least 50 percent of the medicare calendar year part B deductible;

(f) 80 percent of charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by medicare or pursuant to paragraphs (a) to (e); and

(g) Shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services. The coverage must be subject to a maximum lifetime benefit of not less than $100,000.

History: *1981 c 318 s 2*

62A.33 MEDICARE SUPPLEMENT 1; COVERAGE.

Medicare supplement 1 must have a level of coverage that, at a minimum, will provide:

(a) 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 co-payment required under medicare for the first 60 days of any medicare benefit period;

(b) 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;

(c) 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;

(d) 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;

(e) Coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of the medicare calendar year part B deductible and a maximum benefit of at least $5,000 per calendar year; and

(f) 50 percent of charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by medicare or pursuant to paragraphs (a) to (e).

History: *1981 c 318 s 3*

62A.34 MEDICARE SUPPLEMENT 2; COVERAGE.

Medicare supplement 2 must have a level of coverage that, at a minimum, will provide:

(a) 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;

(b) 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;

(c) 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 lifetime maximum benefit of an additional 365 days; and

(d) Coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of the medicare calendar year part B deductible and a maximum benefit of at least $5,000 per calendar year.

History: *1981 c 318 s 4*

62A.35 MEDICARE SUPPLEMENT 3; COVERAGE.

Medicare supplement 3 must have a level of coverage that, at a minimum, will provide:

(a) 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;

(b) 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;

(c) 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; and

(d) Coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year.

History: *1981 c 318 s 5*

62A.36 LOSS RATIO STANDARDS.

Subdivision 1. **Minimum loss ratios.** Notwithstanding the provisions of section 62A.02, subdivision 3, relating to loss ratios, medicare supplement policies shall be expected to return to policyholders in the form of aggregate benefits under the policy, as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices:

(a) At least 75 percent of the aggregate amount of premiums collected in the case of group policies, and

(b) At least 65 percent of the aggregate amount of premiums collected in the case of individual policies.

Subd. 2. **Solicitations by mail or media advertisement.** For purposes of this section, medicare supplement policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

History: *1981 c 318 s 6*

62A.37 SEALS AND EMBLEM PROHIBITED.

Subdivision 1. No graphic seal or emblem shall be displayed on any policy or promotional literature to indicate or give the impression that there is any connection, certification, approval or endorsement from medicare or any governmental body of this state or any agency thereof or of the United States of America or any agency thereof.

Subd. 2. Any false statement or representation printed on the policy or on promotional literature that indicates the policy has a connection with, is certified by, or has the approval or endorsement of any agency of this state or of the United States of America shall be unlawful.

History: *1981 c 318 s 7*

62A.38 NOTICE OF FREE EXAMINATION.

Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded in full if, after examination of the policy or certificate, the insured person is not satisfied for any reason. Medicare supplement policies or certificates, issued pursuant to a direct response solicitation to persons eligible for medicare by reason of age, shall have a notice prominently printed on the first page or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason.

History: *1981 c 318 s 8*

62A.39 DISCLOSURE.

No individual medicare supplement plan shall be delivered or issued in this state and no certificate shall be delivered pursuant to a group medicare supplement plan delivered or issued in this state unless an outline containing at least the following information is delivered to the applicant at the time the application is made:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the exceptions, reductions, and limitations contained in the policy including the following language, as applicable, in bold print: "THIS POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THIS POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL NURSING CARE.";

(c) A statement of the renewal provisions including any reservations by the insurer of a right to change premiums;

(d) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(e) A statement of the policy's loss ratio as follows: "This policy provides an anticipated loss ratio of [. . %]. This means that, on the average, policyholders may expect that [$. . . .] of every $100.00 in premium will be returned as benefits to policyholders over the life of the contract.".

History: *1981 c 318 s 9*

62A.40 REPLACEMENT.

No insurer or agent shall replace a medicare supplement plan with another medicare supplement plan of the same category unless there is a substantial difference in cost favorable to the policyholder, or the insured has previously demonstrated a dissatisfaction with the service he is presently receiving from his current insurer. An insurer or agent may replace a medicare supplement plan with a less comprehensive plan only if the prospective insured signs an acknowledgment that he understands that he will receive less benefits under the new policy than under the policy he presently has in force.

History: *1981 c 318 s 10*

62A.41 PENALTIES.

Any insurer, general agent, agent, or other person who knowingly or willfully, either directly or indirectly, makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to compliance of any policy with the standards and requirements set forth in this section; falsely assumes or pretends to be acting, or misrepresents in any way, including a violation of section 62A.37, that he is acting, under the authority or in association with medicare, or any federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value; or knowingly sells a health insurance policy to an individual entitled to benefits under part A or part B of medicare with the knowledge that such policy substantially duplicates health benefits to which such individual is otherwise entitled under a requirement of state or federal law other than under medicare shall be guilty of a felony and subject to a civil penalty of not more than $5,000 per violation, and the commissioner may revoke or suspend the license of any company, association, society, other insurer, or agent thereof.

History: *1981 c 318 s 11*

62A.42 RULEMAKING AUTHORITY.

To carry out the purposes of sections 62A.31 to 62A.42, the commissioner may promulgate rules pursuant to chapter 15. These rules may:

(a) Prescribe additional disclosure requirements for medicare supplement plans, designed to adequately inform the prospective insured of the need and extent of coverage offered;

(b) Prescribe uniform policy forms in order to give the insurance purchaser a reasonable opportunity to compare the cost of insuring with various insurers; and

(c) Establish other reasonable standards to further the purpose of sections 62A.31 to 62A.42.

History: *1981 c 318 s 12*