CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

62A.041 MATERNITY BENEFITS.

Each group policy of accident and health insurance and each group health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each group policy and each group contract shall provide the same coverage for that child as that provided for the child of a married employee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

Each individual policy of accident and health insurance and each individual health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each individual policy and each individual contract shall also provide the same coverage for that child as that provided for the child of a married insured or a married enrollee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

Except for policies which only provide coverage for specified diseases, each group subscriber contract of accident and health insurance or health maintenance contract, issued or renewed after August 1, 1987, shall include maternity benefits in the same manner as any other illness covered under the policy or contract.

For the purposes of this section, the term "maternity benefits" shall not include elective, induced abortion whether performed in a hospital, other abortion facility, or the office of a physician.

This section applies to policies and contracts issued, delivered, or renewed after August 1, 1985, that cover Minnesota residents.

History: *1987 c 337 s 45*

62A.043 DENTAL PROCEDURES.

[For text of subds 1 and 2, see M.S.1986]

Subd. 3. Except for policies which only provide coverage for specified diseases, no policy or certificate of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D, shall be issued, renewed, continued, delivered, issued for delivery, or executed in this state after August 1, 1987, unless the policy, plan, or contract specifically provides coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage shall be the same as that for treatment to any other joint in the body, and shall apply if the treatment is administered or prescribed by a physician or dentist.

History: *1987 c 337 s 46*

62A.046 COORDINATION OF BENEFITS.

(1) No group contract providing coverage for hospital and medical treatment or expenses issued or renewed after August 1, 1984, which is responsible for secondary coverage for services provided, may deny coverage or payment of the amount it owes as a secondary payor solely on the basis of the failure of another group contract, which is responsible for primary coverage, to pay for those services.

(2) A group contract which provides coverage of a claimant as a dependent of a parent who has legal responsibility for the dependent's medical care pursuant to a court order under section 518.171 must make payments directly to the provider of care. In such cases, liability to the insured is satisfied to the extent of benefit payments made to the provider.

(3) This section applies to an insurer, a vendor of risk management services regulated under section 60A.23, a nonprofit health service plan corporation regulated under chapter 62C and a health maintenance organization regulated under chapter 62D. Nothing in this section shall require a secondary payor to pay the obligations of the primary payor nor shall it prevent the secondary payor from recovering from the primary payor the amount of any obligation of the primary payor that the secondary payor elects to pay.

History: *1987 c 370 art 2 s 1*

62A.12 [Repealed, 1987 c 337 s 131]

62A.141 COVERAGE FOR HANDICAPPED DEPENDENTS.

No group policy or plan of health and accident insurance regulated under this chapter, chapter 62C, or 62D, which provides for dependent coverage may be issued or renewed in this state after August 1, 1983, unless it covers the handicapped dependents of the insured, subscriber, or enrollee of the policy or plan. Consequently, the policy or plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning handicapped dependents.

If ordered by the commissioner of commerce, the insurer of a Minnesota-domiciled nonprofit association which is composed solely of agricultural members may restrict coverage under this section to apply only to Minnesota residents.

History: *1987 c 337 s 47*

62A.146 CONTINUATION OF BENEFITS TO SURVIVORS.

No policy or plan of accident and health protection issued by an insurer, nonprofit health service plan corporation, or health maintenance organization, providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis which in addition to coverage of the insured, subscriber, or enrollee, also provides coverage to dependents, shall, except upon the written consent of the survivor or survivors of the deceased insured, subscriber, or enrollee, terminate, suspend, or otherwise restrict the participation in or the receipt of benefits otherwise payable under the policy or plan to the survivor or survivors until the earlier of the following dates:

(a) the date the surviving spouse becomes covered under another group health plan; or

(b) the date coverage would have terminated under the policy or plan had the insured, subscriber, or enrollee lived.

The survivor or survivors, in order to have the coverage and benefits extended, may be required to pay the entire cost of the protection on a monthly basis. In no event shall the amount of premium or fee contributions charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children who are not the survivors of a deceased insured, without regard to whether such cost is paid by the employer or employee. Failure of the survivor to make

premium or fee payments within 90 days after notice of the requirement to pay the premiums or fees shall be a basis for the termination of the coverage without written consent. In event of termination by reason of the survivor's failure to make required premium or fee contributions, written notice of cancellation must be mailed to the survivor's last known address at least 30 days before the cancellation. If the coverage is provided under a group policy or plan, any required premium or fee contributions for the coverage shall be paid by the survivor to the group policyholder or contract holder for remittance to the insurer, nonprofit health service plan corporation, or health maintenance organization.

History: *1987 c 337 s 48*

62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES.

[For text of subd 1, see M.S.1986]

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 on the same basis as coverage for other benefits for at least 80 percent of the cost of the usual and customary charges of the first ten hours of treatment incurred over a 12-month benefit period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient in a hospital, and at least 75 percent of the cost of the usual and customary charges for any additional hours of treatment during the same 12-month benefit period for serious and persistent mental or nervous disorders, 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 human services 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. Prior authorization from an accident and health insurance company, or a nonprofit health service corporation, shall be required for an extension of coverage beyond ten hours of treatment. This prior authorization must be based upon the severity of the disorder, the patient's risk of deterioration without ongoing treatment and maintenance, degree of functional impairment, and a concise treatment plan. Authorization for extended treatment may not exceed a maximum of 30 visit hours during any 12-month benefit period.

For purposes of this section, covered treatment for a minor shall include treatment for the family if family therapy is recommended by a provider listed above in item (1), (2) or (3).

[For text of subd 3, see M.S.1986]

History: *1987 c 337 s 49*

62A.17 TERMINATION OF OR LAYOFF FROM EMPLOYMENT.

Subdivision 1. **Continuation of coverage.** Every group insurance policy, group subscriber contract, and health care plan included within the provisions of section 62A.16, except policies, contracts, or health care plans covering employees of an agency of the federal government, shall contain a provision which permits every covered employee who is voluntarily or involuntarily terminated or laid off from employment, if the policy, contract, or health care plan remains in force for active employees of the employer, to elect to continue the coverage for the employee and dependents.

An employee shall be considered to be laid off from employment if there is a reduction in hours to the point where the employee is no longer eligible under the policy, contract, or health care plan. Termination shall not include discharge for gross misconduct.

Subd. 2. **Responsibility of employee.** Every covered employee electing to continue coverage shall pay the former employer, on a monthly basis, the cost of the continued

coverage. If the policy, contract, or health care plan is administered by a trust, every covered employee electing to continue coverage shall pay the trust the cost of continued coverage according to the eligibility rules established by the trust. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for similarly situated employees with respect to whom neither termination nor layoff has occurred, without regard to whether such cost is paid by the employer or employee. The employee shall be eligible to continue the coverage until the employee becomes covered under another group health plan, or for a period of 18 months after the termination of or lay off from employment, whichever is shorter.

Subd. 3. [Repealed by amendment 1987 c 337 s 50]

Subd. 4. **Responsibility of employer.** After timely receipt of the monthly payment from a covered employee, if the employer, or the trustee, if the policy, contract, or health care plan is administered by a trust, fails to make the payment to the insurer, nonprofit health service plan corporation, or health maintenance organization, with the result that the employee's coverage is terminated, the employer or trust shall become liable for the employee's coverage to the same extent as the insurer, nonprofit health service plan corporation, or health maintenance organization would be if the coverage were still in effect.

In the case of a policy, contract or plan administered by a trust, the employer must notify the trustee within 30 days of the termination or layoff of a covered employee of the name and last known address of the employee.

If the employer or trust fails to notify a covered employee, the employer or trust shall continue to remain liable for the employee's coverage to the same extent as the insurer would be if the coverage were still in effect.

Subd. 5. **Notice of options.** Upon the termination of or lay off from employment of an eligible employee, the employer shall inform the employee within ten days after termination or lay off of:

(a) the right to elect to continue the coverage;

(b) the amount the employee must pay monthly to the employer to retain the coverage;

(c) the manner in which and the office of the employer to which the payment to the employer must be made; and

(d) the time by which the payments to the employer must be made to retain coverage.

If the policy, contract, or health care plan is administered by a trust, the employer is relieved of the obligation imposed by clauses (a) to (d). The trust shall inform the employee of the information required by clauses (a) to (d).

The employee shall have 60 days within which to elect coverage. The 60-day period shall begin to run on the date plan coverage would otherwise terminate or on the date upon which notice of the right to coverage is received, whichever is later.

Notice must be in writing and sent by first class mail to the employee's last known address which the employee has provided the employer or trust.

A notice in substantially the following form shall be sufficient: "As a terminated or laid off employee, the law authorizes you to maintain your group medical insurance for a period of up to 18 months. To do so you must notify your former employer within 60 days of your receipt of this notice that you intend to retain this coverage and must make a monthly payment of $..... to ..... at ..... by the ..... of each month."

Subd. 6. **Conversion to individual policy.** A group insurance policy that provides posttermination or layoff coverage as required by this section shall also include a provision allowing a covered employee, surviving spouse, or dependent at the expiration of the posttermination or layoff coverage provided by subdivision 2 to obtain from the insurer offering the group policy or group subscriber contract, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability

and without interruption of coverage, an individual policy of insurance or an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, and a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the insurer within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate premium. The required conversion contract must treat pregnancy the same as any other covered illness under the conversion contract. A health maintenance contract issued by a health maintenance organization that provides posttermination or layoff coverage as required by this section shall also include a provision allowing a former employee, surviving spouse, or dependent at the expiration of the posttermination or layoff coverage provided in subdivision 2 to obtain from the health maintenance organization, at the former employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual health maintenance contract. Effective January 1, 1985, enrollees who have become nonresidents of the health maintenance organization's service area shall be given the option, to be arranged by the health maintenance organization, of a number three qualified plan, a number two qualified plan, or a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3 if an arrangement with an insurer can reasonably be made by the health maintenance organization. This option shall be made available at the enrollee's expense, without further evidence of insurability and without interruption of coverage.

A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, the spouse, or a dependent in lieu of the optional coverage otherwise required by this subdivision.

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

History: *1987 c 337 s 50*

62A.20 COVERAGE OF CURRENT SPOUSE AND CHILDREN.

Subdivision 1. **Requirement.** Every policy of accident and health insurance providing coverage of hospital or medical expense on either an expense-incurred basis or other than an expense-incurred basis, which in addition to covering the insured also provides coverage to the spouse and dependent children of the insured shall contain:

(1) a provision which permits the spouse and dependent children to elect to continue coverage when the insured becomes enrolled for benefits under Title XVIII of the Social Security Act (Medicare); and

(2) a provision which permits the dependent children to continue coverage when they cease to be dependent children under the generally applicable requirement of the plan.

Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be continued until the earlier of the following dates:

(1) the date coverage would otherwise terminate under the policy;

(2) 36 months after continuation by the spouse or dependent was elected; or

(3) the spouse or dependent children become covered under another group health plan.

If coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouse and dependent children to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

History: *1987 c 337 s 51*

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

Subdivision 1. No policy of accident and health insurance providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis, which in addition to covering the insured also provides coverage to the spouse of the insured shall contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship.

Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's former spouse and dependent children upon entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

(a) The date the insured's former spouse becomes covered under any other group health plan; or

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

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Subd. 2b. **Conversion privilege.** Every policy described in subdivision 1 shall contain a provision allowing a former spouse and dependent children 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 sections 62A.146 and 62A.20, 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 notice of 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 and dependent children 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: *1987 c 337 s 52*

62A.27 COVERAGE FOR ADOPTED CHILDREN.

No individual or group policy or plan of health and accident insurance regulated under this chapter or chapter 64B, subscriber contract regulated under chapter 62C, or health maintenance contract regulated under chapter 62D, providing coverage for more than one person may be issued or renewed in this state after August 1, 1983, unless the policy, plan, or contract covers adopted children of the insured, subscriber, or enrollee on the same basis as other dependents. Consequently, the policy or plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning adopted children.

The coverage required by this section is effective from the date of placement for the purpose of adoption and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement.

History: *1987 c 337 s 53*

62A.28 COVERAGE FOR SCALP HAIR PROSTHESES.

Subdivision 1. **Scope of coverage.** This section applies to all policies of accident and health insurance, health maintenance contracts regulated under chapter 62D, health benefit certificates offered through a fraternal beneficiary association regulated under chapter 64B, and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C. This section does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis, or policies that provide only accident coverage.

Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1987, must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata.

The coverage required by this section is subject to a policy's copayment requirement and is limited to a maximum of $350 in any benefit year, exclusive of any deductible.

History: *1987 c 202 s 1*

62A.29 SURETY BOND OR SECURITY FOR CERTAIN HEALTH BENEFIT PLANS.

Subdivision 1. **Surety bond or security requirement.** Any employer, except the state and its political subdivisions as defined in section 65B.43, subdivision 20, who provides a health benefit plan to its Minnesota employees, which is to some extent self-insured by the employer, and who purchases stop-loss insurance coverage, or any other insurance coverage, in connection with the health benefit plan, shall annually file with the commissioner, within 60 days of the end of the employer's fiscal year, security acceptable to the commissioner in an amount specified under subdivision 2, or a surety bond in the form and amount prescribed by subdivisions 2 and 3. An acceptable surety bond is one issued by a corporate surety authorized by the commissioner to transact this business in the state of Minnesota for the purposes of this section. The term "Minnesota employees" includes any Minnesota resident who is employed by the employer.

Subd. 2. **Amount of surety bond or security.** The amount of surety bond or acceptable security required by subdivision 1 shall be equal to one-fourth of the projected annual medical and hospital expenses to be incurred by the employer or $1,000, whichever is greater, with respect to its Minnesota employees by reason of the portion of the employer's health benefit plan which is self-insured by the employer.

Subd. 3. **Form of the surety bond.** The surety bond shall provide as follows:

SURETY BOND

KNOW ALL PERSONS BY THESE PRESENTS: That (entity to be bonded), of (location), (hereinafter called the "principal"), as principal, and (bonding company name), a (name of state) corporation, of (location) (hereinafter called the "surety"), as surety are held and firmly bound unto the commissioner of commerce of the state of Minnesota for the use and benefit of Minnesota residents entitled to health benefits from the principal in the sum of ($.....), for the payment of which well and truly to be made, the principal binds itself, its successor and assigns, and the surety binds itself and its successors and assigns, jointly and severally, firmly by these presents.

WHEREAS, in accordance with section (.....) of the Minnesota Statute, principal is required to file a surety bond with the commissioner of commerce of the state of Minnesota.

NOW, THEREFORE, the condition of this obligation is such that if the said principal shall, according to the terms, provisions, and limitations of principals' health benefit program for its Minnesota employees, pay all of its liabilities and obligations, including all benefits as provided in the attached plan, then, this obligation shall be null and void, otherwise to remain in full force and effect, subject, however, to the following terms and conditions:

1. The liability of the surety is limited to the payment of the benefits of the employee benefit plan which are payable by the principal and within the amount of the bond. The surety shall be bound to payments owed by the principal for obligations arising from a default of the principal or any loss incurred during the period to which the bond applies.

2. In the event of any default on the part of the principal to abide by the terms and provision of the attached plan, the commissioner of commerce may, upon ten-days notice to the surety and opportunity to be heard, require the surety to pay all of the principal's past and future obligations under the attached plan with respect to the principal's Minnesota employees.

3. Service on the surety shall be deemed to be service on the principals.

4. This bond shall be in effect from ..... to ....., and may not be canceled by either the surety or the principal.

5. Any Minnesota employee of principal aggrieved by a default of principal under the attached plan, and/or the commissioner of commerce on behalf of any such employee, may enforce the provisions of this bond.

6. This bond shall become effective at (time of day, month, day, year).

IN TESTIMONY WHEREOF, said principals and said surety have caused this instrument to be signed by their respective, duly authorized officers and their corporate seals to be hereunto affixed this (day, month, year).

Signed, sealed and delivered in the presence of:

_____

_____

_____

_____

Corporation Name

_____

_____

Bonding Company Name

By:_____

Subd. 4. **Penalty for failure to comply.** The commissioner of revenue shall deny any business tax deduction to an employer for the employer's contribution to a health plan for the period which the employer fails to comply with this section. This section does not apply to trusts established under chapter 62H which have been approved by the commissioner.

Subd. 5. **Petition to reduce bond or security amount.** An employer subject to this section may petition the commissioner to, and the commissioner may, allow the use of a surety bond not in the form specified in subdivision 3, or grant a reduction in the amount of the surety bond or security required.

In reviewing a petition submitted under this subdivision, the commissioner must consider, in addition to any other factors, information provided by the petitioner in regard to the following:

(1) the size of the petitioner's business;

(2) the number of employees;

(3) the cost of providing the bond or security and the effect the cost will have on the petitioner's financial condition;

(4) whether the cost of the bond or security will impair the petitioner's ability to self-insure; and

(5) the petitioner's likelihood of being able to meet the petitioner's future obligations in regard to the health plan.

History: *1987 c 337 s 54*

62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.

[For text of subd 1, see M.S.1986]

Subd. 1a. **Application to certain policies.** The requirements of sections 62A.31 to 62A.44 shall not apply to disability income protection insurance policies, long-term care policies issued pursuant to sections 62A.46 to 62A.56, 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 bylaws 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, (3) the members have voting privileges and representation on the governing board and committees, and (4) the members are not, within the first 30 days of membership, directly solicited, offered, or sold a long-term care policy or Medicare supplement policy if the policy is available as an association benefit. This clause does not prohibit direct solicitations, offers, or sales made exclusively by mail.

[For text of subd 2, see M.S.1986]

History: *1987 c 337 s 55*

62A.43 LIMITATIONS ON SALES.

[For text of subd 1, see M.S.1986]

Subd. 2. **Refunds.** Notwithstanding the provisions of section 62A.38, an insurer which issues a Medicare supplement plan to any person who has one plan then in effect, except as permitted in subdivision 1, shall, at the request of the insured, either refund the premiums or pay any claims on the policy, whichever is greater. Any refund of premium pursuant to this section or section 62A.38 shall be sent by the insurer directly to the insured within 15 days of the request by the insured.

[For text of subd 3, see M.S.1986]

Subd. 4. **Other policies not prohibited.** The prohibition in this section against the sale of duplicate Medicare supplement coverage does not preclude the sale of insurance coverage, such as travel accident and sickness coverage, the effect or purpose of which is not to supplement Medicare coverage. Notwithstanding this provision, if the commissioner determines that the coverage being sold is in fact Medicare supplement insurance, the commissioner shall notify the insurer in writing of the determination. If the insurer does not thereafter comply with sections 62A.31 to 62A.44, the commissioner may, pursuant to chapter 14, revoke or suspend the insurer's authority to sell accident and health insurance in this state or impose a civil penalty not to exceed $10,000, or both.

History: *1987 c 337 s 56,57*

62A.46 DEFINITIONS.

[For text of subds 1 to 10, see M.S.1986]

Subd. 11. **Benefit period.** "Benefit period" means one or more separate or combined periods of confinement covered by a long-term care policy in a nursing facility or at home while receiving home care services. A benefit period begins on the first day the insured receives a benefit under the policy and ends when the insured has received no benefits for the same or related cause for an interval of 180 consecutive days.

History: *1987 c 337 s 58*

62A.48 LONG-TERM CARE POLICIES.

Subdivision 1. **Policy requirements.** No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long-term care services shall be offered, issued, delivered, or renewed in this state, whether or not the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long-term care policy must cover medically prescribed long-term care in nursing facilities and at least the medically prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long-term care policy AA must include: a maximum lifetime benefit limit of at least $100,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums, and a requirement of prior hospitalization for up to one day may be imposed only for long-term care in a nursing facility. Coverage under a long-term care policy A must include: a maximum lifetime benefit limit of at least $50,000 for services, nursing facility and home care coverages must not be subject to separate lifetime maximums, and a requirement of prior hospitalization for up to three days may be imposed for long-term care in a nursing facility or home care services. If long-term care policies require the policyholder to be admitted to a nursing facility or begin home care services within a specified period after discharge from a hospital, that period may be no less than 30 days.

Coverage under either policy designation must cover preexisting 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. Coverage under either policy designation may include a waiting period of up to 90 days before benefits are paid, but there must be no more than one waiting period per benefit period. No policy may exclude coverage for mental or nervous disorders which have a demonstrable organic cause, such as Alzheimer's and related dementias. No policy may require the insured to meet a prior hospitalization test more than once during a single benefit period. The policy must include a provision that the plan will not be canceled or renewal refused except on the grounds of nonpayment of the premium, provided that the insurer may change the premium rate on a class basis on any policy anniversary date. A provision that the policyholder may elect to have the premium paid in full at age 65 by payment of a higher premium up to age 65 may be offered. A provision that the premium would be waived during any period in which benefits are being paid to the insured during confinement in a nursing facility must be included. A nongroup policyholder may return a policy within 30 days of its delivery and have the premium refunded in full, less any benefits paid under the policy, if the policyholder is not satisfied for any reason.

Subd. 2. **Per diem coverage.** If benefits are provided on a per diem basis, the minimum daily benefit for care in a nursing facility must be the lesser of $60 or actual charges under a long-term care policy AA or the lesser of $40 or actual charges under a long-term care policy A and the minimum benefit per visit for home care under a long-term care policy AA or A must be the lesser of $25 or actual charges. The home care services benefit must cover at least seven paid visits per week.

[For text of subds 3 to 5, see M.S.1986]

Subd. 6. **Coordination of benefits.** A long-term care policy may be secondary coverage for services provided under sections 62A.46 to 62A.56. Nothing in sections

62A.46 to 62A.56 shall require the secondary payor to pay the obligations of the primary payor nor shall it prevent the secondary payor from recovering from the primary payor the amount of any obligation of the primary payor that the secondary payor elects to pay.

There shall be no coordination of benefits between a long-term care policy and 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. 7. **Existing policies.** Nothing in sections 62A.46 to 62A.56 prohibits the renewal of policies sold outside the state of Minnesota to persons who at the time of sale were not residents of the state of Minnesota.

History: *1987 c 337 s 59-62*

62A.50 DISCLOSURES AND REPRESENTATIONS.

[For text of subds 1 and 2, see M.S.1986]

Subd. 3. **Disclosures.** No long-term care policy shall be offered or delivered in this state, whether or not the policy is issued in this state, and no certificate of coverage under a group long-term care policy shall be offered or delivered in this state, unless a statement containing at least the following information is delivered to the applicant at the time the application is made:

(1) a description of the benefits and coverage provided by the policy and the differences between this policy, a supplemental Medicare policy and the benefits to which an individual is entitled under parts A and B of Medicare and the differences between policy designations A and AA;

(2) a statement of the exceptions and limitations in the policy including the following language, as applicable, in bold print: "THIS POLICY DOES NOT COVER ALL NURSING CARE FACILITIES OR NURSING HOME OR HOME CARE EXPENSES AND DOES NOT COVER RESIDENTIAL CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.";

(3) a statement of the renewal provisions including any reservation by the insurer of the right to change premiums;

(4) 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;

(5) an explanation of the policy's loss ratio including at least the following language: "This means that, on the average, policyholders may expect that $..... of every $100 in premium will be returned as benefits to policyholders over the life of the contract."; and

(6) a statement of the out-of-pocket expenses, including deductibles and copayments for which the insured is responsible, and an explanation of the specific out-of-pocket expenses that may be accumulated toward any out-of-pocket maximum as specified in the policy.

History: *1987 c 337 s 63*