CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

62A.01	Policy of accident and sickness insurance.	62A.17	Termination of or layoff from employment.
62A.041	Maternity benefits.	62A.31	Medicare supplement benefits; minimum standards.
62A.045	Payments on behalf of welfare recipients.	62A.315	Extended basic Medicare supplement plan; coverage.
62A.046	Coordination of benefits.	62A.316	Basic Medicare supplement plan; coverage.
62A.047	Children's health supervision services and prenatal care services.	62A.32	Repealed.
62A.049	Limitation on preauthorizations.	62A.33	Repealed.
62A.08	Coverage of policy, continuance in force.	62A.34	Repealed.
62A.09	Limitation.	62A.35	Repealed.
62A.15	Licensed health professional services in accident and health and nonprofit health service policies.	62A.41	Penalties.
62A.152	Benefits for ambulatory mental health services.	62A.436	Commissions.
		62A.46	Definitions.
		62A.48	Long-term care policies.
		62A.60	Retroactive denial of expenses.

62A.01 POLICY OF ACCIDENT AND SICKNESS INSURANCE.

Subdivision 1. **Definition.** The term "policy of accident and sickness insurance" as used herein includes any policy covering the kind of insurance described in section 60A.06, subdivision 1, clause (5)(a).

Subd. 2. **Equal protection.** A certificate of insurance or similar evidence of coverage issued to a Minnesota resident shall provide coverage for all benefits required to be covered in group policies in Minnesota by this chapter and chapter 62E.

This subdivision supersedes any inconsistent provision of this chapter and chapter 62E.

A policy of accident and sickness insurance that is issued or delivered in this state and that covers a person residing in another state may provide coverage or contain provisions that are less favorable to that person than required by this chapter and chapter 62E. Less favorable coverages or provisions must meet the requirements that the state in which the person resides would have required had the policy been issued or delivered in that state.

Subd. 3. **Exclusions.** Subdivision 2 does not apply to certificates issued in regard to a master policy issued outside the state of Minnesota if all of the following are true:

(1) the policyholder or certificate holder exists primarily for purposes other than to obtain insurance;

(2) the policyholder or certificate holder is not a Minnesota corporation and does not have its principal office in Minnesota;

(3) the policy or certificate covers fewer than 25 employees who are residents of Minnesota and the Minnesota employees represent less than 25 percent of all covered employees; and

(4) on request of the commissioner, the issuer files with the commissioner a copy of the policy and a copy of each form of certificate.

This subdivision applies to employers who are not corporations if they are policyholders or certificate holders providing coverage to employees through the certificate or policy.

Subd. 4. **Application of other laws.** Section 60A.08, subdivision 4, shall not be construed as requiring a certificate of insurance or similar evidence of insurance that meets the conditions of subdivision 3 to comply with this chapter or chapter 62E.

History: *1989 c 330 s 8*

62A.041 MATERNITY BENEFITS.

Subdivision 1. **Discrimination prohibited against unmarried women.** 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.

Subd. 2. **Limitation on coverage prohibited.** Each group policy of accident and health insurance, except for policies which only provide coverage for specified diseases, or 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.

Subd. 3. **Abortion.** 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: *1989 c 330 s 9*

62A.045 PAYMENTS ON BEHALF OF WELFARE RECIPIENTS.

No policy of accident and sickness insurance regulated under this chapter; vendor of risk management services regulated under section 60A.23; nonprofit health service plan corporation regulated under chapter 62C; health maintenance organization regulated under chapter 62D; or self-insured plan regulated under chapter 62E shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to chapter 256B or 256D or services pursuant to section 252.27; 256.936; 260.251, subdivision 1a; 261.27; or 393.07, subdivision 1 or 2.

Notwithstanding any law to the contrary, when a person covered under a policy of accident and sickness insurance, risk management plan, nonprofit health service plan, health maintenance organization, or self-insured plan receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the department of human services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the insurer for those services. If the commissioner of human services notifies the insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the insurer must be issued directly to the commissioner. Submission by the department to the insurer of the claim on a department of human services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the insurer to the provider or the commissioner.

History: *1989 c 282 art 3 s 1*

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.

(4) Payments made by an enrollee or by the commissioner on behalf of an enrollee in the children's health plan under section 256.936, or a person receiving benefits under chapter 256B or 256D, for services that are covered by the policy or plan of health insurance shall, for purposes of the deductible, be treated as if made by the insured.

(5) The commissioner of human services shall recover payments made by the children's health plan from the responsible insurer, for services provided by the children's health plan and covered by the policy or plan of health insurance.

History: *1989 c 282 art 3 s 2*

62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES.

A policy of individual or group health and accident insurance regulated under this chapter, or individual or group subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or health benefit certificate regulated under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota resident, must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, copayment, or other coinsurance or dollar limitation requirement. For individual policies, this section does not prohibit the use of waiting periods or preexisting condition limitations for these services. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section subject to the schedule set forth in this section. Nothing in this section applies to a commercial health insurance policy issued as a companion to a health maintenance organization contract, 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.

"Child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months.

"Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when

needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

History: *1989 c 69 s 1*

62A.049 LIMITATION ON PREAUTHORIZATIONS.

No policy of accident and sickness insurance or group subscriber contract regulated under chapter 62C issued or renewed in this state may contain a provision that makes an insured person ineligible to receive full benefits because of the insured's failure to obtain preauthorization, if that failure occurs because of the need for emergency confinement or emergency treatment. The insured or an authorized representative of the insured shall notify the insurer as soon after the beginning of emergency confinement or emergency treatment as reasonably possible. However, to the extent that the insurer suffers actual prejudice caused by the failure to obtain preauthorization, the insured may be denied all or part of the insured's benefits. This provision does not apply to admissions for treatment of chemical dependency and nervous and mental disorders.

History: *1989 c 330 s 10*

62A.08 COVERAGE OF POLICY, CONTINUANCE IN FORCE.

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the policy would not have been issued, the insurer may, within 90 days of discovering the misstatement, limit its liability to a refund of all premiums paid. In all other instances the insurer may either adjust the premium to reflect the actual age of the insured or adjust the benefits to reflect the actual age and the premium.

History: *1989 c 330 s 11*

62A.09 LIMITATION.

Nothing in sections 62A.01, 62A.02, 62A.03, 62A.04, 62A.05, 62A.06, 62A.07, and 62A.08 shall apply to or affect:

(1) any policy of workers' compensation insurance or any policy of casualty or fire and allied lines insurance with or without supplementary coverage therein; or

(2) any policy or contract of reinsurance; or

(3) any group policy of insurance, except when specifically referred to; or

(4) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

History: *1989 c 330 s 12*

62A.15 LICENSED HEALTH PROFESSIONAL SERVICES IN ACCIDENT AND HEALTH AND NONPROFIT HEALTH SERVICE POLICIES.

[For text of subds 1 to 3, see M.S.1988]

Subd. 3a. **Nursing services.** All benefits provided by a policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of

a duly licensed physician must include services provided by a registered nurse who is licensed pursuant to section 148.171 and who is certified by the profession to engage in advanced nursing practice. "Advanced nursing practice" means the performance of health services by professional nurses who have gained additional knowledge and skills through an organized program of study and clinical experience preparing nurses for advanced practice roles as nurse anesthetists, nurse midwives, nurse practitioners, or clinical specialists in psychiatric or mental health nursing. The program of study must be beyond the education required for registered nurse licensure and must meet criteria established by the professional nursing organization having authority to certify the registered nurse in advanced nursing practice. For the purposes of this subdivision, the board of nursing shall, by rule, adopt a list of professional nursing organizations which have the authority to certify nurses in advanced nursing practice.

This subdivision is intended to provide payment of benefits for treatment and services by a licensed registered nurse certified in advanced nursing practice as defined in this subdivision and is not intended to add to the benefits provided for in these policies or contracts.

Subd. 4. **Denial of benefits.** (a) No carrier referred to in subdivision 1 may, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a licensed chiropractor, licensed optometrist, or a registered nurse meeting the requirements of subdivision 3a.

(b) When carriers referred to in subdivision 1 make claim determinations concerning the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any of these determinations that are made by health care professionals must be made by, or under the direction of, or subject to the review of licensed doctors of chiropractic.

History: *1989 c 330 s 13,14*

62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES.

[For text of subd 1, see M.S.1988]

Subd. 2. **Minimum benefits.** (a) 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 or 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, (3) a licensed psychologist licensed under the provisions of sections 148.88 to 148.98, (4) a licensed consulting psychologist licensed under the provisions of sections 148.88 to 148.98, or (5) 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 be limited to a maximum of 30 visit hours during any 12-month benefit period.

(b) For purposes of this section, covered treatment for a minor includes treatment for the family if family therapy is recommended by a provider listed in paragraph (a). For purposes of determining benefits under this section, "hours of treatment" means treatment rendered on an individual or single-family basis. If treatment is rendered on a group basis, the hours of covered group treatment must be provided at a ratio of no less than two group treatment sessions to one individual treatment hour.

Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services if performed by a licensed psychologist or a licensed consulting psychologist to the extent that the services and treatment are within the scope of licensed psychologist or licensed consulting psychologist licensure. The order of the physician requesting the services of the licensed psychologist or licensed consulting psychologist may be required to be submitted with the claim for payment.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed psychologist or a licensed consulting psychologist in a hospital and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

History: *1989 c 330 s 15,16*

62A.17 TERMINATION OF OR LAYOFF FROM EMPLOYMENT.

[For text of subd 1, see M.S.1988]

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. If the employee becomes covered under another group policy, contract, or health plan and the new group policy, contract, or health plan contains any preexisting condition limitations, the employee may, subject to the 18-month maximum continuation limit, continue coverage with the former employer until the preexisting condition limitations have been satisfied. The new policy, contract, or health plan is primary except as to the preexisting condition. In the case of a newborn child who is a dependent of the employee, the new policy, contract, or health plan is primary upon the date of birth of the child, regardless of which policy, contract, or health plan coverage is deemed primary for the mother of the child.

[For text of subds 4 to 6, see M.S.1988]

History: *1989 c 330 s 17*

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 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;

(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;

(d) Before the policy is sold or issued, an offer of both categories of Medicare supplement insurance has been made to the individual, together with an explanation of both coverages; and

(e) 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.

[For text of subd 1a, see M.S.1988]

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 an extended basic Medicare supplement plan or a basic Medicare supplement plan, (2) a caption stating that the commissioner has established two categories of Medicare supplement insurance and minimum standards for each, with the extended basic Medicare supplement being the most comprehensive and the basic Medicare supplement being the least comprehensive, and (3) the policy must provide the minimum coverage prescribed in sections 62A.315 and 62A.316 for the supplement specified, provided that an annual deductible of not more than $200 is permissible for those covered charges not paid by Medicare or otherwise included in section 62A.315 or 62A.316.

History: *1989 c 258 s 3,4*

62A.315 EXTENDED BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.

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

(1) coverage for all of the Medicare part A inpatient hospital deductible amount;

(2) coverage for the daily copayment amount of Medicare part A eligible expenses for the first eight days per calendar year incurred for skilled nursing facility care;

(3) coverage for the 20 percent copayment amount of Medicare eligible expenses excluding outpatient prescription drugs under Medicare part B regardless of hospital confinement up to the maximum out-of-pocket amount for Medicare part B and coverage of the Medicare deductible amount;

(4) 80 percent of usual and customary hospital and medical expenses, supplies, and prescription drug expenses, including home intravenous (IV) therapy drugs and immunosuppressive therapy drugs, not covered by Medicare's eligible expenses; and

(5) coverage for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations.

History: *1989 c 258 s 5*

62A.316 BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.

(a) The basic Medicare supplement plan must have a level of coverage that, at a minimum, will provide:

(1) coverage for the daily copayment amount of Medicare part A eligible expenses for the first eight days per calendar year incurred for skilled nursing facility care;

(2) coverage for the 20 percent copayment amount of Medicare eligible expenses excluding outpatient prescription drugs under Medicare part B regardless of hospital confinement up to the maximum out-of-pocket amount for Medicare part B after the Medicare deductible amount;

(3) coverage for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations;

(4) coverage for the copayment amount of Medicare eligible expenses for covered home intravenous (IV) therapy drugs, as determined by the Secretary of Health and Human Services, subject to the Medicare outpatient prescription drug deductible amount, if applicable; and

(5) coverage for the copayment amount of Medicare eligible expenses for outpatient drugs used in immunosuppressive therapy subject to the Medicare outpatient prescription drug deductible, if applicable.

(b) Only the following optional benefit riders may be added to this plan:

(1) coverage for all of the Medicare part A inpatient hospital deductible amount; and

(2) a minimum of 80 percent of usual and customary medical expenses and supplies not covered by Medicare part B eligible expenses. This does not include outpatient prescription drugs.

History: *1989 c 258 s 6*

62A.32 [Repealed, 1989 c 258 s 14]
62A.33 [Repealed, 1989 c 258 s 14]
62A.34 [Repealed, 1989 c 258 s 14]
62A.35 [Repealed, 1989 c 258 s 14]

62A.41 PENALTIES.

Subdivision 1. **Generally.** 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 the person 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.

Subd. 2. **Sales of replacement policies.** An insurer or general agent, agent, manager's general agent, or other representative, who knowingly or willfully violates section 62A.40 is guilty of a felony and is subject to a civil penalty of not more than $5,000 per violation.

Subd. 3. **Sales of duplicate policies.** An agent who knowingly or willfully violates section 62A.43, subdivision 1, is guilty of a felony and is subject to a civil penalty of not more than $5,000 per violation.

Subd. 4. **Unlicensed sales.** Notwithstanding section 60A.17, subdivision 1, paragraph (d), a person who acts or assumes to act as an insurance agent without a valid license for the purpose of selling or attempting to sell Medicare supplement insurance, and the person who aids or abets the actor, is guilty of a felony and is subject to a civil penalty of not more than $5,000 per violation.

History: *1989 c 258 s 7*

62A.436 COMMISSIONS.

The commission, sales allowance, service fee, or compensation to an agent for the sale of a Medicare supplement plan must be the same for each of the first four years of the policy. The commissioner may grant a waiver of this restriction on commissions when the commissioner believes that the insurer's fee structure does not encourage deceptive practices.

In no event may the rate of commission, sales allowance, service fee, or compensation for the sale of a basic Medicare supplement plan exceed that which applies to the sale of an extended basic Medicare supplement plan.

This section also applies to sales of replacement policies.

History: *1989 c 258 s 8*

62A.46 DEFINITIONS.

[For text of subds 1 to 11, see M.S.1988]

Subd. 12. **Homebound or house confined.** "Homebound or house confined" means that a person is physically unable to leave the home without another person's aid because the person has lost the capacity of independent transportation or is disoriented.

History: *1989 c 330 s 18*

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. Coverage under a long-term care policy A must include: a maximum lifetime benefit limit of at least $50,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums. Prior hospitalization may not be required under a long-term care policy.

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 be homebound or house confined to receive home care services. 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.

[For text of subds 2 to 7, see M.S.1988]

History: *1989 c 330 s 19*

62A.60 RETROACTIVE DENIAL OF EXPENSES.

In cases where the subscriber or insured is liable for costs beyond applicable copayments or deductibles, no insurer may retroactively deny payment to a person who is covered when the services are provided for health care services that are otherwise covered, if the insurer or its representative failed to provide prior or concurrent review or authorization for the expenses when required to do so under the policy, plan, or certificate. If prior or concurrent review or authorization was provided by the insurer or its representative, the insurer may not deny payment for the authorized service or time period except in cases where fraud or substantive misrepresentation occurred.

History: *1989 c 330 s 20*