

## CHAPTER 62A

## ACCIDENT AND HEALTH INSURANCE

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## 62A.011 DEFINITIONS.

*[For text of subds 1 and 2, see M.S.1992]*

Subd. 3. **Health plan.** "Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self-insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified. Health plan does not include coverage that is:

- (1) limited to disability or income protection coverage;
- (2) automobile medical payment coverage;
- (3) supplemental to liability insurance;
- (4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense-incurred basis;
- (5) credit accident and health insurance as defined in section 62B.02;
- (6) designed solely to provide dental or vision care;
- (7) blanket accident and sickness insurance as defined in section 62A.11;
- (8) accident-only coverage;
- (9) a long-term care policy as defined in section 62A.46;
- (10) issued as a supplement to Medicare, as defined in sections 62A.31 to 62A.44, or policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended through December 31, 1991;
- (11) workers' compensation insurance; or
- (12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health plan.

**History:** 1993 c 247 art 3 s 4

## 62A.02 POLICY FORMS.

Subdivision 1. **Filing.** For purposes of this section, "health plan" means a health plan as defined in section 62A.011 or a policy of accident and sickness insurance as

defined in section 62A.01. No health plan shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection with the health plan, until a copy of its form and of the classification of risks and the premium rates pertaining to the form have been filed with the commissioner. The filing for nongroup health plan forms shall include a statement of actuarial reasons and data to support the rate. For health benefit plans as defined in section 62L.02, and for health plans to be issued to individuals, the health carrier shall file with the commissioner the information required in section 62L.08, subdivision 8. For group health plans for which approval is sought for sales only outside of the small employer market as defined in section 62L.02, this section applies only to policies or contracts of accident and sickness insurance. All forms intended for issuance in the individual or small employer market must be accompanied by a statement as to the expected loss ratio for the form. Premium rates and forms relating to specific insureds or proposed insureds, whether individuals or groups, need not be filed, unless requested by the commissioner.

*[For text of subds 2 to 6, see M.S. 1992]*

**History:** 1993 c 247 art 3 s 5

## 62A.021 HEALTH CARE POLICY RATES.

**Subdivision 1. Loss ratio standards.** Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, health care policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate benefits not including anticipated refunds or credits, provided under the policies or certificates, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27, calculated on an aggregate basis; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of each policy form or certificate form issued in the individual market; calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. Assessments by the reinsurance association created in chapter 62L and any types of taxes, surcharges, or assessments created by Laws 1992, chapter 549, or created on or after April 23, 1992, are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for policies and certificates issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until a 72 percent loss ratio is reached on July 1, 2000. A health carrier that enters a market after July 1, 1993, does not start at the beginning of the phase-in schedule and must instead comply with the loss ratio requirements applicable to other health carriers in that market for each time period. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

Notwithstanding section 645.26, any act enacted at the 1992 regular legislative session that amends or repeals section 62A.135 or that otherwise changes the loss ratios provided in that section is void.

All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy form or certificate form shall equal or exceed the appropriate loss ratio standards.

A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner shall order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

Each sale of a policy or certificate that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

For purposes of this section, health care 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.

For purposes of this section, (1) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and (2) "health carrier" has the meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

*[For text of subd. 2, see M.S. 1992]*

**History:** 1993 c 345 art 8 s 2

## 62A.024 RATE DISCLOSURE.

If any health carrier, as defined in section 62A.011, informs a policyholder or contract holder that a rate increase is due to a statutory change, the health carrier must disclose the specific amount of the rate increase directly due to the statutory change and must identify the specific statutory change. This disclosure must also separate any rate increase due to medical inflation or other reasons from the rate increase directly due to statutory changes in this chapter, chapter 62C, 62D, 62E, 62H, 62J, 62L, or 64B.

**History:** 1993 c 345 art 5 s 4

## 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 256; 256B; or 256D or services pursuant to section 252.27; 256.9351 to 256.9361; 260.251, subdivision 1a; or 393.07, subdivision 1 or 2. No insurer providing benefits under policies covered by

this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

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:** 1Sp1993 c 1 art 5 s 1

## 62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES.

*[For text of subd 1, see M.S.1992]*

**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, or (3) a mental health professional, as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision 27, clauses (1) to (5). 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 mental health professional, as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision 27, clauses (1) to (5), to the extent that the services and treatment are within the scope of mental health professional licensure.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed mental health professional 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:** 1993 c 81 s 1,2

## **62A.304 COVERAGE FOR PORT-WINE STAIN ELIMINATION.**

**Subdivision 1. Scope of coverage.** This section applies to all health plans as defined in section 62A.011 that provide coverage to a Minnesota resident.

**Subd. 2. Required coverage.** Every health plan included in subdivision 1 must cover elimination or maximum feasible treatment of port-wine stains for any covered person who is a Minnesota resident. No health carrier may reduce or eliminate coverage due to this requirement.

**Subd. 3. Rate increases prohibited.** The commissioner of commerce shall not approve any rate increases due to coverage required under subdivision 2. No health maintenance organization, as defined in chapter 62D, shall increase rates due to coverage required under subdivision 2.

**History:** 1993 c 116 s 1

## **62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.**

**Subdivision 1. Policy requirements.** No individual or group policy, certificate, subscriber contract issued by a health service plan corporation regulated under chapter 62C, or other evidence of accident and health insurance the effect or purpose of which is to supplement Medicare coverage issued or delivered in this state or offered to a resident of this state shall be sold or issued to an individual covered by Medicare unless the requirements in subdivisions 1a to 1s are met.

**Subd. 1a. Minimum coverage.** The policy must provide a minimum of the coverage set out in subdivision 2 and section 62E.07.

**Subd. 1b. Preexisting condition coverage.** 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.

**Subd. 1c. Limitation on cancellation or nonrenewal.** 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.

**Subd. 1d. Mandatory offer.** Before the policy is sold or issued, an offer of both categories of Medicare supplement insurance must be made to the individual, together with an explanation of both coverages.

**Subd. 1e. Delivery of outline of coverage.** 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 and, except for direct response policies, an acknowledgment of receipt of this outline must be obtained from the applicant.

**Subd. 1f. Suspension based on entitlement to medical assistance.** (a) The policy must provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period, not to exceed 24 months, in which the policyholder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder notifies the issuer of the policy within 90 days after the date the individual becomes entitled to this assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to this medical assistance, the policy shall be automatically reinstated, effective as of the date of termination of this entitlement, if the policyholder provides notice of loss of the entitlement within 90 days after the date of the loss.

(c) The policy must provide that upon reinstatement (1) there is no additional waiting period with respect to treatment of preexisting conditions, (2) coverage is provided which is substantially equivalent to coverage in effect before the date of the suspension, and (3) premiums are classified on terms that are at least as favorable to the

policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had coverage not been suspended.

**Subd. 1g. Notification of counseling services.** The written statement required by an application for Medicare supplement insurance pursuant to section 62A.43, subdivision 1, shall be made on a form, approved by the commissioner, that states that counseling services may be available in the state to provide advice concerning the purchase of Medicare supplement policies and enrollment under the Medicaid program.

**Subd. 1h. Limitations on denials, conditions, and pricing of coverage.** No issuer of Medicare supplement policies, including policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., in this state may impose preexisting condition limitations or otherwise deny or condition the issuance or effectiveness of any Medicare supplement insurance policy form available for sale in this state, nor may it discriminate in the pricing of such a policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such insurance is submitted during the six-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B. This paragraph applies regardless of whether the individual has attained the age of 65 years.

**Subd. 1i. Replacement coverage.** If a Medicare supplement policy replaces another Medicare supplement policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for benefits to the extent the time was spent under the original policy.

**Subd. 1j. Filing and approval.** The policy must have been filed with and approved by the department as meeting all the requirements of sections 62A.31 to 62A.44.

**Subd. 1k. Guaranteed renewability.** The policy must guarantee renewability.

Only the following standards for renewability may be used in Medicare supplement insurance policy forms.

No issuer of Medicare supplement insurance policies may cancel or nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

If a group Medicare supplement insurance policy is terminated by the group policyholder and is not replaced as provided in this clause, the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder, provides for continuation of the benefits contained in the group policy; or provides for such benefits and benefit packages as otherwise meet the requirements of this clause.

If an individual is a certificate holder in a group Medicare supplement insurance policy and the individual terminates membership in the group, the issuer of the policy shall offer the certificate holder the conversion opportunities described in this clause; or offer the certificate holder continuation of coverage under the group policy.

**Subd. 1l. Treatment of sickness and accident losses.** A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

**Subd. 1m. Medicare cost sharing coverage changes.** A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with the changes.

As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. Such notice shall:

(1) include a description of revisions to the Medicare program and a description

of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(2) inform each policyholder or certificate holder as to when any premium adjustment is to be made, due to changes in Medicare.

The notice of benefit modifications and any premium adjustments must be in outline form and in clear and simple terms so as to facilitate comprehension.

The notices must not contain or be accompanied by any solicitation.

**Subd. 1n. Termination of coverage.** Termination by an issuer of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that began while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy or certificate was in force may be conditioned on the continuous total disability of the insured, limited to the duration of the policy or certificate benefit period, if any, or payment of the maximum benefits. The extension of benefits does not apply when the termination is based on fraud, misrepresentation, or nonpayment of premium. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days before discontinuing the availability of the form of the policy or certificate. An issuer that discontinues the availability of a policy form or certificate shall not file for approval a new policy form or certificate form of the same type for the same Medicare supplement benefit plan as the discontinued form for five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section. A change in the rating structure or methodology shall be considered a discontinuance under this section unless the issuer complies with the following requirements:

(1) the issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resulting rates differ from the existing rating methodology and resulting rates; and

(2) the issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

**Subd. 1o. Refund or credit calculation.** (a) Except as provided in paragraph (b), the Minnesota experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section 62A.36.

(b) Forms assumed under an assumption reinsurance agreement shall not be combined with the Minnesota experience of other forms for purposes of the refund or credit calculation.

**Subd. 1p. Renewal or continuation provisions.** Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy or certificate, and shall include any reservation by the issuer of the right to change premiums. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy or certificate, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy or certificate after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy or certificate shall require a signed acceptance by the insured. After the date of policy or certificate issue, a rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy or certificate term shall be agreed to in writing and signed by the insured, unless

the benefits are required by the minimum standards for Medicare supplement policies or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, declaration page, or certificate. If a Medicare supplement policy or certificate contains limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "preexisting condition limitations."

Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person eligible for Medicare by reason of age shall provide to such applicants a Medicare Supplement Buyer's Guide in the form developed by the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the Buyer's Guide must be made whether or not such policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this section. Except in the case of direct response issuers, delivery of the Buyer's Guide must be made to the applicant at the time of application, and acknowledgment of receipt of the Buyer's Guide must be obtained by the issuer. Direct response issuers shall deliver the Buyer's Guide to the applicant upon request, but no later than the time at which the policy is delivered.

**Subd. 1q. Marketing procedures.** (1) An issuer, directly or through its producers, shall:

(i) establish marketing procedures to assure that a comparison of policies by its agents or other producers will be fair and accurate;

(ii) establish marketing procedures to ensure that excessive insurance is not sold or issued;

(iii) establish marketing procedures that set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than the benefits under the replaced policy or certificate;

(iv) display prominently by type or other appropriate means, on the first page of the policy or certificate, the following:

"Notice to buyer: This policy or certificate may not cover all of your medical expenses";

(v) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of the insurance;

(vi) establish auditable procedures for verifying compliance with this subdivision;

(2) in addition to the practices prohibited in chapter 72A, the following acts and practices are prohibited:

(i) knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or issuers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer;

(ii) employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance;

(iii) making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company;

(3) the terms "Medicare supplement," "medigap," and words of similar import shall not be used unless the policy or certificate is issued in compliance with this subdivision.

**Subd. 1r. Community rate.** Each health maintenance organization, health service

plan corporation, insurer, or fraternal benefit society that sells coverage that supplements Medicare coverage shall establish a separate community rate for that coverage. Beginning January 1, 1993, no coverage that supplements Medicare or that is governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., may be offered, issued, sold, or renewed to a Minnesota resident, except at the community rate required by this subdivision. The same community rate must apply to newly issued coverage and to renewal coverage.

For coverage that supplements Medicare and for the Part A rate calculation for plans governed by section 1833 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., the community rate may take into account only the following factors:

- (1) actuarially valid differences in benefit designs or provider networks;
- (2) geographic variations in rates if preapproved by the commissioner of commerce; and
- (3) premium reductions in recognition of healthy lifestyle behaviors, including but not limited to, refraining from the use of tobacco. Premium reductions must be actuarially valid and must relate only to those healthy lifestyle behaviors that have a proven positive impact on health. Factors used by the health carrier making this premium reduction must be filed with and approved by the commissioner of commerce.

For insureds not residing in Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, or Washington county, a health plan may, at the option of the health carrier, phase in compliance under the following timetable:

(i) a premium adjustment as of March 1, 1993, that consists of one-half of the difference between the community rate that would be applicable to the person as of March 1, 1993, and the premium rate that would be applicable to the person as of March 1, 1993, under the rate schedule permitted on December 31, 1992. A health plan may, at the option of the health carrier, implement the entire premium difference described in this clause for any person as of March 1, 1993, if the premium difference would be 15 percent or less of the premium rate that would be applicable to the person as of March 1, 1993, under the rate schedule permitted on December 31, 1992, if the health plan does so uniformly regardless of whether the premium difference causes premiums to rise or to fall. The premium difference described in this clause is in addition to any premium adjustment attributable to medical cost inflation or any other lawful factor and is intended to describe only the premium difference attributable to the transition to the community rate; and

(ii) with respect to any person whose premium adjustment was constrained under clause (i), a premium adjustment as of January 1, 1994, that consists of the remaining one-half of the premium difference attributable to the transition to the community rate, as described in clause (i).

A health plan that initially follows the phase-in timetable may at any subsequent time comply on a more rapid timetable. A health plan that is in full compliance as of January 1, 1993, may not use the phase-in timetable and must remain in full compliance. Health plans that follow the phase-in timetable must charge the same premium rate for newly issued coverage that they charge for renewal coverage. A health plan whose premiums are constrained by clause (i) may take the constraint into account in establishing its community rate.

From January 1, 1993 to February 28, 1993, a health plan may, at the health carrier's option, charge the community rate under this paragraph or may instead charge premiums permitted as of December 31, 1992.

**Subd. 1s. Prescription drug coverage.** Beginning January 1, 1993, a health maintenance organization that issues coverage that supplements Medicare or that issues coverage governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., must offer, to each person to whom it offers any contract described in this subdivision, at least one contract that either:

- (1) covers 80 percent of the reasonable and customary charge for prescription drugs or the copayment equivalency; or

(2) offers the coverage described in clause (1) as an optional rider that may be purchased separately from other optional coverages.

**Subd. 1t. Notice of lack of drug coverage.** Each policy or contract issued without prescription drug coverage by any insurer, health service plan corporation, health maintenance organization, or fraternal benefit society must contain, displayed prominently by type or other appropriate means, on the first page of the contract, the following:

“Notice to buyer: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to you. Please ask for further details.”

From January 1, 1993 to February 28, 1993, compliance with this paragraph is optional. If a health maintenance organization does not comply with this paragraph during that period, the health maintenance organization must extend any person's six-month eligibility period provided under subdivision 1h that began prior to or during that period and ends during or after that period. The length of the extension must be no less than that portion of the person's six-month eligibility period during which the health carrier did not comply with this paragraph. The extended eligibility period applies only to contracts that provide the prescription drug coverage required by this paragraph.

*[For text of subds 2 and 3, see M.S. 1992]*

**Subd. 4. Prohibited policy provisions.** A Medicare supplement policy or certificate in force in the state shall not contain benefits that duplicate benefits provided by Medicare or contain exclusions on coverage that are more restrictive than those of Medicare.

No Medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions, except as permitted under subdivision 1b.

**Subd. 5. Advertising.** An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through printed or electronic medium to the commissioner for review or approval to the extent it may be required.

**Subd. 6. 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.

An association may apply to the commissioner for a waiver of the 30-day waiting period as to that association. The commissioner may grant the waiver upon a finding of all of the following: (1) that the association is in full compliance with this section;

(2) that sanctions have not been imposed against the association as a result of significant disciplinary action by the department of commerce; and (3) that at least 90 percent of the association's income comes from dues, contributions, or sources other than income from the sale of insurance.

**History:** 1993 c 1 s 1; 1993 c 330 s 1-3,12

## 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 section 62E.07, and will provide:

(1) coverage for all of the Medicare part A inpatient hospital deductible and coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare;

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

(3) coverage for the copayment amount of Medicare eligible expenses under Medicare part B regardless of hospital confinement, and the Medicare part B deductible amount;

(4) 80 percent of usual and customary hospital and medical expenses and supplies, not to exceed any charge limitation established by the Medicare program or state law, and prescription drug expenses, not covered by Medicare's eligible expenses;

(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;

(6) 100 percent of the cost of immunizations and routine screening procedures for cancer, including mammograms and pap smears;

(7) preventive medical care benefit: coverage for the following preventive health services:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) and patient education to address preventive health care measures;

(ii) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) fecal occult blood test and/or digital rectal examination;

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(C) pure tone (air only) hearing screening test administered or ordered by a physician;

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

(iii) any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare;

(8) at-home recovery benefit: coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:

(i) for purposes of this benefit, the following definitions shall apply:

(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "at-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;

(ii) coverage requirements and limitations:

(A) at-home recovery services provided must be primarily services that assist in activities of daily living;

(B) the insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as medically necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of \$40 per visit;

(III) \$1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit;

(iii) coverage is excluded for:

(A) home care visits paid for by Medicare or other government programs; and

(B) care provided by family members, unpaid volunteers, or providers who are not care providers.

**History:** 1993 c 330 s 4

## **62A.316 BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.**

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

(1) coverage for all of the Medicare part A inpatient hospital coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare, after satisfying the Medicare part A deductible;

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

(3) coverage for the copayment amount of Medicare eligible expenses under Medicare part B regardless of hospital confinement, subject to the Medicare part B deductible amount;

(4) 80 percent of the hospital and medical expenses and supplies incurred during travel outside the United States as a result of a medical emergency;

(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; and

(6) 100 percent of the cost of immunizations and routine screening procedures for cancer screening including mammograms and pap smears.

(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;

(2) a minimum of 80 percent of eligible medical expenses and supplies not covered by Medicare part B, not to exceed any charge limitation established by the Medicare program or state law;

(3) coverage for all of the Medicare part B annual deductible;

(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses;

(5) coverage for the following preventive health services:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) and patient education to address preventive health care measures;

(ii) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) fecal occult blood test and/or digital rectal examination;

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(C) pure tone (air only) hearing screening test, administered or ordered by a physician;

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

(iii) any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for a procedure covered by Medicare;

(6) coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:

(i) For purposes of this benefit, the following definitions apply:

(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aid, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "at-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;

(ii) Coverage requirements and limitations:

(A) at-home recovery services provided must be primarily services that assist in activities of daily living;

(B) the insured's attending physician must certify that the specific type and fre-

quency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home care visits under a Medicare-approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of \$40 per visit;

(III) \$1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit;

(iii) Coverage is excluded for:

(A) home care visits paid for by Medicare or other government programs; and

(B) care provided by family members, unpaid volunteers, or providers who are not care providers.

**History:** 1993 c 330 s 5

## **62A.318 MEDICARE SELECT POLICIES AND CERTIFICATES.**

(a) This section applies to Medicare select policies and certificates, as defined in this section, including those issued by health maintenance organizations. No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

(b) For the purposes of this section:

(1) "complaint" means any dissatisfaction expressed by an individual concerning a Medicare select issuer or its network providers;

(2) "grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare select issuer or its network providers;

(3) "Medicare select issuer" means an issuer offering, or seeking to offer, a Medicare select policy or certificate;

(4) "Medicare select policy" or "Medicare select certificate" means a Medicare supplement policy or certificate that contains restricted network provisions;

(5) "network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy or certificate;

(6) "restricted network provision" means a provision that conditions the payment of benefits, in whole or in part, on the use of network providers; and

(7) "service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare select policy or certificate.

(c) The commissioner may authorize an issuer to offer a Medicare select policy or certificate pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, Public Law Number 101-508, if the commissioner finds that the issuer has satisfied all of the requirements of Minnesota Statutes.

(d) A Medicare select issuer shall not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(e) A Medicare select issuer shall file a proposed plan of operation with the commissioner, in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(i) the services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

(ii) the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(A) to deliver adequately all services that are subject to a restricted network provision; or

(B) to make appropriate referrals;

(iii) there are written agreements with network providers describing specific responsibilities;

(iv) emergency care is available 24 hours per day and seven days per week; and

(v) in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against an individual insured under a Medicare select policy or certificate. This section does not apply to supplemental charges or coinsurance amounts as stated in the Medicare select policy or certificate;

(2) a statement or map providing a clear description of the service area;

(3) a description of the grievance procedure to be used;

(4) a description of the quality assurance program, including:

(i) the formal organizational structure;

(ii) the written criteria for selection, retention, and removal of network providers; and

(iii) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted;

(5) a list and description, by specialty, of the network providers;

(6) copies of the written information proposed to be used by the issuer to comply with paragraph (i); and

(7) any other information requested by the commissioner.

(f) A Medicare select issuer shall file proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner before implementing the changes. The changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

An updated list of network providers shall be filed with the commissioner at least quarterly.

(g) A Medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or condition; and

(2) it is not reasonable to obtain the services through a network provider.

(h) A Medicare select policy or certificate shall provide payment for full coverage under the policy or certificate for covered services that are not available through network providers.

(i) A Medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare select policy or certificate to each applicant. This disclosure must include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate with:

- (i) other Medicare supplement policies or certificates offered by the issuer; and
- (ii) other Medicare select policies or certificates;

(2) a description, including address, phone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are used;

(4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

(7) a description of the Medicare select issuer's quality assurance program and grievance procedure.

(j) Before the sale of a Medicare select policy or certificate, a Medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to paragraph (i) and that the applicant understands the restrictions of the Medicare select policy or certificate.

(k) A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure must be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances must be considered in a timely manner and must be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action must be taken promptly.

(5) All concerned parties must be notified about the results of a grievance.

(6) The issuer shall report no later than March 31 of each year to the commissioner regarding the grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of the grievances.

(l) At the time of initial purchase, a Medicare select issuer shall make available to each applicant for a Medicare select policy or certificate the opportunity to purchase a Medicare supplement policy or certificate otherwise offered by the issuer.

(m)(1) At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare supplement policy or certificate has been in force for six months. If the issuer does not have available for sale a policy or certificate without restrictive network provisions, the issuer shall provide enrollment information for the Minnesota comprehensive health association Medicare supplement plans.

(2) For the purposes of this paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more

significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for part B excess charges.

(n) Medicare select policies and certificates shall provide for continuation of coverage if the secretary of health and human services determines that Medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare select program to be reauthorized under law or its substantial amendment.

(1) Each Medicare select issuer shall make available to each individual insured under a Medicare select policy or certificate the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for part B excess charges.

(o) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare select program.

(p) Medicare select policies and certificates under this section shall be regulated and approved by the department of commerce.

(q) Medicare select policies and certificates must be either a basic plan or an extended basic plan. The basic plan may also include any of the optional benefit riders authorized by section 62A.316. Preventive care provided by Medicare select policies or certificates must be provided as set forth in section 62A.315 or 62A.316, except that the benefits are as defined in chapter 62D.

(r) Medicare select policies and certificates are exempt from the requirements of section 62A.31, subdivision 1, paragraph (d). This paragraph expires January 1, 1994.

**History:** 1993 c 330 s 6

## 62A.36 LOSS RATIO STANDARDS.

**Subdivision 1. Loss ratio standards.** (a) A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

(1) at least 75 percent of the aggregate amount of premiums earned in the case of group policies, and

(2) at least 65 percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. An insurer shall demonstrate that the third year loss ratio is greater than or equal to the applicable percentage.

All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy or certificate shall equal or exceed the appropriate loss ratio standards.

(b) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the National Association of Insurance Commissioners Medicare Supplement Refund Calculating form, for each type of Medicare supplement benefit plan.

If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation must be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week treasury bills. A refund or credit against premiums due shall be made by September 30 following the experience year on which the refund or credit is based.

(c) An issuer of Medicare supplement policies and certificates in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy or certificate duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but before the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(1) a premium adjustment that is necessary to produce an expected loss ratio under the policy or certificate that will conform with minimum loss ratio standards for Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy or certificate other than the adjustments described herein shall be made with respect to a policy or certificate at any time other than on its renewal date or anniversary date;

(2) if an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits considered necessary to achieve the loss ratio required by this section;

(3) any appropriate riders, endorsements, or policy or certificate forms needed to accomplish the Medicare supplement insurance policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy or certificate forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(d) The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of a refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner considered appropriate by the commissioner.

(e) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with, and approved by, the commissioner according to the filing requirements and procedures prescribed by the commissioner.

*[For text of subds 1a to 2, see M.S.1992]*

**History:** 1993 c 330 s 7

## 62A.39 DISCLOSURE.

No individual Medicare supplement plan shall be delivered or issued in this state and no certificate shall be delivered under a group Medicare supplement plan delivered or issued in this state unless the plan is shown on the cover page and an outline containing at least the following information in no less than 12-point type 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 OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.;"
- (c) A statement of the renewal provisions including any reservations by the insurer of a right to change premiums. The premium and manner of payment shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated;
- (d) **Read your policy or certificate very carefully.** 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. Additionally, it does not give all the details of Medicare coverage. Contact your local Social Security office or consult the Medicare handbook for more details;
- (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.;"
- (f) When the outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.;"
- (g) **Right to return policy or certificate.** "If you find that you are not satisfied with your policy or certificate for any reason, you may return it to (insert issuer's address). If you send the policy or certificate back to us within 30 days after you receive it, we will treat the policy or certificate as if it had never been issued and return all of your payments within ten days.;"
- (h) **Policy or certificate replacement.** "If you are replacing another health insurance policy or certificate, do NOT cancel it until you have actually received your new policy or certificate and are sure you want to keep it.;"
- (i) **Notice.** "This policy or certificate may not fully cover all of your medical costs."
  - A. (for agents:) "Neither (insert company's name) nor its agents are connected with Medicare."
  - B. (for direct response:) "(insert company's name) is not connected with Medicare."
- (j) Notice regarding policies or certificates which are not Medicare supplement policies.

Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, or a policy or certificate issued pursuant to a contract under the fed-

eral Social Security Act, section 1833 or 1876 (United States Code, title 42, section 1395, et seq.), disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy; or other policy, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

**“THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Medicare supplement buyer’s guide available from the company.”**

(k) **Complete answers are very important.** “When you fill out the application for the new policy or certificate, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy or certificate and refuse to pay any claims if you leave out or falsify important medical information.” If the policy or certificate is guaranteed issue, this paragraph need not appear.

“Review the application carefully before you sign it. Be certain that all information has been properly recorded.”

Include for each plan, prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments, and insured payments for each plan, using the same language, in the same order, using uniform layout and format.

The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the insurer.

**History:** 1993 c 330 s 8

## **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.

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.

For purposes of this section, “compensation” includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, awards, and finder’s fees.

This section also applies to sales of replacement policies.

**History:** 1993 c 330 s 9

## **62A.44 APPLICATIONS.**

*[For text of subd 1, see M.S.1992]*

**Subd. 2. Questions.** (a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing the questions and statements may be used.

“(1) You do not need more than one Medicare supplement policy or certificate.

(2) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy or certificate.

(3) The benefits and premiums under your Medicare supplement policy or certificate will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy or certificate will be reinstated if requested within 90 days of losing Medicaid eligibility.

To the best of your knowledge:

(1) Do you have another Medicare supplement policy or certificate in force, including health care service contract or health maintenance organization contract? If so, with which company?

(2) Do you have any other health insurance policies that provide benefits that this Medicare supplement policy or certificate would duplicate? If you do, please name the company and the kind of policy.

(3) If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy or certificate?

(4) Are you covered by Medicaid?"

(b) Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold that are still in force.

(2) List policies sold in the past five years that are no longer in force.

(c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer on delivery of the policy or certificate.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, before issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy or certificate the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by paragraph (d) for an issuer shall be provided in substantially the following form in no less than 12-point type:

**"NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE**  
(Insurance company's name and address)

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement insurance and replace it with a policy or certificate to be issued by (Company Name) Insurance Company. Your new policy or certificate will provide 30 days within which you may decide without cost whether you desire to keep the policy or certificate.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

**STATEMENT TO APPLICANT BY ISSUER, AGENT, (BROKER OR  
OTHER REPRESENTATIVE):** I have reviewed your current medical or  
health insurance coverage. The replacement of insurance involved in this  
transaction does not duplicate coverage, to the best of my knowledge. The  
replacement policy or certificate is being purchased for the following rea-  
son(s) (check one):

Additional benefits  
 No change in benefits, but lower premiums  
 Fewer benefits and lower premiums  
 Other (please specify)

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(1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy or certificate. This could result in denial or delay of a claim for benefits under the new policy or certificate, whereas a similar claim might have been payable under your present policy or certificate.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent the time was spent (depleted) under the original policy or certificate.

(3) If you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Do not cancel your present policy or certificate until you have received your new policy or certificate and you are sure that you want to keep it.

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(Signature of Agent, Broker, or Other Representative)\*

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(Typed Name and Address of Issuer, Agent, or Broker)

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(Date)

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(Applicant's Signature)

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(Date)

\*Signature not required for direct response sales."

(f) Paragraph (e), clauses (1) and (2), of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

**History:** 1993 c 13 art 1 s 18; 1993 c 330 s 10

## 62A.46 DEFINITIONS.

*[For text of subds 1 to 6, see M.S.1992]*

**Subd. 7. Physician.** "Physician" means a medical practitioner licensed or holding a temporary permit under sections 147.02, 147.03, 147.031, 147.037, or holding a residency permit under section 147.0391.

*[For text of subds 8 to 12, see M.S.1992]*

**History:** 1993 c 21 s 1

## 62A.48 LONG-TERM CARE POLICIES.

*[For text of subds 1 to 6, see M.S.1992]*

**Subd. 7. Existing policies.** Nothing in sections 62A.46 to 62A.56 prohibits the renewal of the following long-term care policies:

- (1) policies sold outside the state of Minnesota to persons who at the time of sale were not residents of the state of Minnesota;
- (2) policies sold before August 1, 1986; and
- (3) policies sold before July 1, 1988, by associations exempted from sections 62A.31 to 62A.44 under section 62A.31, subdivision 6.

*[For text of subd 8, see M.S.1992]*

**History:** 1993 c 330 s 12

## 62A.61 DISCLOSURE OF METHODS USED BY HEALTH CARRIERS TO DETERMINE USUAL AND CUSTOMARY FEES.

(a) A health carrier that bases reimbursement to health care providers upon a usual and customary fee must maintain in its office a copy of a description of the methodology used to calculate fees including at least the following:

- (1) the frequency of the determination of usual and customary fees;
- (2) a general description of the methodology used to determine usual and customary fees; and
- (3) the percentile of usual and customary fees that determines the maximum allowable reimbursement.

(b) A health carrier must provide a copy of the information described in paragraph (a) to the Minnesota health care commission, the commissioner of health, or the commissioner of commerce, upon request.

(c) The commissioner of health or the commissioner of commerce, as appropriate, may use to enforce this section any enforcement powers otherwise available to the commissioner with respect to the health carrier. The appropriate commissioner shall enforce compliance with a request made under this section by the Minnesota health care commission, at the request of the commissioner. The commissioner of health or commerce, as appropriate, may require health carriers to provide the information required under this section and may use any powers granted under other laws relating to the regulation of health carriers to enforce compliance.

(d) For purposes of this section, "health carrier" has the meaning given in section 62A.011.

**History:** 1993 c 345 art 8 s 3

## 62A.65 INDIVIDUAL MARKET REGULATION.

**Subdivision 1. Applicability.** No health carrier, as defined in section 62A.011, shall offer, sell, issue, or renew any individual health plan, as defined in section 62A.011, to a Minnesota resident except in compliance with this section. This section does not apply to the comprehensive health association established in section 62E.10.

**Subd. 2. Guaranteed renewal.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the health plan provides that the plan is guaranteed renewable at a premium rate that does not take into account the claims

experience or any change in the health status of any covered person that occurred after the initial issuance of the health plan to the person. The premium rate upon renewal must also otherwise comply with this section. An individual health plan may be subject to refusal to renew only under the conditions provided in chapter 62L for health benefit plans.

**Subd. 3. Premium rate restrictions.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the rating and premium restrictions provided under chapter 62L, except that the minimum loss ratio applicable to an individual health plan is as provided in section 62A.021. All rating and premium restrictions of chapter 62L apply to the individual market, unless clearly inapplicable to the individual market.

**Subd. 4. Gender rating prohibited.** No individual health plan offered, sold, issued, or renewed to a Minnesota resident may determine the premium rate or any other underwriting decision, including initial issuance, on the gender of any person covered or to be covered under the health plan.

**Subd. 5. Portability of coverage.** (a) No individual health plan may be offered, sold, issued, or with respect to children age 18 or under renewed, to a Minnesota resident that contains a preexisting condition limitation or exclusion, unless the limitation or exclusion would be permitted under chapter 62L, provided that, except for children age 18 or under, underwriting restrictions may be retained on individual contracts that are issued without evidence of insurability as a replacement for prior individual coverage that was sold before May 17, 1993. The individual may be treated as a late entrant, as defined in chapter 62L, unless the individual has maintained continuous coverage as defined in chapter 62L. An individual who has maintained continuous coverage may be subjected to a one-time preexisting condition limitation as permitted under chapter 62L for persons who are not late entrants, at the time that the individual first is covered under an individual health plan by any health carrier. Thereafter, the individual must not be subject to any preexisting condition limitation under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health benefit plan issued by that health carrier, so long as the individual maintained continuous coverage as defined in chapter 62L. A health plan issued under this paragraph must be a qualified plan and must not contain any pre-existing condition limitation or exclusion, except for any unexpired limitation or exclusion under the previous coverage. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. In no event shall the premium rate exceed 90 percent of the premium charged for comparable individual coverage by the Minnesota comprehensive health association.

**Subd. 6. Guaranteed issue not required.** Nothing in this section requires a health carrier to initially issue a health plan to a Minnesota resident, except as otherwise expressly provided in subdivision 4 or 5.

**History:** 1993 c 247 art 3 s 6; 1993 c 345 art 8 s 4

## 62A.651 PHASE-IN.

**Subdivision 1. Compliance.** No health carrier, as defined in section 62A.011, shall renew any individual health plan, as defined in section 62A.011, except in compliance with this section.

**Subd. 2. Premium adjustments.** Any increase or decrease in premiums by a health carrier that is caused by section 62A.65, is subject to the premium adjustments in this subdivision. A health carrier shall determine renewal premiums for any coverage under subdivision 1 as follows:

(1) one-half of the premium increase or decrease may be charged upon the first renewal of the coverage on or after July 1, 1993; and

(2) the remaining half of the premium increase or decrease may be charged upon the first renewal of the coverage one year after the date of the renewal under clause (1).

**History:** 1993 c 345 art 8 s 6