

## CHAPTER 62A

## ACCIDENT AND HEALTH INSURANCE

62A.021	Health care policy rates.	62A.315	Extended basic Medicare supplement plan; coverage.
62A.14	Handicapped children.	62A.316	Basic Medicare supplement plan; coverage.
62A.27	Coverage of adopted children.	62A.48	Long-term care policies.
62A.301	Coverage of full-time students.	62A.49	Home care services coverage.
62A.31	Medicare supplement benefits; minimum standards.	62A.65	Individual market regulation.

**62A.021 HEALTH CARE POLICY RATES.**

Subdivision 1. **Loss ratio standards.** (a) 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 all 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.

(b) 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.

(c) 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.

(d) 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.

(e)(1) 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.

(2) For purposes of this section, (i) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and (ii) "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.

(f) The loss ratio phase-in as described in paragraph (a) does not apply to individual policies and small employer policies issued by a health plan company that is assessed less than three percent of the total annual amount assessed by the Minnesota Comprehensive Health Association. These policies must meet a 68 percent loss ratio for individual policies, a 71 percent loss ratio for small employer policies with fewer than ten employees, and a 75 percent loss ratio for all other small employer policies.

(g) Notwithstanding paragraphs (a) and (f), the loss ratio shall be 60 percent for a health plan as defined in section 62A.011, offered by an insurance company licensed under chapter 60A that is assessed less than ten percent of the total annual amount assessed by the Minnesota Comprehensive Health Association. For purposes of the percentage calculation of the association's assessments, an insurance company's assessments include those of its affiliates.

(h) The commissioners of commerce and health shall each annually issue a public report listing, by health plan company, the actual loss ratios experienced in the individual and small employer markets in this state by the health plan companies that the commissioners respectively regulate. The commissioners shall coordinate release of these reports so as to release them as a joint report or as separate reports issued the same day. The report or reports shall be released no later than June 1 for loss ratios experienced for the preceding calendar year. Health plan companies shall provide to the commissioners any information requested by the commissioners for purposes of this paragraph.

*[For text of subs 2 and 3, see M.S.2002]*

**History:** 2003 c 109 s 1

#### **62A.14 HANDICAPPED CHILDREN.**

**Subdivision 1. Individual family policies.** An individual hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, or an individual health maintenance contract delivered or issued for delivery in this state after August 1, 1984, which provides that coverage of a

dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap and (b) chiefly dependent upon the policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or health maintenance organization by the policyholder or enrollee within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two-year period following the child's attainment of the limiting age. Any notice regarding termination of coverage due to attainment of the limiting age must include all the information in this section.

**Subd. 2. Group policies.** A group hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, or a group health maintenance contract delivered or issued for delivery in this state after August 1, 1984, which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap and (b) chiefly dependent upon the employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or organization by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two-year period following the child's attainment of the limiting age. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this provision.

**History:** 2003 c 40 s 1

#### **62A.27 COVERAGE OF ADOPTED CHILDREN.**

(a) A health plan that provides coverage to a Minnesota resident must cover adopted children of the insured, subscriber, participant, or enrollee on the same basis as other dependents. Consequently, the plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning children placed for adoption with the participant.

(b) The coverage required by this section is effective from the date of placement for adoption. For purposes of this section, placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation for total or partial support.

(c) For the purpose of this section, health plan includes:

(1) coverage offered by community integrated service networks;

(2) coverage that is designed solely to provide dental or vision care; and

(3) any plan under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461.

**History:** 2003 c 2 art 1 s 7

#### **62A.301 COVERAGE OF FULL-TIME STUDENTS.**

If an insurer provides individual or group accident and health coverage for dependents after what otherwise would be the limiting age based on full-time student status the insurer must include in its definition of full-time student, any student who by reason of illness, injury, or physical or mental disability as documented by a physician is unable to carry what the educational institution considers a full-time course load so long as the student's course load is at least 60 percent of what otherwise is considered

by the institution to be a full-time course load. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this provision.

For purposes of this section, "insurer" means an insurer providing accident and health insurance regulated under this chapter, a nonprofit health service plan corporation regulated under chapter 62C, a health maintenance organization regulated under chapter 62D, or a fraternal benefit society regulated under chapter 64B.

**History:** 2003 c 40 s 2

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

*[For text of subds 1 to 1e, see M.S.2002]*

**Subd. 1f. Suspension based on entitlement to medical assistance.** (a) The policy or certificate must provide that benefits and premiums under the policy or certificate shall be suspended for any period that may be provided by federal regulation at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder 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 or certificate holder notifies the issuer of the policy or certificate 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 or certificate shall be automatically reinstated, effective as of the date of termination of this entitlement, if the policyholder or certificate holder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(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.

*[For text of subds 1g to 1t, see M.S.2002]*

**Subd. 1u. Guaranteed issue for eligible persons.** (a)(1) Eligible persons are those individuals described in paragraph (b) who seek to enroll under the policy during the period specified in paragraph (c) and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not: deny or condition the issuance or effectiveness of a Medicare supplement policy described in paragraph (c) that is offered and is available for issuance to new enrollees by the issuer; discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, medical condition, or age; or impose an exclusion of benefits based upon a preexisting condition under such a Medicare supplement policy.

(b) An eligible person is an individual described in any of the following:

(1) the individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(2) the individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the federal Social Security Act, and there are circumstances similar to those described in this clause that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare+Choice plan:

(i) the organization's or plan's certification under Medicare Part C has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(ii) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act, United States Code, title 42, section 1395w-21(g)(3)(b) (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the federal Social Security Act, United States Code, title 42, section 1395w-26), or the plan is terminated for all individuals within a residence area;

(iii) the individual demonstrates, in accordance with guidelines established by the Secretary; that:

(A) the organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(B) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(iv) the individual meets such other exceptional conditions as the secretary may provide;

(3)(i) the individual is enrolled with:

(A) an eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) an organization under an agreement under section 1833(a)(1)(A) of the federal Social Security Act, United States Code, title 42, section 1395l(a)(1)(A) (health care prepayment plan); or

(D) an organization under a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under clause (2);

(4) the individual is enrolled under a Medicare supplement policy, and the enrollment ceases because:

(i)(A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(B) of other involuntary termination of coverage or enrollment under the policy;

(ii) the issuer of the policy substantially violated a material provision of the policy; or

(iii) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5)(i) the individual was enrolled under a Medicare supplement policy and terminates that enrollment and subsequently enrolls, for the first time, with any Medicare + Choice organization under a Medicare + Choice plan under Medicare Part C; any eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare cost); any similar organization operating under demonstration project authority; any PACE provider under section 1894 of the federal Social Security Act, or a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the subsequent enrollment under item (i) is terminated by the enrollee during any period within the first 12 months of the subsequent enrollment during which the

enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the federal Social Security Act; or

(6) the individual, upon first enrolling for benefits under Medicare Part B, enrolls in a Medicare + Choice plan under Medicare Part C, or with a PACE provider under section 1894 of the federal Social Security Act, and disenrolls from the plan by not later than 12 months after the effective date of enrollment.

(c)(1) In the case of an individual described in paragraph (b), clause (1), the guaranteed issue period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, notice that a claim has been denied because of a termination or cessation, and ends 63 days after the date of the applicable notice.

(2) In the case of an individual described in paragraph (b), clause (2), (3), (5), or (6), whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in paragraph (b), clause (4), item (i), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and (ii) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(4) In the case of an individual described in paragraph (b), clause (2), (4), (5), or (6), who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(5) In the case of an individual described in paragraph (b) but not described in this paragraph, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(d)(1) In the case of an individual described in paragraph (b), clause (5), or deemed to be so described, pursuant to this paragraph, whose enrollment with an organization or provider described in paragraph (b), clause (5), item (i), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (5).

(2) In the case of an individual described in paragraph (b), clause (6), or deemed to be so described, pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (b), clause (6), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (6).

(3) For purposes of paragraph (b), clauses (5) and (6), no enrollment of an individual with an organization or provider described in paragraph (b), clause (5), item (i), or with a plan or in a program described in paragraph (b), clause (6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with the organization, provider, plan, or program.

(e) The Medicare supplement policy to which eligible persons are entitled under:

(1) paragraph (b), clauses (1) to (4), is any Medicare supplement policy that has a benefit package consisting of the basic Medicare supplement plan described in section 62A.316, paragraph (a), plus any combination of the three optional riders described in section 62A.316, paragraph (b), clauses (1) to (3), offered by any issuer;

(2) paragraph (b), clause (5), is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, any policy described in clause (1) offered by any issuer;

(3) paragraph (b), clause (6), shall include any Medicare supplement policy offered by any issuer.

(f)(1) At the time of an event described in paragraph (b), because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in paragraph (b), because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated within ten working days of the issuer receiving notification of disenrollment.

(g) Reference in this subdivision to a situation in which, or to a basis upon which, an individual's coverage has been terminated does not provide authority under the laws of this state for the termination in that situation or upon that basis.

(h) An individual's rights under this subdivision are in addition to, and do not modify or limit, the individual's rights under subdivision 1h.

*[For text of subs 2 to 6, see M.S.2002]*

**Subd. 7. Medicare prescription drug benefit.** If Congress enacts legislation creating a prescription drug benefit in the Medicare program, nothing in this section or any other section shall prohibit an issuer of a Medicare supplement policy from offering this prescription drug benefit consistent with the applicable federal law or regulations. If an issuer offers the federal benefit, such an offer shall be deemed to meet the issuer's mandatory offer obligations under this section and may, at the discretion of the issuer, constitute replacement coverage as defined in subdivision 1i for any existing policy containing a prescription drug benefit.

**History:** 1Sp2003 c 14 art 7 s 2-4

## **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 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 co-payment amount of Medicare Part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, and the Medicare Part B deductible amount;

(4) 80 percent of the usual and customary hospital and medical expenses and supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation established by the Medicare program or state law, the usual and customary hospital and medical expenses and supplies, described in section 62E.06, subdivision 1, while in a foreign country, and prescription drug expenses, not covered by Medicare;

(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/home-maker, 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 \$100 per visit;

- (III) \$4,000 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 unpaid volunteers or providers who are not care providers.

**History:** *1Sp2003 c 14 art 2 s 2; art 7 s 5*

#### **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 co-payment amount of Medicare part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the coinsurance amount, or in the case of outpatient department services paid under a prospective payment system, the co-payment 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;

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

(7) 80 percent of coverage for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes. Coverage must include persons with gestational, type I, or type II diabetes.

(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/home-maker, 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 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 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;

(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses to a maximum of \$1,200 paid by the issuer annually under this benefit. An issuer of Medicare supplement insurance policies that elects to offer this benefit rider shall also make available coverage that contains the rider specified in clause (4).

**History:** *1Sp2003 c 14 art 7 s 6*

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

*[For text of subds 1 to 11, see M.S.2002]*

Subd. 12. **Regulatory flexibility.** The commissioner may upon written request issue an order to modify or suspend a specific provision or provisions of sections 62A.46 to 62A.56 with respect to a specific long-term care insurance policy or certificate upon a written finding that:

- (1) the modification or suspension is in the best interest of the insureds;
- (2) the purpose to be achieved could not be effectively or efficiently achieved without the modifications or suspension; and
- (3)(i) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;
- (ii) the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
- (iii) the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

**History:** *1Sp2003 c 14 art 2 s 3*

## 62A.49 HOME CARE SERVICES COVERAGE.

*[For text of subds 1 and 2, see M.S.2002]*

Subd. 3. **Prohibited limitations.** A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits by:

- (1) requiring that the insured would need care in a skilled nursing facility if home health care services were not provided;
- (2) requiring that the insured first or simultaneously receive nursing or therapeutic services in a home, community, or institutional setting before home health care services are covered;
- (3) limiting eligible services to services provided by a registered nurse or licensed practical nurse;
- (4) requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of licensure or certification;
- (5) excluding coverage for personal care services provided by a home health aide;
- (6) requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;
- (7) requiring that the insured have an acute condition before home health care services are covered;
- (8) limiting benefits to services provided by Medicare-certified agencies or providers;
- (9) excluding coverage for adult day care services; or

(10) excluding coverage based upon location or type of residence in which the home health care services would be provided.

**History:** 1Sp2003 c 14 art 2 s 4

## 62A.65 INDIVIDUAL MARKET REGULATION.

*[For text of subds 1 to 6, see M.S.2002]*

Subd. 7. **Short-term coverage.** (a) For purposes of this section, "short-term coverage" means an individual health plan that:

(1) is issued to provide coverage for a period of 185 days or less, except that the health plan may permit coverage to continue until the end of a period of hospitalization for a condition for which the covered person was hospitalized on the day that coverage would otherwise have ended;

(2) is nonrenewable, provided that the health carrier may provide coverage for one or more subsequent periods that satisfy clause (1), if the total of the periods of coverage do not exceed a total of 365 days out of any 555-day period, plus any additional days covered as a result of hospitalization on the day that a period of coverage would otherwise have ended;

(3) does not cover any preexisting conditions, including ones that originated during a previous identical policy or contract with the same health carrier where coverage was continuous between the previous and the current policy or contract; and

(4) is available with an immediate effective date without underwriting upon receipt of a completed application indicating eligibility under the health carrier's eligibility requirements, provided that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(b) Short-term coverage is not subject to subdivisions 2 and 5. Short-term coverage may exclude as a preexisting condition any injury, illness, or condition for which the covered person had medical treatment, symptoms, or any manifestations before the effective date of the coverage, but dependent children born or placed for adoption during the policy period must not be subject to this provision.

(c) Notwithstanding subdivision 3, and section 62A.021, a health carrier may combine short-term coverage with its most commonly sold individual qualified plan, as defined in section 62E.02, other than short-term coverage, for purposes of complying with the loss ratio requirement.

(d) The 365-day coverage limitation provided in paragraph (a) applies to the total number of days of short-term coverage that covers a person, regardless of the number of policies, contracts, or health carriers that provide the coverage. A written application for short-term coverage must ask the applicant whether the applicant has been covered by short-term coverage by any health carrier within the 555 days immediately preceding the effective date of the coverage being applied for. Short-term coverage issued in violation of the 365-day limitation is valid until the end of its term and does not lose its status as short-term coverage, in spite of the violation. A health carrier that knowingly issues short-term coverage in violation of the 365-day limitation is subject to the administrative penalties otherwise available to the commissioner of commerce or the commissioner of health, as appropriate.

(e) Time spent under short-term coverage counts as time spent under a preexisting condition limitation for purposes of group or individual health plans, other than short-term coverage, subsequently issued to that person, or to cover that person, by any health carrier, if the person maintains continuous coverage as defined in section 62L.02. Short-term coverage is a health plan and is qualifying coverage as defined in section 62L.02. Notwithstanding any other law to the contrary, a health carrier is not required under any circumstances to provide a person covered by short-term coverage the right to obtain coverage on a guaranteed issue basis under another health plan offered by the health carrier, as a result of the person's enrollment in short-term coverage.

*[For text of subd 8, see M.S.2002]*

**History:** 1Sp2003 c 14 art 7 s 7