CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

POLICIES, RATES, AND COVERAGES

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62A.001 MS 2006 [Renumbered 15.001]

POLICIES, RATES, AND COVERAGES

62A.01 REQUIREMENTS; CERTIFICATES OF COVERAGE UNDER POLICY OF ACCIDENT AND SICKNESS INSURANCE.

Subdivision 1. **Definition.** The term "policy of accident and sickness insurance" as used herein includes any policy covering the kind of insurance described in section 60A.06, subdivision 1, clause (5)(a), or the paid family and medical leave benefits as described in section 268B.10.

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

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

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

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

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

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

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

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

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

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

Subd. 5. **Direct primary care service agreements.** (a) A direct primary care service agreement under section 62Q.20 is not insurance and is not subject to this chapter. Entering into a direct primary care service agreement is not the business of insurance and is not subject to this chapter or chapter 60A.

(b) A health care provider or agent of a health care provider is not required to obtain a certificate of authority or license under this chapter or chapter 60A, 62C, 62D, or 62N to market, sell, or offer to sell a direct primary care service agreement that meets the requirements of section 62Q.20.

[See Note.]

History: *1967 c 395 art 3 s 1; 1989 c 330 s 8; 2023 c 59 art 1 s 2; 2026 c 127 art 14 s 1*

NOTE: Subdivision 5, as added by Laws 2026, chapter 127, article 14, section 1, is effective August 1, 2027. Laws 2026, chapter 131, section 3.

62A.011 DEFINITIONS.

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

Subd. 1a. **Affordable Care Act.** "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance or regulations issued under, these acts.

Subd. 1b. **Grandfathered plan.** "Grandfathered plan" means a health plan in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with the Affordable Care Act. Unless otherwise specified, grandfathered plans include both individual and group health plans.

Subd. 1c. **Group health plan.** "Group health plan" means a policy or certificate issued to an employer or an employee organization that is both:

(1) a health plan as defined in subdivision 3; and

(2) an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, United States Code, title 29, section 1002, if the plan provides payment for medical care to employees, including both current and former employees, or their dependents, directly or through insurance, reimbursement, or otherwise, including employee welfare benefit plans specifically exempt from the provisions of the Employee Retirement Income Security Act of 1974 under United States Code, title 29, section 1003.

Subd. 2. **Health carrier.** "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a fraternal benefit society operating under chapter 64B; or a joint self-insurance employee health plan operating under chapter 62H.

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) liability insurance, including general liability insurance and automobile liability insurance, or coverage issued as a supplement to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, including coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity insurance, if the benefits are provided under a separate policy, certificate, or contract for insurance; there is no coordination between the provision of benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor;

(5) credit accident and health insurance as defined in section 62B.02;

(6) designed solely to provide hearing, 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 or 62S.01;

(10) issued as a supplement to Medicare, as defined in sections 62A.3099 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876, section 1851, et seq.; or section 1860D-1, et seq., of title XVIII of the federal Social Security Act, et seq., as amended;

(11) workers' compensation insurance;

(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;

(13) coverage for on-site medical clinics;

(14) coverage supplemental to the coverage provided under United States Code, title 10, chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or

(15) coverage provided under a direct primary care service agreement described under section 62Q.20.

[See Note.]

Subd. 4. **Individual health plan.** "Individual health plan" means a health plan as defined in subdivision 3 that is offered to individuals in the individual market as defined in subdivision 5, but does not mean short-term coverage as defined in section 62A.65, subdivision 7. For purposes of this chapter, a health carrier shall not be deemed to be offering individual health plan coverage solely because the carrier maintains a conversion policy in connection with a group health plan.

Subd. 5. **Individual market.** "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

Subd. 6. **MNsure.** "MNsure" means MNsure as defined in section 62V.02.

Subd. 7. **Qualified health plan.** "Qualified health plan" means a health plan that meets the definition in section 1301(a) of the Affordable Care Act and has been certified by the board of MNsure in accordance with chapter 62V to be offered through MNsure.

History: *1992 c 549 art 3 s 2; 1993 c 247 art 3 s 4; 1994 c 625 art 10 s 3; 1997 c 71 art 2 s 3; 2005 c 17 art 1 s 14; 2009 c 178 art 1 s 20; 2013 c 84 art 1 s 4-11; 2013 c 108 art 1 s 67; 2026 c 127 art 14 s 2*

NOTE: The amendment to subdivision 3 by Laws 2026, chapter 127, article 14, section 2, is effective August 1, 2027. Laws 2026, chapter 131, section 3.

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.

Subd. 2. **Approval.** (a) The health plan form shall not be issued, nor shall any application, rider, endorsement, or rate be used in connection with it, until the expiration of 60 days after it has been filed unless the commissioner approves it before that time.

(b) Notwithstanding paragraph (a), a rate filed with respect to a policy of accident and sickness insurance as defined in section 62A.01 by an insurer licensed under chapter 60A, may be used on or after the date of filing with the commissioner. Rates that are not approved or disapproved within the 60-day time period are deemed approved. This paragraph does not apply to Medicare-related coverage as defined in section 62A.3099, subdivision 17.

(c) For coverage to begin on or after January 1, 2016, and each January 1 thereafter, health plans in the individual and small group markets that are not grandfathered plans to be offered outside MNsure and qualified health plans to be offered inside MNsure must receive rate approval from the commissioner no later than 30 days prior to the beginning of the annual open enrollment period for MNsure. Premium rates for all carriers in the applicable market for the next calendar year must be made available to the public by the commissioner only after all rates for the applicable market are final and approved. Final and approved rates must be publicly released at a uniform time for all individual and small group health plans that are not grandfathered plans to be offered outside MNsure and qualified health plans to be offered inside MNsure, and no later than 30 days prior to the beginning of the annual open enrollment period for MNsure.

Subd. 3. **Standards for disapproval.** (a) The commissioner shall, within 60 days after the filing of any form or rate, disapprove the form or rate:

(1) if the benefits provided are not reasonable in relation to the premium charged;

(2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A;

(3) if the proposed premium rate is excessive or not adequate; or

(4) the actuarial reasons and data submitted do not justify the rate.

The party proposing a rate has the burden of proving by a preponderance of the evidence that it does not violate this subdivision.

In determining the reasonableness of a rate, the commissioner shall also review all administrative contracts, service contracts, and other agreements to determine the reasonableness of the cost of the contracts or agreement and effect of the contracts on the rate. If the commissioner determines that a contract or agreement is not reasonable, the commissioner shall disapprove any rate that reflects any unreasonable cost arising out of the contract or agreement. The commissioner may require any information that the commissioner deems necessary to determine the reasonableness of the cost.

For the purposes of this subdivision, the commissioner shall establish by rule a schedule of minimum anticipated loss ratios which shall be based on (i) the type or types of coverage provided, (ii) whether the policy is for group or individual coverage, and (iii) the size of the group for group policies. Except for individual policies of disability or income protection insurance, the minimum anticipated loss ratio shall not be less than 50 percent after the first year that a policy is in force. All applicants for a policy shall be informed in writing at the time of application of the anticipated loss ratio of the policy. "Anticipated loss ratio" means the ratio at the time of filing, at the time of notice of withdrawal under subdivision 4a, or at the time of subsequent rate revision of the present value of all expected future benefits, excluding dividends, to the present value of all expected future premiums.

If the commissioner notifies a health carrier that has filed any form or rate that it does not comply with this chapter, chapter 62L, or chapter 72A, it shall be unlawful for the health carrier to issue or use the form or rate. In the notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the health carrier.

The 60-day period within which the commissioner is to approve or disapprove the form or rate does not begin to run until a complete filing of all data and materials required by statute or requested by the commissioner has been submitted.

However, if the supporting data is not filed within 30 days after a request by the commissioner, the rate is not effective and is presumed to be an excessive rate.

(b) When an insurer or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission.

Subd. 3a. **Individual policy rates; file and use; minimum lifetime loss ratio guarantee.** (a) Notwithstanding subdivisions 2, 3, 4a, 5a, and 6, individual premium rates may be used upon filing with the department of an individual policy form if the filing is accompanied by the individual policy form filing and a minimum lifetime loss ratio guarantee. Insurers may use the filing procedure specified in this subdivision only if the affected individual policy forms disclose the benefit of a minimum lifetime loss ratio guarantee. Insurers may amend individual policy forms to provide for a minimum lifetime loss ratio guarantee. If an insurer elects to use the filing procedure in this subdivision for an individual policy rate, the insurer shall

not use a filing of premium rates that does not provide a minimum lifetime loss ratio guarantee for that individual policy rate.

(b) The minimum lifetime loss ratio guarantee must be in writing and must contain at least the following:

(1) an actuarial memorandum specifying the expected loss ratio that complies with the standards as set forth in this subdivision;

(2) a statement certifying that all rates, fees, dues, and other charges are not excessive, inadequate, or unfairly discriminatory;

(3) detailed experience information concerning the policy forms;

(4) a step-by-step description of the process used to develop the minimum lifetime loss ratio, including demonstration with supporting data;

(5) guarantee of specific minimum lifetime loss ratio that must be greater than or equal to 65 percent for policies issued to individuals or for certificates issued to members of an association that does not offer coverage to small employers, taking into consideration adjustments for duration;

(6) a guarantee that the actual Minnesota loss ratio for the calendar year in which the new rates take effect, and for each year thereafter until new rates are filed, will meet or exceed the minimum lifetime loss ratio standards referred to in clause (5), adjusted for duration;

(7) a guarantee that the actual Minnesota lifetime loss ratio shall meet or exceed the minimum lifetime loss ratio standards referred to in clause (5); and

(8) if the annual earned premium volume in Minnesota under the particular policy form is less than $2,500,000, the minimum lifetime loss ratio guarantee must be based partially on the Minnesota earned premium and other credible factors as specified by the commissioner.

(c) The actual Minnesota minimum loss ratio results for each year at issue must be independently audited at the insurer's expense, and the audit report must be filed with the commissioner not later than 120 days after the end of the year at issue.

(d) The insurer shall refund premiums in the amount necessary to bring the actual loss ratio up to the guaranteed minimum lifetime loss ratio. For the purpose of this paragraph, loss ratio and guaranteed minimum lifetime loss ratio are the expected aggregate loss ratio of all approved individual policy forms that provide for a minimum lifetime loss ratio guarantee.

(e) A Minnesota policyholder affected by the guaranteed minimum lifetime loss ratio shall receive a portion of the premium refund relative to the premium paid by the policyholder. The refund must be made to all Minnesota policyholders insured under the applicable policy form during the year at issue if the refund would equal $10 or more per policy. The refund must include statutory interest from July 1 of the year at issue until the date of payment. Payment must be made not later than 180 days after the end of the year at issue.

(f) Premium refunds of less than $10 per insured must be credited to the policyholder's account.

(g) Subdivisions 2 and 3 do not apply if premium rates are filed with the department and accompanied by a minimum lifetime loss ratio guarantee that meets the requirements of this subdivision. Such filings are deemed approved. When determining a loss ratio for the purposes of a minimum lifetime loss ratio guarantee, the insurer shall divide the total of the claims incurred, plus preferred provider organization expenses, case

management, and utilization review expenses, plus reinsurance premiums less reinsurance recoveries by the premiums earned less state and local taxes less other assessments. The insurer shall identify any assessment allocated.

(h) The policy form filing of an insurer using the filing procedure with a minimum lifetime loss ratio guarantee must disclose to the enrollee, member, or subscriber an explanation of the minimum lifetime loss ratio guarantee, and the actual loss ratio, and any adjustments for duration.

(i) The insurer who elects to use the filing procedure with a minimum lifetime loss ratio guarantee shall notify all policyholders of the refund calculation, the result of the refund calculation, the percentage of premium on an aggregate basis to be refunded, if any, any amount of the refund attributed to the payment of interests, and an explanation of amounts less than $10.

Subd. 4. [Repealed, 1992 c 549 art 3 s 23]

Subd. 4a. **Withdrawal of approval.** The commissioner may, at any time after a 20-day written notice has been given to the insurer, withdraw approval of any form or rate that has previously been approved on any of the grounds stated in this section. It is unlawful for the health carrier to issue a form or rate or use it in connection with any health plan after the effective date of the withdrawal of approval. The notice of withdrawal of approval must advise the health carrier of the right to a hearing under the contested case procedures of chapter 14, and must specify the matters to be considered at the hearing.

The commissioner may request a health carrier to provide actuarial reasons and data, as well as other information, needed to determine if a previously approved rate continues to satisfy the requirements of this section. If the requested information is not provided within 30 days after request by the commissioner, the rate is presumed to be an excessive rate.

Subd. 5. [Repealed, 1992 c 549 art 3 s 23; 1994 c 625 art 10 s 49]

Subd. 5a. **Hearing.** The health carrier must request a hearing before the 20-day notice period has ended, or the commissioner's order is final. A request for hearing stays the commissioner's order until the commissioner notifies the health carrier of the result of the hearing. The commissioner's order may require the modification of any rate or form and may require continued coverage to persons covered under a health plan to which the disapproved form or rate applies.

Subd. 6. **Appeal.** Any order or decision of the commissioner under this section shall be subject to appeal in accordance with chapter 14.

Subd. 7. **Filing by domestic insurers for purposes of complying with another state's filing requirements.** A domestic insurer may file with the commissioner for informational purposes only a policy or certificate of insurance that is not intended to be offered or sold within this state. This subdivision only applies to the filing in Minnesota of a policy or certificate of insurance issued to an insured or certificate holder located outside of this state when the filing is for the express purpose of complying with the law of the state in which the insured or certificate holder resides. In no event may a policy or certificate of insurance filed under this subdivision for out-of-state use be issued or delivered in Minnesota unless and until the policy or certificate of insurance is approved under subdivision 2.

Subd. 8. **Filing by health carriers for purposes of complying with the certification requirements of MNsure.** No qualified health plan shall be offered through MNsure until its form and the premium rates pertaining to the form have been approved by the commissioner of commerce or health, as appropriate, and

the health plan has been determined to comply with the certification requirements of MNsure in accordance with an agreement between the commissioners of commerce and health and MNsure.

History: *1967 c 395 art 3 s 2; 1976 c 296 art 2 s 10,11; 1977 c 409 s 1; 1979 c 207 s 1; 1980 c 509 s 18; 1982 c 424 s 130; 1983 c 247 s 31; 1986 c 444; 1986 c 455 s 9,10; 1992 c 549 art 3 s 3-7; 1993 c 247 art 3 s 5; 1996 c 446 art 1 s 22; 2002 c 330 s 8; 2002 c 387 s 1; 2005 c 17 art 1 s 14; 2006 c 255 s 7,8; 2013 c 84 art 1 s 12; 2013 c 108 art 1 s 67; 2015 c 71 art 12 s 1*

62A.021 HEALTH CARE POLICY RATES.

Subdivision 1. **Loss ratio standards.** (a) Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, and except as otherwise authorized by section 62A.02, subdivision 3a, for individual policies or certificates, 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.

Subd. 2. **Compliance audit.** The commissioner has the authority to audit any health carrier to assure compliance with this section. Health carriers shall retain at their principal place of business information necessary for the commissioner to perform compliance audits.

Subd. 3. **Loss ratio disclosure.** (a) Each health care policy form or health care certificate form for which subdivision 1 requires compliance with a loss ratio requirement shall prominently display the disclosure

provided in paragraph (b) on its declarations sheet if it has one and, if not, on its front page. The disclosure must also be prominently displayed in any marketing materials used in connection with it.

(b) The disclosure must be in the following format:

Notice: This disclosure is required by Minnesota law. This policy or certificate is expected to return on average (fill in anticipated loss ratio approved by the commissioner) percent of your premium dollar for health care. The lowest percentage permitted by state law for this policy or certificate is (fill in applicable minimum loss ratio).

(c) This subdivision applies to policies and certificates issued on or after January 1, 1998.

History: *1992 c 549 art 3 s 8; 1993 c 345 art 8 s 2; 1997 c 225 art 2 s 2,3; 2002 c 330 s 9; 2003 c 109 s 1; 2006 c 255 s 9*

62A.023 NOTICE OF RATE CHANGE.

A health insurer or service plan corporation must send written notice to its policyholders and contract holders at their last known address at least 30 days in advance of the effective date of a proposed rate change. This notice requirement does not apply to individual certificate holders covered by group insurance policies or group subscriber contracts.

History: *1995 c 258 s 21*

62A.024 EXPLANATIONS OF RATE INCREASES; ATTRIBUTION TO STATUTORY CHANGES.

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.025 [Repealed, 1Sp1985 c 10 s 123]

62A.03 GENERAL PROVISIONS OF POLICY.

Subdivision 1. **Conditions.** No policy of individual accident and sickness insurance may be delivered or issued for delivery to a person in this state unless:

(1) **Premium.** The entire money and other considerations therefor are expressed therein.

(2) **Time effective.** The time at which the insurance takes effect and terminates is expressed therein.

(3) **One person.** It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family deemed the policyholder, any two or more eligible members of that family, including:

(a) spouses,

(b) dependent children as described in sections 62A.302 and 62A.3021, or

(c) any other person dependent upon the policyholder.

(4) **Appearance.** The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-face type of a style in general use. The type size must be uniform and not less than ten point with a lowercase unspaced alphabet length not less than 120 point. The "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, the reference to renewal or cancellation by a separate statement, if any, and the captions and subcaptions.

(5) **Description of policy.** The policy, on the first page, indicates or refers to its provisions for renewal or cancellation either in the brief description, if any, or by a separate statement printed in type not smaller than the type used for captions or a separate provision bearing a caption which accurately describes the renewability or cancelability of the policy.

(6) **Exceptions in policy.** The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 62A.04, printed, at the insurer's option, either with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS." However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(7) **Form number.** Each form, including riders and endorsements, is identified by a form number in the lower left hand corner of the first page thereof.

(8) **No incorporation by reference.** It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates, classification of risks, or short rate table filed with the commissioner.

(9) **Medical benefits.** If the policy contains a provision for medical expense benefits, the term "medical benefits" or similar terms as used therein includes treatments by all licensed practitioners of the healing arts unless, subject to the qualifications contained in clause (10), the policy specifically states the practitioners whose services are covered.

(10) **Osteopathic physician, optometrist, chiropractor, or registered nurse services.** With respect to any policy of individual accident and sickness insurance issued or entered into subsequent to August 1, 1974, notwithstanding the provisions of the policy, if it contains a provision providing for reimbursement for any service which is in the lawful scope of practice of a duly licensed osteopathic physician, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, the person entitled to benefits or person performing services under the policy is entitled to reimbursement on an equal basis for the service, whether the service is performed by a physician, osteopathic physician, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, licensed under the laws of this state.

Subd. 2. **Delivery of policy to nonresident.** If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subdivision 1 and in section 62A.04.

History: *1967 c 395 art 3 s 3; 1969 c 985 s 1; 1974 c 30 s 1; 1983 c 221 s 1; 2013 c 84 art 1 s 13; 2016 c 119 s 7; 2024 c 101 art 3 s 2*

62A.04 STANDARD PROVISIONS.

Subdivision 1. **Reference.** (a) Any reference to "standard provisions" which may appear in other sections and which refer to accident and sickness or accident and health insurance shall hereinafter be construed as referring to accident and sickness policy provisions.

(b) Notwithstanding paragraph (a), the following do not apply to health plans:

(1) subdivision 2, clauses (5) to (10) and (12);

(2) subdivision 3, clauses (1) and (3) to (7); and

(3) subdivisions 6 and 10.

Subd. 2. **Required provisions.** Except as provided in subdivision 4 each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subdivision in the words in which the same appear in this section. The insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) A provision as follows:

TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of clauses (1), (2), (3), (4) and (5), in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3)(a) Except as required for qualified health plans sold through MNsure to individuals receiving advance payments of the premium tax credit, a provision as follows:

GRACE PERIOD: A grace period of ..... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy which contains a cancellation provision may add, at the end of the above provision,

subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

(b) For qualified health plans sold through MNsure to individuals receiving advance payments of the premium tax credit, a grace period provision must be included that complies with the Affordable Care Act and is no less restrictive than the grace period required by the Affordable Care Act.

(4) A provision as follows:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. For health plans described in section 62A.011, subdivision 3, clause (10), an insurer must accept payment of a renewal premium and reinstate the policy, if the insured applies for reinstatement no later than 60 days after the due date for the premium payment, unless:

(1) the insured has in the interim left the state or the insurer's service area; or

(2) the insured has applied for reinstatement on two or more prior occasions.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

(5) A provision as follows:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

(6) A provision as follows:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(7) A provision as follows:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) A provision as follows:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option

of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

(10) A provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) A provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy. The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

Subd. 3. **Optional provisions.** Except as provided in subdivision 4, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section. The insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows:

CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed occupations to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premiums paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes occupations to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change of occupation.

(2) A provision as follows:

MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) A provision as follows:

OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... (insert type of coverage or coverages) in excess of $..... (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the insured's estate, or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, or the insured's beneficiary or estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) A provision as follows:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any

other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage."

(5) A provision as follows:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase -- "OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage."

(6) A provision as follows:

RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the insured's average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

(7) A provision as follows:

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(8) A provision as follows:

CANCELLATION: The insurer may cancel this policy at any time by written notice delivered to the insured or mailed to the insured's last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. Regardless of whether it is the insurer or the insured who cancels, the earned premium shall be computed pro rata, unless the mode of payment is monthly or less, or if the unearned amount is for less than one month. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(9) A provision as follows:

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(10) A provision as follows:

ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(11) A provision as follows:

NARCOTICS: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being under the influence of any narcotic unless administered on the advice of a physician.

Subd. 4. **Coverage inconsistent.** If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

Subd. 5. **Order of provisions.** The provisions which are the subject of subdivisions 2 and 3, or any corresponding provisions which are used in lieu thereof in accordance with subdivisions 2 and 3, shall be printed in the consecutive order of the provisions in subdivisions 2 and 3 or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

Subd. 6. **Applicant other than insured.** The word "insured," as used in sections 62A.01 to 62A.09, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

Subd. 7. **Reciprocal provisions; foreign insurer.** Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of sections 62A.01 to 62A.09 hereof, and which is prescribed or required by the law of the state under which the insurer is organized.

Subd. 8. **Reciprocal provisions; domestic insurer.** Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

Subd. 9. **Rules.** The commissioner may make such reasonable rules concerning the procedure for the filing or submission of policies subject to sections 62A.01 to 62A.09, as are necessary, proper or advisable to the administration of sections 62A.01 to 62A.09. This provision shall not abridge any other authority granted the commissioner by law.

Subd. 10. **Return of premium.** A policy of accident and sickness insurance as defined in section 62A.01 may contain or may be amended by rider to provide for a return of premium benefit so long as:

(1) the return of premium benefit is not applicable until the policy has been in force for five years;

(2) the return of premium benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy;

(3) the return of premium benefit is not included in or used with a policy with benefits that are reduced based on an insured's age;

(4) the return of premium benefit is not payable in lieu of benefits at the option of the insurer;

(5) the insurer demonstrates that the reserve basis for such benefit is adequate; and

(6) the cost of the benefit is disclosed to the insured and the insured is given the option of the coverage.

History: *1967 c 395 art 3 s 4; 1975 c 359 s 23; 1985 c 248 s 70; 1986 c 444; 1988 c 642 s 1; 1995 c 75 s 1; 1999 c 177 s 37; 2013 c 84 art 1 s 14; 2013 c 108 art 1 s 67; 1Sp2017 c 6 art 5 s 1*

62A.041 MATERNITY BENEFITS.

Subdivision 1. **Discrimination prohibited against unmarried women.** Each group policy of accident and health insurance and each group health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each group policy and each group contract shall provide

the same coverage for that child as that provided for the child of a married employee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

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

Subd. 2. **Limitation on coverage prohibited.** Each group policy of accident and health insurance, except for policies which only provide coverage for specified diseases, or each group subscriber contract of accident and health insurance or health maintenance contract, issued or renewed after August 1, 1987, shall include maternity benefits in the same manner as any other illness covered under the policy or contract.

Subd. 3. MS 2022 [Repealed, 2024 c 127 art 57 s 71]

History: *1971 c 680 s 1; 1973 c 651 s 1; 1976 c 121 s 3; 1980 c 589 s 25; 1984 c 464 s 2; 1986 c 397 s 1; 1987 c 337 s 45; 1989 c 330 s 9*

62A.0411 MATERNITY CARE.

Subdivision 1. **Minimum inpatient care.** Every health plan must provide coverage of a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newborn. The health plan shall not provide any compensation or other nonmedical remuneration to encourage a mother and newborn to leave inpatient care before the duration minimums specified in this section.

Subd. 2. **Medical facility transfer.** (a) If a health care provider acting within the provider's scope of practice recommends that either the mother or newborn be transferred to a different medical facility, every health plan must provide the coverage required under subdivision 1 for the mother, newborn, and newborn siblings at both medical facilities. The coverage required under this subdivision includes but is not limited to expenses related to transferring all individuals from one medical facility to a different medical facility.

(b) The coverage required under this subdivision must be provided without cost sharing, including but not limited to deductible, co-pay, or coinsurance. The coverage required under this paragraph must be provided without any limitation that is not generally applicable to other coverages under the plan.

(c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in conjunction with a health savings account must include cost-sharing for the coverage required under this subdivision at the minimum level necessary to preserve the enrollee's ability to make tax-exempt contributions and withdrawals from the health savings account as provided in section 223 of the Internal Revenue Code of 1986.

Subd. 3. **Minimum postdelivery outpatient care.** (a) The health plan must also provide coverage for postdelivery outpatient care to a mother and her newborn if the duration of inpatient care is less than the minimums provided in this section.

(b) Postdelivery care consists of a minimum of one home visit by a registered nurse. Services provided by the registered nurse include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four days following the discharge of the mother and her child.

Subd. 4. **Health plan defined.** For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, and county-based purchasing plans.

History: *1996 c 335 s 1; 2024 c 127 art 57 s 2*

62A.042 FAMILY COVERAGE; COVERAGE OF NEWBORN INFANTS.

Subdivision 1. **Individual family policies.** (a) No policy of individual accident and sickness insurance which provides for insurance for more than one person under section 62A.03, subdivision 1, clause (3), and no individual health maintenance contract which provides for coverage for more than one person under chapter 62D, shall be renewed to insure or cover any person in this state or be delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered members of the family any newborn infants immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth. For purposes of this paragraph, "newborn infants" includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. No policy or contract covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy or contract mandates an additional premium for each dependent, the health carrier shall be entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may withhold payment of any health benefits for the new dependent until it has been compensated with the applicable premium which would have been owed if the health carrier had been informed of the additional dependent immediately.

(b) The coverage under paragraph (a) includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to the limiting age for coverage of the dependent, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. Benefits for individuals age 19 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision.

Subd. 2. **Group policies.** (a) No group accident and sickness insurance policy and no group health maintenance contract which provide for coverage of family members or other dependents of an employee or other member of the covered group shall be renewed to cover members of a group located in this state or delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered family members or dependents any newborn infants immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth. For purposes of this paragraph, "newborn infants" includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. No policy or contract covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy or contract mandates an additional premium for each dependent, the health carrier shall be entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may reduce the health benefits owed to the insured, certificate holder, member, or subscriber by the amount of past due premiums applicable to the additional dependent.

(b) The coverage under paragraph (a) includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to the limiting age for coverage of the dependent, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. Benefits for individuals age 19 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision.

History: *1973 c 303 s 1; 1984 c 464 s 3; 1988 c 656 s 1; 1995 c 258 s 22; 1996 c 446 art 1 s 23; 2004 c 288 art 3 s 3*

62A.043 DENTAL AND PODIATRIC COVERAGE.

Subdivision 1. **Policies and contracts covered.** The provisions of this section shall apply to all individual or group policies or subscriber contracts providing payment for care in this state, which policies or contracts are issued or renewed after August 1, 1976 by an accident and health insurance company regulated under this chapter, or a nonprofit health service plan corporation regulated under chapter 62C.

Subd. 2. **Services covered.** Any policy or contract referred to in subdivision 1 which provides coverage for services which can be lawfully performed within the scope of the license of a duly licensed dentist or podiatrist, shall provide benefits for such services whether performed by a duly licensed physician, dentist or podiatrist.

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

History: *1973 c 430 s 1; 1976 c 207 s 1; 1987 c 337 s 46*

62A.044 PAYMENTS TO GOVERNMENTAL INSTITUTIONS.

No group or individual policy of accident and sickness insurance issued or renewed after May 22, 1973, pursuant to this chapter, no group or individual service plan or subscriber contract issued or renewed after May 22, 1973, pursuant to chapter 62C, and no group or individual health maintenance contract issued or renewed after August 1, 1984, pursuant to chapter 62D, shall contain any provision excluding, denying, or prohibiting payments for covered and authorized services rendered or paid by a hospital or medical institution owned or operated by the federal, state, or local government, including correctional facilities, or practitioners therein in any instance wherein charges for such services are imposed against the policyholder, subscriber, or enrollee. The unit of government operating the institution may maintain an action for recovery of such charges.

History: *1973 c 471 s 1; 1984 c 464 s 4; 1988 c 656 s 2*

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota or providing coverage to residents of Minnesota covered by this section, each health insurer shall comply with the requirements for health insurers under the federal Deficit Reduction Act of 2005, Public Law 109-171 and the federal Consolidated Appropriations Act of 2022, Public Law 117-103, including any federal regulations adopted under those acts, to the extent that they impose a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal acts prior to the effective dates provided for those provisions in the federal acts. The commissioner shall enforce this section.

For the purpose of this section, "health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a health-care item or service for an individual receiving benefits under paragraph (b).

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident 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 title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B; or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans 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.

(c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

(d) Notwithstanding any law to the contrary, when a person covered by a plan offered by a health insurer 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 health insurer for those services. If the commissioner of human services notifies the health insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health insurer must be issued directly to the commissioner. Submission by the department to the health 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 health 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 health insurer to the provider or the commissioner as required by this section.

(e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health insurer, the health insurer shall not impose

requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

(f) A health insurer must process a clean claim made by a state agency for covered expenses paid under state medical programs within 90 business days of the claim's submission. A health insurer must process all other claims made by a state agency for covered expenses paid under a state medical program within the timeline set forth in Code of Federal Regulations, title 42, section 447.45(d)(4).

(g) A health insurer may request a refund of a claim paid in error to the Department of Human Services within two years of the date the payment was made to the department. A request for a refund shall not be honored by the department if the health insurer makes the request after the time period has lapsed.

History: *1975 c 247 s 1; 1979 c 174 s 1; 1989 c 282 art 3 s 1; 1990 c 426 art 2 s 2; 1992 c 549 art 4 s 19; 1Sp1993 c 1 art 5 s 1; 1995 c 207 art 10 s 1; 1997 c 225 art 2 s 62; 1999 c 139 art 4 s 2; 1999 c 245 art 4 s 1; 2004 c 228 art 1 s 75; 2006 c 282 art 17 s 1; 2010 c 310 art 13 s 1; 2015 c 71 art 11 s 1; 2016 c 158 art 2 s 7; 2023 c 70 art 2 s 1*

62A.046 COORDINATION OF BENEFITS.

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

Subd. 2. **Dependent coverage.** A group contract which provides coverage of a claimant as a dependent of a parent who has legal responsibility for the dependent's medical care pursuant to a court order under section 518A.41 must make payments directly to the provider of care, the custodial parent, or the Department of Human Services pursuant to section 62A.045. In such cases, liability to the insured is satisfied to the extent of benefit payments made under this section.

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

Subd. 4. **Deductible provision.** Payments made by an enrollee or by the commissioner on behalf of an enrollee in the MinnesotaCare program under sections 256L.01 to 256L.10, or a person receiving benefits under chapter 256B, for services that are covered by the policy or plan of health insurance shall, for purposes of the deductible, be treated as if made by the insured.

Subd. 5. **Payment recovery.** The commissioner of human services shall recover payments made by the MinnesotaCare program from the responsible insurer, for services provided by the MinnesotaCare program and covered by the policy or plan of health insurance.

Subd. 6. **Coordination of benefits.** Insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations may coordinate benefits to prohibit greater than 100 percent coverage when an insured, subscriber, or enrollee is covered by both an individual and a group contract providing coverage for hospital and medical treatment or expenses. Benefits coordinated under this paragraph must provide for 100 percent coverage of an insured, subscriber, or enrollee.

To the extent appropriate, all coordination of benefits provisions currently applicable by law or rule to insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations, shall apply to coordination of benefits between individual and group contracts. Notwithstanding the definition of "plan" in Minnesota Rules, parts 2742.0200, subpart 2, and 4685.0910, subpart 7, an individual contract must coordinate benefits with a group contract under this subdivision consistent with applicable coordination of benefit rules. When a covered person's other coverage is Medicare or TRICARE, a health plan company must determine primacy and coordinate benefits in accordance with the Medicare Secondary Payor or TRICARE provisions of federal law. This subdivision does not apply to specified accident, hospital indemnity, specified disease, or other limited benefit insurance policies.

Subd. 7. **High-deductible health plans.** If a health carrier is advised by a covered person that all health plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

History: *1984 c 538 s 2; 1984 c 655 art 2 s 6 subd 1; 1987 c 370 art 2 s 1; 1989 c 282 art 3 s 2; 1990 c 404 s 1; 1992 c 549 art 4 s 19; 1995 c 207 art 10 s 2; 1995 c 234 art 8 s 56; 2005 c 164 s 29; 1Sp2005 c 7 s 28; 2006 c 280 s 46; 2010 c 384 s 15,16; 2016 c 158 art 2 s 8*

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

A policy of individual or group health and accident insurance regulated under this chapter, or individual or group subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or health benefit certificate regulated under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota resident, must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, co-payment, or other coinsurance or dollar limitation requirement. This section does not prohibit the use of policy waiting periods for these services. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section subject to the schedule set forth in this section. Nothing in this section applies to a commercial health insurance policy issued as a companion to a health maintenance organization contract, a policy designed primarily to provide coverage payable on a per diem, fixed indemnity, or nonexpense incurred basis, or a policy that provides only accident coverage. A policy, contract, or certificate described under this section may not apply to preexisting condition limitations to individuals under 19 years of age. This section does not apply to individual coverage under a grandfathered plan.

"Child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months.

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

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

History: *1988 c 571 s 1; 1989 c 69 s 1; 1994 c 485 s 26; 1996 c 465 art 5 s 1; 2012 c 247 art 5 s 1; 2013 c 84 art 1 s 15*

62A.048 DEPENDENT COVERAGE.

(a) A health plan that covers a Minnesota resident must, if it provides dependent coverage, allow dependent children who do not reside with the participant to be covered on the same basis as if they reside with the participant. Every health plan must provide coverage in accordance with section 518A.41 to dependents covered by a qualified court or administrative order meeting the requirements of section 518A.41, and enrollment of a child cannot be denied on the basis that the child was born out of wedlock, the child is not claimed as a dependent on a parent's federal income tax return, or the child does not reside with the parent or in the health carrier's service area.

(b) For the purpose of this section, health plan includes coverage offered by community integrated service networks, coverage designed solely to provide dental or vision care, and any plan governed under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461.

History: *1988 c 689 art 2 s 6; 1995 c 207 art 10 s 3; 1997 c 225 art 2 s 62; 2005 c 164 s 29; 1Sp2005 c 7 s 28; 2006 c 280 s 46*

62A.049 LIMITATION ON PREAUTHORIZATIONS; EMERGENCIES.

No policy of accident and sickness insurance or group subscriber contract regulated under chapter 62C issued or renewed in this state may contain a provision that makes an insured person ineligible to receive full benefits because of the insured's failure to obtain preauthorization, if that failure occurs because of the need for emergency confinement or emergency treatment. The insured or an authorized representative of the insured shall notify the insurer as soon after the beginning of emergency confinement or emergency treatment as reasonably possible. However, to the extent that the insurer suffers actual prejudice caused by the failure to obtain preauthorization, the insured may be denied all or part of the insured's benefits.

History: *1989 c 330 s 10; 2013 c 84 art 1 s 16*

62A.05 CONSTRUCTION OF PROVISIONS.

(a) No policy provision which is not subject to section 62A.04 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to sections 62A.01 to 62A.09 hereof.

(b) A policy delivered or issued for delivery to any person in this state in violation of sections 62A.01 to 62A.09 hereof, shall be held valid but shall be construed as provided in sections 62A.01 to 62A.09 hereof. When any provision in a policy subject to sections 62A.01 to 62A.09 hereof, is in conflict with any provision of sections 62A.01 to 62A.09 hereof, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of sections 62A.01 to 62A.09 hereof.

History: *1967 c 395 art 3 s 5*

62A.06 STATEMENTS IN APPLICATION.

Subdivision 1. **Inclusion in policy.** The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within 15 days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

Subd. 2. **Alterations.** No alteration of any written application for any such policy shall be made by any person other than the applicant without written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Subd. 3. **Effect of applicant's statement.** The falsity of any statement in the application for any policy covered by sections 62A.01 to 62A.09 hereof, may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

History: *1967 c 395 art 3 s 6; 1986 c 444*

62A.07 RIGHTS OF INSURER, WHEN NOT WAIVED.

The acknowledgment by an insurer of the receipt of notice given under any policy covered by sections 62A.01 to 62A.09 hereof, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

History: *1967 c 395 art 3 s 7*

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

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

History: *1967 c 395 art 3 s 8; 1989 c 330 s 11*

62A.081 PAYMENTS TO FACILITIES OPERATED BY STATE OR LOCAL GOVERNMENT.

Every group or individual policy of accident and sickness insurance issued or renewed after July 1, 1973 regulated by this chapter, and every group or individual service plan or subscriber contract issued or renewed after July 1, 1973 regulated by chapter 62C, providing care or payment for care in this state, shall provide payments for services rendered by a hospital or medical facility owned or operated by, or on behalf of, the

state or any unit of local government, or practitioners therein, on the same basis as are made for like care in other facilities. The unit of government concerned may maintain an action for recovery of such payments.

History: *1973 c 765 s 24*

62A.082 NONDISCRIMINATION IN ACCESS TO TRANSPLANTS.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given unless the context clearly requires otherwise.

(b) "Disability" has the meaning given in section 363A.03, subdivision 12.

(c) "Enrollee" means a natural person covered by a health plan or group health plan and includes an insured, policy holder, subscriber, covered person, member, contract holder, or certificate holder.

(d) "Organ transplant" means the transplantation or transfusion of a part of a human body into the body of another for the purpose of treating or curing a medical condition.

Subd. 2. **Transplant discrimination prohibited.** A health plan or group health plan that provides coverage for anatomical gifts, organ transplants, or related treatment and services shall not:

(1) deny coverage to an enrollee based on the enrollee's disability;

(2) deny eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the health plan or group health plan solely for the purpose of avoiding the requirements of this section;

(3) penalize or otherwise reduce or limit the reimbursement of a health care provider, or provide monetary or nonmonetary incentives to a health care provider, to induce the provider to provide care to a patient in a manner inconsistent with this section; or

(4) reduce or limit an enrollee's coverage benefits because of the enrollee's disability for medical services and other services related to organ transplantation performed pursuant to this section as determined in consultation with the enrollee's treating health care provider and the enrollee.

Subd. 3. **Collective bargaining.** In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement imposed pursuant to this section shall not be treated as a termination of the collective bargaining agreement.

Subd. 4. **Coverage limitation.** Nothing in this section shall be deemed to require a health plan or group health plan to provide coverage for a medically inappropriate organ transplant.

History: *2021 c 30 art 14 s 1*

62A.09 LIMITATION.

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

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

(2) any policy or contract of reinsurance; or

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

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

History: *1967 c 395 art 3 s 9; 1975 c 359 s 23; 1989 c 330 s 12*

62A.095 SUBROGATION CLAUSES REGULATED.

Subdivision 1. **Applicability.** (a) A health plan may not be offered, sold, or issued to a resident of this state, or to cover a resident of this state, unless the health plan complies with subdivision 2.

(b) Health plans providing benefits under health care programs administered by the commissioner of human services are not subject to the limits described in subdivision 2 but are subject to the right of subrogation provisions under section 256B.37 and the lien provisions under section 256.015; 256B.042; Minnesota Statutes 2010, section 256D.03, subdivision 8; or 256L.03, subdivision 6.

For purposes of this section, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clauses (4), (6), (7), (8), (9), and (10).

Subd. 2. **Subrogation clause; limits.** No health plan described in subdivision 1 shall contain a subrogation, reimbursement, or similar clause that provides subrogation, reimbursement, or similar rights to the health carrier issuing the health plan, unless:

(1) the clause provides that it applies only after the covered person has received a full recovery from another source; and

(2) the clause provides that the health carrier's subrogation right is subject to subtraction for actual monies paid to account for the pro rata share of the covered person's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the health carrier is separately represented by an attorney.

If the health carrier is separately represented by an attorney, the health carrier and the covered person, by their attorneys, may enter into an agreement regarding allocation of the covered person's costs, disbursements, and reasonable attorney fees and other expenses. If the health carrier and covered person cannot reach agreement on allocation, the health carrier and covered person shall submit the matter to binding arbitration.

Nothing in this section shall limit a health carrier's right to recovery from another source which may otherwise exist at law.

For the purposes of this section, full recovery does not include payments made by a health plan to or for the benefit of a covered person.

Subd. 3. **Retroactive amendments regulated.** No addition of, or amendment of, a subrogation, reimbursement, or similar clause in a health plan shall be applied to the disadvantage of a covered person

with respect to benefits provided by the health carrier in connection with an injury, illness, condition, or other covered situation that originated prior to the addition of or amendment to the clause.

History: *1995 c 219 s 1; 1Sp2001 c 9 art 2 s 1; 2002 c 379 art 1 s 113; 2006 c 255 s 10; 2011 c 108 s 32; 2016 c 158 art 2 s 9*

62A.096 NOTICE TO INSURER OF SUBROGATION CLAIM REQUIRED.

A person covered by a health carrier who makes a claim against a collateral source for damages that include repayment for medical and medically related expenses incurred for the covered person's benefit shall provide timely notice, in writing, to the health carrier of the pending or potential claim. Notwithstanding any other law to the contrary, the statute of limitations applicable to the rights with respect to reimbursement or subrogation by the health carrier against the covered person does not commence to run until the notice has been given.

History: *1995 c 219 s 2*

62A.10 GROUP INSURANCE.

Subdivision 1. **Requirements.** Group accident and health insurance may be issued to cover groups of not less than two employees nor less than ten members, and which may include the employee's or member's dependents, consisting of spouses, children, and actual dependents residing in the household. The master policy may be issued to any governmental corporation, unit, agency, or department thereof, or to any corporation, copartnership, individual, employer, to a purchasing pool as described in section 62Q.17, to any association as defined by section 60A.02, subdivision 1a, or to a multiple employer trust, or to the trustee of a fund, established or adopted by two or more employers or maintained for the benefit of members of an association, where officers, members, employees, or classes or divisions thereof, may be insured for their individual benefit.

Subd. 2. **Group accidental death and group disability income policies.** Group accidental death insurance and group disability income insurance policies may be issued in connection with first real estate mortgage loans to cover groups of not less than ten debtors of a creditor written under a master policy issued to a creditor to insure its debtors in connection with first real estate mortgage loans, in amounts not to exceed the actual or scheduled amount of their indebtedness. No other accident and health coverages may be issued in connection with first real estate mortgage loans on a group basis to a debtor-creditor group.

Subd. 3. **Authority to issue.** Any insurer authorized to write accident and health insurance in this state shall have power to issue group accident and health policies.

Subd. 4. **Policy forms.** No policy or certificate of group accident and health insurance may be issued or delivered in this state unless the same has been approved by the commissioner in accordance with section 62A.02, subdivisions 1 to 6. These forms shall contain the standard provisions relating and applicable to health and accident insurance and shall conform with the other requirements of law relating to the contents and terms of policies of accident and sickness insurance insofar as they may be applicable to group accident and health insurance, and also the following provisions:

(1) **Entire contract.** A provision that the policy and the application of the creditor, employer, trustee, or executive officer or trustee of any association, and the individual applications, if any, of the debtors, employees, or members, insured, shall constitute the entire contract between the parties, and that all statements made by the creditor, employer, trustee, or any executive officer or trustee on behalf of the group to be insured, shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in the written application;

(2) **Master policy-certificates.** A provision that the insurer will issue a master policy to the creditor, employer, trustee, or to the executive officer or trustee of the association; and the insurer shall also issue to the creditor, the employer, trustee, or to the executive officer or trustee of the association, for delivery to the debtor, employee, or member, who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which the debtor, employee, or member is entitled and to whom payable, together with a statement as to when and where the master policy, or a copy thereof, may be seen for inspection by the individual insured. The individual certificate may contain the names of, and insure the dependents of, the employee, or member, as provided for herein;

(3) **New insureds.** A provision that to the group or class thereof originally insured may be added, from time to time, all new employees of the employer, members of the association, or debtors of the creditor eligible to and applying for insurance in that group or class and covered or to be covered by the master policy;

(4) **Conversion privilege.** In the case of accidental death insurance and disability income insurance issued to debtors of a creditor, the policy must contain a conversion privilege permitting an insured debtor to convert, without evidence of insurability, to an individual policy within 30 days of the date the insured debtor's group coverage is terminated, and not replaced with other group coverage, for any reason other than nonpayment of premiums. The individual policy must provide the same amount of insurance and be subject to the same terms and conditions as the group policy and the initial premium for the individual policy must be the same premium the insured debtor was paying under the group policy. This provision does not apply to a group policy which provides that the certificate holder may, upon termination of coverage under the group policy for any reason other than nonpayment of premium, retain coverage provided under the group policy by paying premiums directly to the insurer.

History: *1967 c 395 art 3 s 10; 1973 c 303 s 2; 1986 c 444; 1992 c 564 art 1 s 30; 1995 c 234 art 7 s 2,3; 1995 c 258 s 23; 2024 c 101 art 3 s 2*

62A.105 COVERAGES; TRANSFERS TO SUBSTANTIALLY SIMILAR PRODUCTS.

Subdivision 1. **Scope.** No individual policy of accident and sickness regulated under this chapter or subscriber contract regulated under chapter 62C shall be issued, renewed, or continued to provide coverage to a Minnesota resident unless it satisfies the requirements of subdivision 2.

Subd. 2. **Requirement.** If an issuer of policies or plans referred to in subdivision 1 ceases to offer a particular policy or subscriber contract to the general public or otherwise stops adding new insureds to the group of covered persons, the issuer shall allow any covered person to transfer to another substantially similar policy or contract currently being sold by the issuer. The issuer shall permit the transfer without any preexisting condition limitation, waiting period, or other restriction of any type other than those which applied to the insured under the prior policy or contract. This section does not apply to persons who were covered under an individual policy or contract prior to July 1, 1994.

History: *1994 c 485 s 27*

62A.11 BLANKET ACCIDENT AND SICKNESS INSURANCE.

Subdivision 1. **Requirements.** Blanket accident and sickness insurance is hereby declared to be that form of accident and sickness insurance covering special groups of persons as enumerated in one of the following paragraphs:

(1) Under a policy issued to any common carrier, which shall be deemed the policyholder, covering a group defined as all or any class of persons who may become passengers on such common carrier.

(2) Under a policy issued to an employer, who shall be deemed the policyholder, covering all employees or any group of employees defined by reference to exceptional hazards incident to such employment.

(3) Under a policy issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers.

(4) Under a policy issued in the name of any volunteer fire department, first aid, or other such volunteer group, which shall be deemed the policyholder, covering all of the members of such department or group.

(5) Under a policy issued to a sports team or to a camp, which team or camp or sponsor thereof shall be deemed the policyholder, covering members or campers.

(6) Under a policy issued to any other substantially similar group which, in the discretion of the commissioner, may be subject to the issuance of a blanket accident and sickness policy.

Subd. 2. **Authority.** Any insurer authorized to write accident and sickness insurance in this state shall have the power to issue blanket accident and sickness policies.

Subd. 3. **Policy forms.** No policy of blanket accident and sickness insurance may be issued or delivered in this state unless a copy of the form thereof has been approved by the commissioner and it contains in substance such of the provisions required for individual policies as may be applicable to blanket accident and sickness insurance and the following provisions:

(1) A provision that the policy and the application of the policyholder shall constitute the entire contract between the parties, and that, in the absence of fraud, all statements made by the policyholder shall be deemed representations and not warranties, and that no statement made for the purpose of affecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder, a copy of which has been furnished to such policyholder.

(2) A provision that to the group or class originally insured shall be added from time to time all new persons eligible for coverage.

Subd. 4. **Application; certificate.** An individual application shall not be required from a person covered under a blanket accident and sickness policy, nor shall it be necessary for the insurer to furnish each person a certificate.

Subd. 5. **Benefits.** All benefits under any blanket accident and sickness policy shall be payable to the person insured, or to a designated beneficiary, or beneficiaries, or to the insured's estate, except that if the person insured be a minor, such benefits may be made payable to the insured's parent, guardian, or other person actually supporting the insured. Provided further, however, that the policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

Subd. 6. **Legal liability.** Nothing contained in this section shall be deemed to affect the legal liability of policyholders for the death of, or injury to, any such member of such group.

History: *1967 c 395 art 3 s 11; 1986 c 444*

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

62A.13 COMMERCIAL TRAVELER INSURANCE COMPANIES.

Any domestic assessment, health or accident association now licensed to do business in this state, which confines its membership to commercial travelers, professionals, and others whose occupation is of such character as to be ordinarily classified as no more hazardous than commercial travelers, and which does not pay any other commissions or compensations, other than prizes to members of nominal value in proportion to the membership fees charged for securing new members, may issue certificates of membership, which, with the application of the member and the bylaws of the association, shall constitute the contract between the association and the member. A printed copy of the bylaws and a copy of the application shall be attached to the membership certificate when issued, and a copy of any amendment to the bylaws shall be mailed to the members following their adoption. Certified copies of certificate, bylaws and amendments shall be filed with the commissioner of commerce and subject to the commissioner's approval. The bylaws shall conform to the requirements of this chapter, so far as applicable, and wherever the word "policy" appears in this chapter, it shall, for the purpose of this section, be construed to mean the contract as herein defined.

History: *1967 c 395 art 3 s 13; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 444*

62A.135 FIXED INDEMNITY POLICIES; MINIMUM LOSS RATIOS.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given:

(1) "fixed indemnity policy" is a policy form, other than an accidental death and dismemberment policy, a disability income policy, or a long-term care policy as defined in section 62A.46, subdivision 2, that pays a predetermined, specified, fixed benefit for services provided. Fixed indemnity policy includes short-term home health and nursing care insurance under section 62A.70. Claim costs under these forms are generally not subject to inflation, although they may be subject to changes in the utilization of health care services. For policy forms providing both expense-incurred and fixed benefits, the policy form is a fixed indemnity policy if 50 percent or more of the total claims are for predetermined, specified, fixed benefits;

(2) "guaranteed renewable" means that, during the renewal period (to a specified age) renewal cannot be declined nor coverage changed by the insurer for any reason other than nonpayment of premiums, fraud, or misrepresentation, but the insurer can revise rates on a class basis upon approval by the commissioner;

(3) "noncancelable" means that, during the renewal period (to a specified age) renewal cannot be declined nor coverage changed by the insurer for any reason other than nonpayment of premiums, fraud, or misrepresentation and that rates cannot be revised by the insurer. This includes policies that are guaranteed renewable to a specified age, such as 60 or 65, at guaranteed rates; and

(4) "average annualized premium" means the average of the estimated annualized premium per covered person based on the anticipated distribution of business using all significant criteria having a price difference, such as age, sex, amount, dependent status, mode of payment, and rider frequency. For filing of rate revisions, the amount is the anticipated average assuming the revised rates have fully taken effect.

Subd. 2. **Applicability.** This section applies to individual or group policies, certificates, or other evidence of coverage meeting the definition of a fixed indemnity policy, offered, issued, or renewed, to provide coverage to a Minnesota resident.

Subd. 3. **Minimum loss ratio standards.** Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, the minimum loss ratios for fixed indemnity policies are:

(1) as shown in the following table:

Type of Coverage	Renewal Provision	
	Guaranteed Renewable	Noncancelable
Group	75%	70%
Individual	65%	60%

or

(2) for policies or certificates where the average annualized premium is less than $1,000, the average annualized premium less $30, multiplied by the required loss ratio in clause (1), divided by the average annualized premium. However, in no event may the minimum loss ratio be less than the required loss ratio from clause (1) minus ten percent.

The commissioner of commerce may adjust the constant dollar amounts provided in clause (2) on January 1 of any year, based upon changes in the CPI-U, the Consumer Price Index for all urban consumers, published by the United States Department of Labor, Bureau of Labor Statistics. Adjustments must be in increments of $5 and must not be made unless at least that amount of adjustment is required to each amount.

All rate filings must include a demonstration that the rates are not excessive. Rates are not excessive if the anticipated loss ratio and the lifetime anticipated loss ratio meet or exceed the minimum loss ratio standard in this subdivision.

Subd. 4. **Renewal provision.** An insurer may only issue or renew an individual policy on a guaranteed renewable or noncancelable basis.

Subd. 5. **Supplemental filings.** Each insurer that has fixed indemnity policies in force in this state shall, upon request by the commissioner, submit, in a form prescribed by the commissioner, experience data showing its incurred claims, earned premiums, incurred to earned loss ratio, and the ratio of the actual loss ratio to the expected loss ratio for each fixed indemnity policy form in force in Minnesota. The experience data must be provided on both a Minnesota only and a national basis. If in the opinion of the company's actuary, the deviation of the actual loss ratio from the expected loss ratio for a policy form is due to unusual reserve fluctuations, economic conditions, or other nonrecurring conditions, the insurer should also file that opinion with appropriate justification.

If the data submitted does not confirm that the insurer has satisfied the loss ratio requirements of this section, the commissioner shall notify the insurer in writing of the deficiency. The insurer shall have 30 days from the date of receipt of the commissioner's notice to file amended rates that comply with this section or a request for an exemption with appropriate justification. If the insurer fails to file amended rates within the prescribed time and the commissioner does not exempt the policy form from the need for a rate revision, the commissioner shall order that the insurer's filed rates for the nonconforming policy 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 insurer's failure to file amended rates within the specified time of the issuance of the commissioner's order amending the rates does not preclude the insurer from filing an amendment of its rates at a later time.

Subd. 6. **Penalties.** Each sale of a policy that does not comply with the loss ratio requirements of this section is subject to the penalties in sections 72A.17 to 72A.32.

Subd. 7. **Solicitations by mail or media advertisement.** For purposes of this section, fixed indemnity policies issued without the use of an agent as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, must be treated as group policies.

History: *1991 c 325 art 21 s 5; 1995 c 258 s 24; 1996 c 446 art 1 s 26; 1999 c 177 s 38; 2026 c 124 art 1 s 35*

62A.136 HEARING, DENTAL, AND VISION PLAN COVERAGE.

The following provisions do not apply to health plans as defined in section 62A.011, subdivision 3, clause (6), providing hearing, dental, or vision coverage only: sections 62A.041; 62A.0411; 62A.047; 62A.149; 62A.151; 62A.152; 62A.154; 62A.155; 62A.17, subdivision 6; 62A.21, subdivision 2b; 62A.26; 62A.28; 62A.285; 62A.30; 62A.304; and 62A.3093.

History: *1994 c 485 s 28; 1995 c 258 s 25; 2000 c 483 s 11; 2005 c 132 s 9; 2009 c 178 art 1 s 21; 2013 c 84 art 1 s 17*

62A.14 DISABLED 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 developmental disability, mental illness or disorder, or physical disability 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 developmental disability, mental illness or disorder, or physical disability 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: *1969 c 436 s 1; 1984 c 464 s 5; 1995 c 258 s 26; 2003 c 40 s 1; 2005 c 56 s 1*

62A.141 COVERAGE FOR DISABLED DEPENDENTS.

No group policy or group plan of health and accident insurance regulated under this chapter, chapter 62C, or 62D, which provides for dependent coverage may be issued or renewed in this state after August 1, 1983, unless it covers the disabled dependents of the insured, subscriber, or enrollee of the policy or plan. For purposes of this section, a disabled dependent is a person that is and continues to be both: (1) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and (2) chiefly dependent upon the policyholder for support and maintenance. Consequently, the policy or plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning disabled dependents.

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

History: *1983 c 263 s 8; 1Sp1985 c 10 s 58; 1987 c 337 s 47; 1995 c 258 s 27; 2005 c 56 s 1*

62A.145 SURVIVOR; DEFINITION.

For the purposes of section 62A.146, "survivor" means a person who would be entitled to and be dependent upon economic support by an insured, subscriber or enrollee if that person were alive; including a spouse, child or children as defined by the policy or plan of accident and health protection.

History: *1973 c 339 s 1; 1982 c 555 s 5; 1986 c 444*

62A.146 CONTINUATION OF BENEFITS TO SURVIVORS.

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

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

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

The survivor or survivors, in order to have the coverage and benefits extended, may be required to pay the entire cost of the protection on a monthly basis. The policy, contract, or plan must require the group policyholder or contract holder to, upon request, provide the insured, subscriber, or enrollee with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium or fee contributions charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children who are not the survivors of a deceased insured, without regard to whether such cost is paid by the employer or employee. Failure of the survivor to make premium or fee payments within 90 days after notice of the requirement to pay the premiums or fees shall be a basis for the termination of the coverage without written consent. In event of termination by reason of the survivor's failure to make required premium or fee contributions, written notice of cancellation must be mailed to the survivor's last known address at least 30 days before the cancellation. If the coverage is provided under a group policy,

contract, or plan, any required premium or fee contributions for the coverage shall be paid by the survivor to the group policyholder or contract holder for remittance to the insurer, nonprofit health service plan corporation, or health maintenance organization.

History: *1973 c 339 s 2; 1982 c 555 s 6; 1Sp1985 c 10 s 59; 1986 c 444; 1987 c 337 s 48; 1992 c 564 art 4 s 5*

62A.147 DISABLED EMPLOYEES' BENEFITS; DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this section and section 62A.148, the terms defined in this section shall have the meanings here given them.

Subd. 2. **Covered employee.** "Covered employee" means any person who, at the time that person suffered an injury resulting in total disability or became totally disabled by reason of illness, was employed by and receiving a salary, commission, hourly wage, or other remuneration for services by any employer providing, offering or contributing to group insurance coverage or group coverage through a health maintenance contract, for that employee who was so enrolled for the coverage.

Subd. 3. **Total disability.** "Total disability" means (a) the inability of an injured or ill employee to engage in or perform the duties of the employee's regular occupation or employment within the first two years of such disability and (b) after the first two years of such disability, the inability of the employee to engage in any paid employment or work for which the employee may, by education and training, including rehabilitative training, be or reasonably become qualified.

Subd. 4. **Group insurance.** "Group insurance" means any policy or contract of accident and health protection, including health maintenance contracts, regardless of by whom underwritten, which provides benefits, including cash payments for reimbursement of expenses or the provision of usual needed health care and medical services as the result of any injury, sickness, disability or disease suffered by a group of employees, or any one of them, and which protection is paid for or otherwise provided in full or in part by an employer.

Subd. 5. **Employer.** "Employer" means any natural person, company, corporation, partnership, association, firm, or franchise which employs any employee.

Subd. 6. **Insurer.** "Insurer" means any person, company, corporation including a nonprofit corporation and a health maintenance organization, partnership, association, firm or franchise which underwrites or is by contract or other agreement obligated to provide accident and health protection benefits to any group of employees of any employer.

History: *1973 c 340 s 1; 1984 c 464 s 6; 1986 c 444*

62A.148 GROUP INSURANCE; PROVISION OF BENEFITS FOR DISABLED EMPLOYEES.

No employer or insurer of that employer shall terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under any program or policy of group insurance to any covered employee who becomes totally disabled while employed by the employer solely on account of absence caused by such total disability. This includes coverage of dependents of the employee. If the employee is required to pay all or any part of the premium for the extension of coverage, payment shall be made to the employer, by the employee.

History: *1973 c 340 s 2; 1994 c 485 s 29*

62A.149 BENEFITS FOR ALCOHOLICS AND DRUG DEPENDENTS.

Subdivision 1. **Application.** The provisions of this section apply to all group policies of accident and health insurance and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, and to a plan or policy that is individually underwritten or provided for a specific individual and family members as a nongroup policy, when the policies or subscriber contracts are issued or delivered in Minnesota or provide benefits to Minnesota residents enrolled thereunder.

This section does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis or policies that provide accident only coverage.

Every insurance policy or subscriber contract included within the provisions of this subdivision, upon issuance or renewal, shall provide coverage that complies with the requirements of section 62Q.47, paragraphs (b) and (c), for the treatment of alcoholism, chemical dependency, or drug addiction to any Minnesota resident entitled to coverage.

Subd. 2. [Repealed, 2008 c 344 s 56]

History: *1973 c 585 s 1,2; 1976 c 262 s 1; 1978 c 793 s 60; 1980 c 496 s 2; 1986 c 444; 2008 c 344 s 9; 2013 c 84 art 1 s 18; 2022 c 98 art 4 s 51*

62A.15 COVERAGE OF CERTAIN LICENSED HEALTH PROFESSIONAL SERVICES.

Subdivision 1. **Applicability.** The provisions of this section apply to all group policies or subscriber contracts providing payment for care in this state, which are issued by accident and health insurance companies regulated under this chapter and nonprofit health service plan corporations regulated under chapter 62C.

Subd. 2. **Chiropractic services.** All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician must also include chiropractic treatment and services of a chiropractor to the extent that the chiropractic services and treatment are within the scope of chiropractic licensure.

This subdivision is intended to provide equal access to benefits for insureds and subscribers who choose to obtain treatment for illness or injury from a doctor of chiropractic, as long as the treatment falls within the chiropractor's scope of practice. This subdivision is not intended to change or add to the benefits provided for in these policies or contracts.

Subd. 3. **Optometric services.** All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician must also include optometric treatment and services of an optometrist to the extent that the optometric services and treatment are within the scope of optometric licensure.

This subdivision is intended to provide equal payment of benefits for optometric treatment and services and is not intended to change or add to the benefits provided for in those policies or contracts.

Subd. 3a. **Nursing services.** All benefits provided by a policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a duly licensed physician must include services provided by a registered nurse who is licensed pursuant to section 148.171 and who is certified as an advanced practice registered nurse. "Advanced practice registered nurse" has the meaning given in section 148.171, subdivision 3. The advanced practice registered nurse must meet the requirements of sections 148.171 to 148.285.

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

Subd. 3b. **Acupuncture services.** (a) This subdivision, subdivision 4, and section 62D.107 may be cited as the "Equal Access to Acupuncture Act" and as a memorial to Edith R. Davis, Minnesota's pioneer acupuncturist.

(b) All benefits provided by a policy or contract referred to in subdivision 1 relating to expenses for acupuncture services that are provided by a physician must also include acupuncture treatment and services of a licensed acupuncture practitioner to the extent that the acupuncture services and treatment are within the scope of acupuncture practitioner licensure.

This subdivision is intended to provide equal access to benefits for insureds and subscribers who choose to directly obtain treatment for illness or injury from a licensed acupuncture practitioner, as long as the treatment falls within the scope of practice of the licensed acupuncture practitioner.

This subdivision is not intended to change or add to the benefits provided for in these policies or contracts.

Subd. 3c. **Physician assistant services.** All benefits provided by a policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a licensed physician, must include services provided by a physician assistant licensed under chapter 147A. This subdivision is intended to provide payment of benefits for treatment and services by a physician assistant and is not intended to add to the benefits provided for in these policies or contracts.

Subd. 3d. **Pharmacist.** All benefits provided by a policy or contract referred to in subdivision 1 relating to expenses incurred for medical treatment or services provided by a licensed physician must include services provided by a licensed pharmacist, according to the requirements of section 151.01, to the extent a licensed pharmacist's services are within the pharmacist's scope of practice.

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

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

(c) When a carrier referred to in subdivision 1 makes a denial of payment claim determination concerning the appropriateness, quality, or utilization of acupuncture services for individuals in this state performed by a licensed acupuncture practitioner, a denial of payment claim determination that is made by a health professional must be made by, under the direction of, or subject to the review of a licensed acupuncture practitioner.

History: *1973 c 252 s 1; 1976 c 192 s 1,2; 1976 c 242 s 1; 1983 c 221 s 2; 1988 c 441 s 1; 1988 c 642 s 2-4; 1989 c 330 s 13,14; 1999 c 172 s 1,18; 2009 c 45 s 1,2; 2022 c 58 s 2,3; 2024 c 127 art 57 s 3,4*

62A.151 HEALTH INSURANCE BENEFITS FOR EMOTIONALLY DISABLED CHILDREN.

No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D which provides coverage of or reimbursement for inpatient hospital and medical expenses shall be delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the commissioner of commerce, after July 1, 1975 unless the policy or plan includes and provides health service benefits to any subscriber or other person covered thereunder, on the same basis as other benefits, for the treatment of emotionally disabled children in a residential treatment facility licensed by the commissioner of human services. For purposes of this section "emotionally disabled child" shall have the meaning set forth by the commissioner of human services in the rules relating to residential treatment facilities. The restrictions and requirements of this section shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and family members as a nongroup policy. The mandatory coverage under this section shall be on the same basis as inpatient hospital medical coverage provided under the policy or plan.

History: *1975 c 40 s 1; 1983 c 289 s 114 subd 1; 1984 c 654 art 5 s 58; 1984 c 655 art 1 s 92; 1985 c 248 s 70; 1986 c 444; 2005 c 56 s 1*

62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES.

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

Subd. 2. **Minimum benefits.** All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage that complies with the requirements of section 62Q.47, paragraphs (b) and (c).

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 at a hospital or psychiatric residential treatment facility if performed by a mental health professional qualified according to section 245I.04, subdivision 2, 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 or psychiatric residential treatment facility and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

[See Note.]

History: *1975 c 89 s 1; 1981 c 265 s 1; 1Sp1981 c 4 art 1 s 49; 1983 c 354 s 1; 1984 c 654 art 5 s 58; 1987 c 337 s 49; 1987 c 384 art 2 s 1; 1988 c 689 art 2 s 7; 1989 c 330 s 15,16; 1991 c 255 s 1,2; 1993 c 81 s 1,2; 2008 c 344 s 10; 2021 c 30 art 17 s 1; 2023 c 57 art 2 s 6*

NOTE: The amendment to subdivision 3 by Laws 2021, chapter 30, article 17, section 1, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2021, chapter 30, article 17, section 114.

62A.153 OUTPATIENT MEDICAL AND SURGICAL SERVICES.

No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C that provides coverage for services in a hospital shall be issued, renewed, continued, delivered, issued for delivery or executed in this state, or approved for issuance or renewal in this state by the commissioner of commerce unless the policy, plan or contract specifically provides coverage for a health care treatment or surgery on an outpatient basis at a facility equipped to perform these services, whether or not the facility is part of a hospital. Coverage shall be on the same basis as coverage provided for the same health care treatment or service in a hospital.

History: *1976 c 45 s 1; 1977 c 305 s 45; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1994 c 485 s 30*

62A.154 BENEFITS FOR DES RELATED CONDITIONS.

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

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

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

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

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

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

History: *1981 c 350 s 1; 1985 c 49 s 41; 1992 c 564 art 1 s 54*

62A.155 COVERAGE FOR SERVICES PROVIDED TO VENTILATOR-DEPENDENT PERSONS.

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

Subd. 2. **Required coverage.** If a policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1988, provides coverage for services provided by a home care nurse or personal care assistant to a ventilator-dependent person in the person's home, it must provide coverage for up to 120 hours of services provided by a home care nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under chapter 144. The personal care assistant or home care nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

History: *1988 c 656 s 3; 1992 c 564 art 1 s 54; 2014 c 291 art 9 s 5*

62A.16 SCOPE OF CERTAIN CONTINUATION AND CONVERSION REQUIREMENTS.

The provisions of this section and section 62A.17 shall apply to all group insurance policies or group subscriber contracts providing coverage for hospital or medical expenses incurred by a Minnesota resident employed within this state. This section and section 62A.17 shall also apply to health care plans established by employers in this state through health maintenance organizations certified under chapter 62D.

History: *1974 c 101 s 1; 1976 c 142 s 1*

62A.17 TERMINATION OF OR LAYOFF FROM EMPLOYMENT; CONTINUATION AND CONVERSION RIGHTS.

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

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

Upon request by the terminated or laid off employee, a health carrier must provide the instructions necessary to enable the employee to elect continuation of coverage.

Subd. 2. **Responsibility of employee.** Every covered employee electing to continue coverage shall pay the former employer, on a monthly basis, the cost of the continued coverage. The policy, contract, or plan must require the group policyholder or contract holder to, upon request, provide the employee with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. If the policy, contract, or health care plan is administered

by a trust, every covered employee electing to continue coverage shall pay the trust the cost of continued coverage according to the eligibility rules established by the trust. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for similarly situated employees with respect to whom neither termination nor layoff has occurred, without regard to whether such cost is paid by the employer or employee. The employee shall be eligible to continue the coverage until the employee becomes covered under another group health plan, or for a period of 18 months after the termination of or lay off from employment, whichever is shorter. For an individual age 19 or older, if the employee becomes covered under another group policy, contract, or health plan and the new group policy, contract, or health plan contains any preexisting condition limitations, the employee may, subject to the 18-month maximum continuation limit, continue coverage with the former employer until the preexisting condition limitations have been satisfied. The new policy, contract, or health plan is primary except as to the preexisting condition. In the case of a newborn child who is a dependent of the employee, the new policy, contract, or health plan is primary upon the date of birth of the child, regardless of which policy, contract, or health plan coverage is deemed primary for the mother of the child.

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

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

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

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

Subd. 5. **Notice of options.** Upon the termination of or lay off from employment of an eligible employee, the employer shall inform the employee within 14 days after termination or lay off of:

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

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

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

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

If the policy, contract, or health care plan is administered by a trust, the employer is relieved of the obligation imposed by clauses (1) to (4). The trust shall inform the employee of the information required by clauses (1) to (4).

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

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

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

Subd. 5a. MS 2008 [Expired, 2009 c 33 s 1]

Subd. 5b. **Notices required by the American Recovery and Reinvestment Act of 2009 (ARRA).** (a) An employer that maintains a group health plan that is not described in Internal Revenue Code, section 6432(b)(1) or (2), as added by section 3001(a)(12)(A) of the American Recovery and Reinvestment Act of 2009 (ARRA), must notify the health carrier of the termination of, or the layoff from, employment of a covered employee, and the name and last known address of the employee, within the later of ten days after the termination or layoff event, or June 8, 2009.

(b) The health carrier for a group health plan that is not described in Internal Revenue Code, section 6432(b)(1) or (2), as added by section 3001(a)(12)(A) of the ARRA, must provide the notice of extended election rights which is required by subdivision 5a, paragraph (a), as well as any other notice that is required by the ARRA regarding the availability of premium reduction rights, to the individual within 30 days after the employer notifies the health carrier as required by paragraph (a).

(c) The notice responsibilities set forth in this subdivision end when the premium reduction provisions under ARRA expire.

Subd. 6. **Conversion to individual policy.** (a) An individual policy or contract issued as a conversion policy prior to January 1, 2014, shall be renewable at the option of the individual as long as the individual is not covered under another qualified plan as defined in section 62E.02, subdivision 4. Any revisions in the table of rate for the individual policy shall apply to the covered person's original age at entry and shall apply equally to all similar conversion policies issued by the insurer.

(b) Notwithstanding paragraph (a), an issuer with five or fewer covered individuals that are not part of the single risk pool, as defined in section 62A.65, subdivision 3b, may nonrenew those conversion policies in accordance with this paragraph. An issuer nonrenewing coverage under this paragraph must notify the commissioner 180 days before the effective date of the nonrenewal, and must provide the commissioner with a complete list of affected policyholders and a copy of the proposed policyholder notice described in this paragraph. The issuer must provide written notice to each policyholder covered under the conversion policy at least 120 days before the effective date of the nonrenewal. This notice must include information on how to obtain individual or family health coverage and contact information for the state agencies regulating health insurance.

History: *1974 c 101 s 2; 1975 c 100 s 1-3; 1976 c 142 s 2,3; 1977 c 409 s 2; 1983 c 44 s 1,2; 1983 c 263 s 9; 1984 c 464 s 7; 1Sp1985 c 10 s 60; 1986 c 444; 1987 c 337 s 50; 1988 c 434 s 2; 1989 c 330 s 17; 1990 c 403 s 1; 1992 c 564 art 4 s 6; 2001 c 215 s 9; 2009 c 33 s 1; 2009 c 178 art 1 s 22; 2010 c 384 s 17; 2013 c 84 art 1 s 19,20; 2016 c 155 s 1*

62A.18 PROHIBITION AGAINST DISABILITY OFFSETS.

No individual or group policy of accident and health insurance issued, amended, renewed, or delivered in this state on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing,

any benefit under the policy by the amount of, or in proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, the Railroad Retirement Act, any Veteran's Disability Compensation and Survivor Benefits Act, Workers' Compensation, or any similar federal or state law, as amended subsequent to the date of commencement of such benefit.

History: *1975 c 323 s 1*

62A.19 PROHIBITION AGAINST NONDIAGNOSTIC X-RAYS.

No individual or group policy of dental insurance offered for sale to a Minnesota resident by an insurer regulated under this chapter, individual or group service plan or subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or fraternal contract benefit regulated under chapter 64B, shall subject any policyholder, subscriber, or enrollee to undue exposure to radiation by requiring a health care provider to take or obtain x-rays that are not directly related to patient care.

Any health care provider receiving such a request may refuse to provide x-rays not necessary to the diagnosis and treatment of the patient. An insurer, nonprofit health service plan corporation, health maintenance organization, fraternal benefit society, or dental plan may not deny or withhold benefits based solely upon the refusal to provide x-rays. Nothing in this section prohibits requests for x-rays or other diagnostic aids routinely taken in conjunction with the diagnosis and treatment of injury or disease, or routinely required by the insurer for preapproval or predetermination of treatment. An insurer may not retroactively request new x-rays not taken in conjunction with the diagnosis or treatment of injury or disease.

History: *1991 c 101 s 1*

62A.20 CONTINUATION COVERAGE OF CURRENT SPOUSE AND CHILDREN.

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

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

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

Upon request by the insured or the insured's spouse or dependent child, a health carrier must provide the instructions necessary to enable the spouse or child to elect continuation of coverage.

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

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

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

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

If coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage

for other similarly situated spouse and dependent children to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

History: *1987 c 337 s 51; 2001 c 215 s 10*

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

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

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

Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's dependent children, which is defined as required by section 62A.302, and former spouse, who was covered on the day before the entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

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

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

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. The policy must require the group policyholder to, upon request, provide the insured with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Upon request by the insured's former spouse, who was covered on the day before the entry of a valid decree of dissolution, or dependent child, a health carrier must provide the instructions necessary to enable the child or former spouse to elect continuation of coverage.

Subd. 2b. **Conversion privilege.** An individual policy or contract issued as a conversion policy prior to January 1, 2014, shall be renewable at the option of the covered person as long as the covered person is not covered under another qualified plan as defined in section 62E.02, subdivision 4. Any revisions in the table of rate for the individual policy shall apply to the covered person's original age at entry and shall apply equally to all similar conversion policies issued by the insurer.

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

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

History: *1977 c 186 s 1; 1981 c 329 s 1-3; 1982 c 555 s 7,8; 1987 c 337 s 52; 1990 c 403 s 2; 1992 c 564 art 1 s 31; art 4 s 7; 2001 c 215 s 11; 2013 c 84 art 1 s 21; 1Sp2017 c 6 art 5 s 2*

62A.22 REFUSAL TO PROVIDE COVERAGE BECAUSE OF OPTION UNDER WORKERS' COMPENSATION.

No insurer offering an individual or group policy of accident or health coverage in this state shall refuse to provide or renew accident or health coverage because the insured has an option to elect workers' compensation coverage pursuant to section 176.041, subdivision 1a.

History: *1979 c 92 s 1; 1989 c 209 art 2 s 1*

62A.23 GROUP DISABILITY INCOME COVERAGE; TERMINATION WITHOUT PREJUDICE; DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this section and section 62A.24, the terms defined in this section have the meanings given them in this section.

Subd. 2. **Employer.** "Employer" means any natural person, company, corporation, partnership, association, firm or franchise which employs any employee.

Subd. 3. **Insurer.** "Insurer" means any person, company, corporation, including a nonprofit corporation, partnership, association, firm or franchise which underwrites or is by contract or other agreement obligated to provide group disability income insurance benefits to any group of employees of any employer.

History: *1980 c 377 s 1*

62A.24 CONTINUATION OF BENEFITS.

No employer or insurer of that employer may offer or provide a policy of group disability income insurance unless the master policy provides that the termination of the policy shall be without prejudice to any claims originating prior to the time of the termination.

Section 62A.23 and this section may be superseded by a rule promulgated by the commissioner of commerce.

History: *1980 c 377 s 2; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92*

62A.25 RECONSTRUCTIVE SURGERY.

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

Subd. 2. **Required coverage.** (a) Every policy, plan, certificate or contract to which this section applies shall provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.

(b) The coverage limitations on reconstructive surgery in paragraph (a) do not apply to reconstructive breast surgery following mastectomies. In these cases, coverage for reconstructive surgery must be provided if the mastectomy is medically necessary as determined by the attending physician.

(c) Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient. Coverage may be subject to annual deductible, co-payment, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Coverage may not:

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

Written notice of the availability of the coverage must be delivered to the participant upon enrollment and annually thereafter.

History: *1980 c 496 s 1; 1985 c 49 s 41; 1992 c 564 art 1 s 54; 2002 c 330 s 10*

62A.26 COVERAGE FOR PHENYLKETONURIA TREATMENT.

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

Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1985, must provide coverage for special dietary treatment for phenylketonuria when recommended by a physician.

History: *1985 c 49 s 41; 1Sp1985 c 9 art 2 s 1; 1992 c 564 art 1 s 54*

62A.265 COVERAGE FOR LYME DISEASE.

Subdivision 1. **Required coverage.** Every health plan, including a plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), must cover treatment for diagnosed Lyme disease.

Subd. 2. **Special restrictions prohibited.** No health plan included in subdivision 1 may impose a special deductible, co-payment, waiting period, or other special restriction on treatment for Lyme disease that the health plan does not apply to nonpreventive treatment in general.

History: *1996 c 465 art 5 s 2*

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.

(d) No policy or contract covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy or contract mandates an additional premium for each dependent, the health carrier is entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may withhold payment of any health benefits for the new dependent until it has been compensated with the applicable premium which would have been owed if the health carrier had been informed of the additional dependent immediately.

History: *1983 c 56 s 1; 1985 c 49 s 41; 1987 c 337 s 53; 1988 c 656 s 4; 1995 c 207 art 10 s 4; 1997 c 225 art 2 s 62; 2003 c 2 art 1 s 7; 2006 c 255 s 11*

62A.28 COVERAGE FOR SCALP HAIR PROSTHESES.

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

Subd. 2. **Required coverage.** (a) Every policy, plan, certificate, or contract referred to in subdivision 1 must provide coverage for scalp hair prostheses, including all equipment and accessories necessary for regular use of scalp hair prostheses, worn for hair loss suffered as a result of a health condition, including but not limited to alopecia areata or the treatment for cancer, unless there is a clinical basis for limitation.

(b) The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items under the policy, plan, certificate, or contract and may be limited to one prosthesis per benefit year.

(c) The coverage required by this section for scalp hair prostheses is limited to $1,000 per benefit year.

(d) A scalp hair prosthesis must be prescribed by a doctor to be covered under this section.

History: *1987 c 202 s 1; 1992 c 564 art 1 s 54; 2004 c 288 art 7 s 1; 2013 c 84 art 1 s 22; 2024 c 127 art 57 s 5*

62A.285 PROHIBITED UNDERWRITING; BREAST IMPLANTS.

Subdivision 1. **Scope of coverage.** This section applies to all policies of accident and health insurance regulated under this chapter, subscriber contracts offered by nonprofit health service plan corporations

regulated under chapter 62C, health maintenance contracts regulated under chapter 62D, and health benefit certificates offered through a fraternal benefit society regulated under chapter 64B. This section does not apply to policies, plans, certificates, or contracts payable on a fixed indemnity or non-expense-incurred basis, or policies, plans, certificates, or contracts that provide only accident coverage.

Subd. 2. **Required coverage.** No policy, plan, certificate, or contract referred to in subdivision 1 shall be issued or renewed to provide coverage to a Minnesota resident if it provides an exclusion, reduction, or other limitation as to coverage, deductible, coinsurance, or co-payment applicable solely to conditions caused by breast implants.

Subd. 3. **Refusal to issue or renew.** No issuer of a policy, plan, certificate, or contract referred to in subdivision 1 shall refuse to issue or renew at standard premium rates a policy, plan, certificate, or contract referred to in subdivision 1 solely because the prospective insured or enrollee has breast implants.

Subd. 4. [Repealed, 2000 c 483 s 55]

History: *1992 c 564 art 4 s 8*

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

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

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

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

SURETY BOND

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

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

NOW, THEREFORE, the condition of this obligation is such that if the said principal shall, according to the terms, provisions, and limitations of principals' health benefit program for its Minnesota employees,

pay all of its liabilities and obligations, including all benefits as provided in the attached plan, then, this obligation shall be null and void, otherwise to remain in full force and effect, subject, however, to the following terms and conditions:

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

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

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

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

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

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

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

Signed, sealed and delivered in the presence of:	Corporation Name
.....	.....
.....	.....
.....	Bonding Company Name
.....	By:.....

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

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

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

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

(2) the number of employees;

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

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

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

History: *1987 c 337 s 54*

62A.30 COVERAGE FOR DIAGNOSTIC PROCEDURES FOR CANCER.

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

Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in subdivision 1 that provides coverage to a Minnesota resident must provide coverage for routine screening procedures for cancer and the office or facility visit, including mammograms, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer as defined in subdivision 3, pap smears, and colorectal screening tests for men and women, when ordered or provided by a physician in accordance with the standard practice of medicine.

Subd. 3. **Ovarian cancer surveillance tests.** For purposes of subdivision 2:

(a) "At risk for ovarian cancer" means:

(1) having a family history:

(i) with one or more first- or second-degree relatives with ovarian cancer;

(ii) of clusters of women relatives with breast cancer; or

(iii) of nonpolyposis colorectal cancer; or

(2) testing positive for BRCA1 or BRCA2 mutations.

(b) "Surveillance tests for ovarian cancer" means annual screening using:

(1) CA-125 serum tumor marker testing;

(2) transvaginal ultrasound;

(3) pelvic examination; or

(4) other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for breast cancer, and (2) is covered as a preventive item or service, as described under section 62Q.46.

(b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. "At risk for breast cancer" means:

(1) having a family history with one or more first- or second-degree relatives with breast cancer;

(2) testing positive for BRCA1 or BRCA2 mutations;

(3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(4) having a previous diagnosis of breast cancer.

(c) This subdivision does not apply to coverage provided through a public health care program under chapter 256B or 256L.

(d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to January 1, 2020.

(e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at risk for breast cancer.

Subd. 5. **Mammogram; diagnostic services and testing.** If a health care provider determines an enrollee requires additional diagnostic services or testing after a mammogram, a health plan must provide coverage for the additional diagnostic services or testing with no cost-sharing, including co-pay, deductible, or coinsurance.

Subd. 6. **Application.** If the application of subdivision 5 before an enrollee has met their health plan's deductible would result in: (1) health savings account ineligibility under United States Code, title 26, section 223; or (2) catastrophic health plan ineligibility under United States Code, title 42, section 18022(e), then subdivision 5 shall apply to diagnostic services or testing only after the enrollee has met their health plan's deductible.

History: *1988 c 441 s 2; 1988 c 642 s 5; 1992 c 564 art 1 s 32,54; 1994 c 465 art 3 s 11; 2004 c 288 art 6 s 2,3; 2007 c 66 s 1; 2008 c 344 s 11; 1Sp2019 c 9 art 8 s 1; 2023 c 70 art 2 s 2,3*

62A.301 [Repealed, 2007 c 147 art 12 s 16]

62A.302 COVERAGE OF DEPENDENTS.

Subdivision 1. **Scope of coverage.** This section applies to:

(1) a health plan as defined in section 62A.011; and

(2) a policy, contract, or certificate issued by a community integrated service network licensed under chapter 62N.

Subd. 2. **Required coverage.** Every health plan included in subdivision 1 that provides dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02, subdivision 11.

Subd. 3. **No additional restrictions permitted.** Any health plan included in subdivision 1 that provides dependent coverage of children shall make that coverage available to children until the child attains 26 years

of age. A health carrier must not place restrictions on this coverage and must comply with the following requirements:

(1) with respect to a child who has not attained 26 years of age, a health carrier shall not define dependent for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the enrollee or spouse of the enrollee;

(2) a health carrier must not deny or restrict coverage for a child who has not attained 26 years of age based on (i) the presence or absence of the child's financial dependency upon the participant, primary subscriber, or any other person; (ii) residency with the participant and in the individual market the primary subscriber, or with any other person; (iii) marital status; (iv) student status; (v) employment; or (vi) any combination of those factors; and

(3) a health carrier must not deny or restrict coverage of a child based on eligibility for other coverage, except as provided in subdivision 5.

Subd. 4. **Grandchildren.** Nothing in this section requires a health carrier to make coverage available for a grandchild, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild or unless the grandchild meets the requirements of section 62A.042. For grandchildren included under a grandparent's policy pursuant to section 62A.042, coverage for the grandchild may terminate if the grandchild does not continue to reside with the covered grandparent continuously from birth, if the grandchild does not remain financially dependent upon the covered grandparent, or when the grandchild reaches age 25, except as provided in section 62A.14 or if coverage is continued under section 62A.20.

Subd. 5. **Terms of coverage of dependents.** The terms of coverage in a health plan offered by a health carrier providing dependent coverage of children cannot vary based on age except for children who are 26 years of age or older.

Subd. 6. **Opportunity to enroll.** A health carrier must comply with all provisions of the Affordable Care Act in regards to providing an opportunity to enroll in coverage to any child whose coverage ended, or was not eligible for coverage under a group health plan or individual health plan because, under the terms of the coverage, the availability of dependent coverage of a child ended before age 26.

Subd. 7. **Grandfathered plan coverage.** (a) For plan years beginning before January 1, 2014, a group health plan that is a grandfathered plan and makes available dependent coverage of children may exclude an adult child who has not attained 26 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.

(b) For plan years beginning on or after January 1, 2014, a group health plan that is a grandfathered plan must comply with all requirements of this section.

Subd. 8. **Compliance.** This section does not require compliance with any provision of the Affordable Care Act before the effective date provided for that provision in the Affordable Care Act.

Subd. 9. **Enforcement.** The commissioner shall enforce this section.

History: *1992 c 549 art 3 s 9; 2001 c 215 s 12; 2013 c 84 art 1 s 23*

62A.3021 COVERAGE OF DEPENDENTS BY PLANS OTHER THAN HEALTH PLANS.

Subdivision 1. **Scope of coverage.** This section applies to coverage described in section 62A.011, subdivision 3, clauses (4), (6), (7), (8), (9), and (10).

Subd. 2. **Dependent.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 25, dependent child of any age who is disabled and who meets the eligibility criteria in section 62A.14, subdivision 2, or any other person whom state or federal law requires to be treated as a dependent for purposes of health plans. For the purpose of this definition, a child includes a child for whom the employee or the employee's spouse has been appointed legal guardian and an adoptive child as provided in section 62A.27. A child also includes grandchildren as provided in section 62A.042 with continued eligibility of grandchildren as provided in section 62A.302, subdivision 4.

History: *2013 c 84 art 1 s 24*

62A.303 PROHIBITION; SEVERING OF GROUPS.

Section 62L.12, subdivisions 3 and 4, apply to all employer group health plans, as defined in section 62A.011, regardless of the size of the group.

History: *1992 c 549 art 3 s 10; 1994 c 625 art 10 s 4*

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.305 FIBROCYSTIC CONDITION; TERMINATION OR REDUCTION OF COVERAGE.

No health plan shall be terminated, canceled, nonrenewed, or contain any increased premium rate, or exclusion, reduction, or limitation on benefits, nor shall coverage be denied, solely because the covered person has been diagnosed as having a fibrocystic breast condition.

History: *1994 c 442 s 1*

62A.306 USE OF GENDER PROHIBITED.

Subdivision 1. **Applicability.** This section applies to all health plans as defined in section 62A.011 offered, sold, issued, or renewed, by a health carrier on or after January 1, 1995.

Subd. 2. **Prohibition on use of gender.** No health plan described in subdivision 1 shall determine the premium rate or any other underwriting decision, including initial issuance, through a method that is in any way based upon the gender of any person covered or to be covered under the health plan. This subdivision prohibits use of marital status or generalized differences in expected costs between employees and spouses or between principal insureds and their spouses.

History: *1994 c 625 art 10 s 5*

62A.307 PRESCRIPTION DRUGS; EQUAL TREATMENT OF PRESCRIBERS.

Subdivision 1. **Scope of requirement.** This section applies to any of the following if issued or renewed to a Minnesota resident or to cover a Minnesota resident:

(1) a health plan, as defined in section 62A.011;

(2) coverage described in section 62A.011, subdivision 3, clause (2), (3), or (6) to (12); and

(3) a policy, contract, or certificate issued by a community integrated service network licensed under chapter 62N.

Subd. 2. **Requirement.** Coverage described in subdivision 1 that covers prescription drugs must provide the same coverage for a prescription written by a health care provider authorized to prescribe the particular drug covered by the health coverage described in subdivision 1, regardless of the type of health care provider that wrote the prescription. This section is intended to prohibit denial of coverage based on the prescription having been written by an advanced practice registered nurse under section 148.235, a physician assistant under section 147A.185, or any other nonphysician health care provider authorized to prescribe the particular drug.

History: *1995 c 69 s 1; 1996 c 305 art 1 s 17; 1997 c 225 art 2 s 62; 2020 c 115 art 2 s 1; 2023 c 25 s 5*

62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE.

(a) A health plan company that provides coverage under a health plan for cancer chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance amount for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells than what the health plan requires for an intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health plan company.

(b) A health plan company must not achieve compliance with this section by imposing an increase in co-payment, deductible, or coinsurance amount for an intravenously administered or injected cancer chemotherapy agent covered under the health plan.

(c) Nothing in this section shall be interpreted to prohibit a health plan company from requiring prior authorization or imposing other appropriate utilization controls in approving coverage for any chemotherapy.

(d) A plan offered by the commissioner of management and budget under section 43A.23 is deemed to be at parity and in compliance with this section.

(e) A health plan company is in compliance with this section if it does not include orally administered anticancer medication in the fourth tier of its pharmacy benefit.

(f) A health plan company that provides coverage under a health plan for cancer chemotherapy treatment must indicate the level of coverage for orally administered anticancer medication within its pharmacy benefit filing with the commissioner.

History: *2010 c 326 s 1; 1Sp2017 c 6 art 5 s 3*

62A.308 HOSPITALIZATION AND ANESTHESIA FOR DENTAL PROCEDURES.

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

Subd. 2. **Required coverages.** (a) A health plan included in subdivision 1 must cover anesthesia and hospital charges for dental care provided to a covered person who: (1) is a child under age five; or (2) is severely disabled; or (3) has a medical condition and who requires hospitalization or general anesthesia for dental care treatment. A health carrier may require prior authorization of hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

(b) A health plan included in subdivision 1 must also provide coverage for general anesthesia and treatment rendered by a dentist for a medical condition covered by the health plan, regardless of whether the services are provided in a hospital or a dental office.

History: *1995 c 91 s 1*

62A.309 [Repealed, 2004 c 288 art 7 s 8]

62A.3091 NONDISCRIMINATE COVERAGE OF TESTS.

Subdivision 1. **Scope of requirement.** This section applies to any of the following if issued or renewed to a Minnesota resident or to cover a Minnesota resident:

(1) a health plan, as defined in section 62A.011;

(2) coverage described in section 62A.011, subdivision 3, clauses (2), (3), or (6) to (12); and

(3) a policy, contract, or certificate issued by a community integrated service network licensed under chapter 62N.

Subd. 2. **Requirement.** Coverage described in subdivision 1 that covers laboratory tests, diagnostic tests, and x-rays must provide the same coverage, without requiring additional signatures, for all such tests ordered by an advanced practice registered nurse operating pursuant to chapter 148 or a physician assistant practicing pursuant to chapter 147A. Nothing in this section shall be construed to interfere with any written agreement between a physician and an advanced practice registered nurse or between a physician and a physician assistant.

History: *1996 c 446 art 1 s 24; 1997 c 225 art 2 s 62; 2022 c 58 s 4; 2023 c 25 s 6*

62A.3092 EQUAL TREATMENT OF SURGICAL FIRST ASSISTING SERVICES.

Subdivision 1. **Scope of requirement.** This section applies to any of the following if issued or renewed to a Minnesota resident or to cover a Minnesota resident:

(1) a health plan, as defined in section 62A.011;

(2) coverage described in section 62A.011, subdivision 3, clauses (2), (3), or (6) to (12); and

(3) a policy, contract, or certificate issued by a community integrated service network licensed under chapter 62N.

Subd. 2. **Requirement.** Coverage described in subdivision 1 that provides for payment for surgical first assisting benefits or services shall be construed as providing for payment for a registered nurse who performs first assistant functions and services that are within the scope of practice of a registered nurse.

History: *1996 c 446 art 1 s 25; 1997 c 225 art 2 s 62*

62A.3093 COVERAGE FOR DIABETES.

Subdivision 1. **Required coverage.** A health plan, including a plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), must provide coverage for: (1) all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes; and (2) diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage must include persons with gestational, type I or type II diabetes. Coverage required under this section is subject to the same deductible or coinsurance provisions applicable to the plan's hospital, medical expense, medical equipment, or prescription drug benefits. A health carrier may not reduce or eliminate coverage due to this requirement.

Subd. 2. **Medicare Part D exception.** A health plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), is not subject to the requirements of subdivision 1, clause (1), with respect to equipment and supplies covered under the Medicare Part D Prescription Drug program, whether or not the covered person is enrolled in a Medicare Part D plan.

This subdivision does not apply to a health plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), that was in effect on December 31, 2005, if the covered person remains enrolled in the plan and does not enroll in a Medicare Part D plan.

History: *1994 c 538 s 1; 1995 c 52 s 1; 1997 c 57 s 1; 2006 c 255 s 12*

62A.3094 COVERAGE FOR AUTISM SPECTRUM DISORDERS.

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in paragraphs (b) to (d) have the meanings given.

(b) "Autism spectrum disorders" means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(c) "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing and preventative services. Medically necessary care must be consistent with generally accepted practice parameters as determined by physicians and licensed psychologists who typically manage patients who have autism spectrum disorders.

(d) "Mental health professional" means a mental health professional who is qualified according to section 245I.04, subdivision 2, clause (1), (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder and child development.

[See Note.]

Subd. 2. **Coverage required.** (a) A health plan issued to a large employer, as defined in section 62Q.18, subdivision 1, must provide coverage for the diagnosis, evaluation, multidisciplinary assessment, and medically necessary care of children under 18 with autism spectrum disorders, including but not limited to the following:

(1) early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention;

(2) neurodevelopmental and behavioral health treatments and management;

(3) speech therapy;

(4) occupational therapy;

(5) physical therapy; and

(6) medications.

(b) The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities.

(c) The coverage required under this subdivision must include treatment that is in accordance with an individualized treatment plan prescribed by the enrollee's treating physician or mental health professional.

(d) A health carrier may not refuse to renew or reissue, or otherwise terminate or restrict, coverage of an individual solely because the individual is diagnosed with an autism spectrum disorder.

(e) A health carrier may request an updated treatment plan only once every six months, unless the health carrier and the treating physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances.

(f) An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made.

Subd. 3. **No effect on other law.** Nothing in this section limits the coverage required under section 62Q.47.

Subd. 4. **State health care programs.** This section does not affect benefits available under the medical assistance and MinnesotaCare programs and does not limit, restrict, or otherwise reduce coverage under these programs.

History: *2013 c 108 art 12 s 3; 2021 c 30 art 17 s 2*

NOTE: The amendment to subdivision 1 by Laws 2021, chapter 30, article 17, section 2, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2021, chapter 30, article 17, section 114.

62A.3095 PRESCRIPTION EYE DROPS COVERAGE.

Subdivision 1. **Scope of coverage.** This section applies to all health plans, as defined in section 62A.011, subdivision 3, that provide coverage to Minnesota residents.

Subd. 2. **Required coverage.** (a) Every health plan included in subdivision 1 that provides coverage for prescription eye drops shall not deny coverage for a refill of the prescription eye drops if the refill is requested by the person insured by the health plan, pursuant to paragraph (b), and if the prescribing practitioner indicated on the original prescription that additional quantities are needed and the refill requested by the insured does not exceed the number of additional quantities needed.

(b) Coverage shall only be provided pursuant to paragraph (a) if the insured makes a refill request for:

(1) a 30-day refill supply and the request is made between 21 and 30 days from the later of:

(i) the original date that the prescription was distributed to the insured; or

(ii) the date the most recent refill was distributed to the insured; or

(2) a 90-day refill supply and the request is made between 75 and 90 days from the later of:

(i) the original date that the prescription was distributed to the insured; or

(ii) the date the most recent refill was distributed to the insured.

History: *2017 c 47 s 1*

62A.3097 PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS (PANDAS) AND PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME (PANS) TREATMENT; COVERAGE.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Pediatric acute-onset neuropsychiatric syndrome" means a class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that are not otherwise explained by another known neurologic or medical disorder.

(c) "Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections" means a condition in which a streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity.

Subd. 2. **Scope of coverage.** This section applies to all health plans that provide coverage to Minnesota residents.

Subd. 3. **Required coverage.** Every health plan included in subdivision 2 must provide coverage for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments that must be covered under this section must be recommended by the insured's licensed health care professional and include but are not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

Subd. 4. **Reimbursement.** The commissioner of commerce shall reimburse health carriers for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health carrier without the requirements of this section. Each fiscal year an amount necessary to make payments to health carriers to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce. Health carriers shall report to the commissioner quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. The commissioner shall evaluate submissions and make payments to health carriers as provided in Code of Federal Regulations, title 45, section 155.170.

History: *1Sp2019 c 9 art 8 s 2*

62A.3098 RAPID WHOLE GENOME SEQUENCING; COVERAGE.

Subdivision 1. **Definition.** For purposes of this section, "rapid whole genome sequencing" or "rWGS" means an investigation of the entire human genome, including coding and noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing genetic changes that returns the final results

in 14 days. Rapid whole genome sequencing includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient and the patient's biological parent or parents.

Subd. 2. **Required coverage.** A health plan that provides coverage to Minnesota residents must cover rWGS testing if the enrollee:

(1) is 21 years of age or younger;

(2) has a complex or acute illness of unknown etiology that is not confirmed to have been caused by an environmental exposure, toxic ingestion, an infection with a normal response to therapy, or trauma; and

(3) is receiving inpatient hospital services in an intensive care unit or a neonatal or high acuity pediatric care unit.

Subd. 3. **Coverage criteria.** Coverage may be based on the following medical necessity criteria:

(1) the enrollee has symptoms that suggest a broad differential diagnosis that would require an evaluation by multiple genetic tests if rWGS testing is not performed;

(2) timely identification of a molecular diagnosis is necessary in order to guide clinical decision making, and the rWGS testing may aid in guiding the treatment or management of the enrollee's condition; and

(3) the enrollee's complex or acute illness of unknown etiology includes at least one of the following conditions:

(i) congenital anomalies involving at least two organ systems, or complex or multiple congenital anomalies in one organ system;

(ii) specific organ malformations that are highly suggestive of a genetic etiology;

(iii) abnormal laboratory tests or abnormal chemistry profiles suggesting the presence of a genetic disease, complex metabolic disorder, or inborn error of metabolism;

(iv) refractory or severe hypoglycemia or hyperglycemia;

(v) abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems;

(vi) severe muscle weakness, rigidity, or spasticity;

(vii) refractory seizures;

(viii) a high-risk stratification on evaluation for a brief resolved unexplained event with any of the following features:

(A) a recurrent event without respiratory infection;

(B) a recurrent seizure-like event; or

(C) a recurrent cardiopulmonary resuscitation;

(ix) abnormal cardiac diagnostic testing results that are suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease;

(x) abnormal diagnostic imaging studies that are suggestive of underlying genetic condition;

(xi) abnormal physiologic function studies that are suggestive of an underlying genetic etiology; or

(xii) family genetic history related to the patient's condition.

Subd. 4. **Cost sharing.** Coverage provided in this section is subject to the enrollee's health plan cost-sharing requirements, including any deductibles, co-payments, or coinsurance requirements that apply to diagnostic testing services.

Subd. 5. **Payment for services provided.** If the enrollee's health plan uses a capitated or bundled payment arrangement to reimburse a provider for services provided in an inpatient setting, reimbursement for services covered under this section must be paid separately and in addition to any reimbursement otherwise payable to the provider under the capitated or bundled payment arrangement, unless the health carrier and the provider have negotiated an increased capitated or bundled payment rate that includes the services covered under this section.

Subd. 6. **Genetic data.** Genetic data generated as a result of performing rWGS and covered under this section: (1) must be used for the primary purpose of assisting the ordering provider and treating care team to diagnose and treat the patient; (2) is protected health information as set forth under the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act, and any promulgated regulations, including but not limited to Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E; and (3) is a protected health record under sections 144.291 to 144.298.

Subd. 7. **Reimbursement.** (a) The commissioner of commerce must reimburse health carriers for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments and services covered by the health plan as of January 1, 2024, are ineligible for payments under this subdivision by the commissioner of commerce.

(b) Health carriers must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's coverage as of January 1, 2024, must be used by the health carrier as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health carriers as provided in Code of Federal Regulations, title 45, section 155.170.

Subd. 8. **Appropriation.** Each fiscal year, an amount necessary to make payments to health carriers to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

History: *2024 c 127 art 57 s 6*

MEDICARE SUPPLEMENT INSURANCE

62A.3099 DEFINITIONS.

Subdivision 1. **Scope.** The definitions provided in this section apply to sections 62A.3099 to 62A.44.

Subd. 2. **Accident, accidental injury, accidental means.** "Accident," "accidental injury," or "accidental means" means to employ "result" language and does not include words that establish an accidental means test or use words such as "external," "violent," "visible wounds," or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under a workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

Subd. 3. **Applicant.** "Applicant" means:

(1) in the case of an individual Medicare supplement policy or certificate, the person who seeks to contract for insurance benefits; and

(2) in the case of a group Medicare supplement policy or certificate, the proposed certificate holder.

Subd. 4. **Bankruptcy.** "Bankruptcy" means a situation in which a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

Subd. 5. **Benefit period, Medicare benefit period.** "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

Subd. 6. **Certificate.** "Certificate" means a certificate delivered or issued for delivery in this state or offered to a resident of this state under a group Medicare supplement policy or certificate.

Subd. 7. **Certificate form.** "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

Subd. 8. **Convalescent nursing home, extended care facility, skilled nursing facility.** "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

Subd. 9. **Employee welfare benefit plan.** "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in United States Code, title 29, section 1002 (Employee Retirement Income Security Act).

Subd. 10. **Health care expenses.** "Health care expenses" means, for purposes of section 62A.36, expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers. The expenses shall not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; and

(7) claims processing costs.

Subd. 11. **Hospital.** "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

Subd. 12. **Insolvency.** "Insolvency" means a situation in which an issuer, licensed to transact the business of insurance in this state, including the right to transact business as any type of issuer, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

Subd. 13. **Issuer.** "Issuer" includes insurance companies, fraternal benefit societies, health service plan corporations, health maintenance organizations, and any other entity delivering or issuing for delivery Medicare supplement policies or certificates in this state or offering these policies or certificates to residents of this state.

Subd. 14. **Medicare.** "Medicare" shall be defined in the policy and certificate. Medicare may be defined as the Health Insurance for the Aged Act, title XVIII of the Social Security Amendments of 1965, as amended, or title I, part I, of Public Law 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as amended.

Subd. 15. **Medicare Advantage plan.** "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in section 1859 of the federal Social Security Act, United States Code, title 42, section 1395w-28, and includes:

(1) coordinated care plans which provide health care services, including, but not limited to, health maintenance organization plans, with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

(3) Medicare Advantage private fee-for-service plans.

Subd. 16. **Medicare eligible expenses.** "Medicare eligible expenses" means health care expenses covered by Medicare Part A or B, to the extent recognized as reasonable and medically necessary by Medicare.

Subd. 17. **Medicare-related coverage.** "Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.3099 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by section 1833 (known as "HCPP" contracts) or 1876 (known as "Cost" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended; or Section 4001 of the Balanced Budget Act of 1997 (BBA)(Public Law 105-33), Sections 1851 to 1859 of the Social Security Act establishing Part C of the Medicare program, known as the "Medicare Advantage program."

Subd. 18. **Medicare supplement policy or certificate.** "Medicare supplement policy or certificate" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than those policies or certificates covered by section 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., or an issued policy under a demonstration project specified under amendments to the federal Social Security Act, which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare or as a supplement to Medicare Advantage plans established under Medicare Part C. "Medicare supplement policy" does not

include Medicare Advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, any health care prepayment plan that provides benefits under an agreement under section 1833(a)(1)(A) of the Social Security Act, or any 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, or any policy issued to a labor union or similar employee organization.

Subd. 18a. **Newly eligible individual.** "Newly eligible individual" means an individual who is eligible for Medicare on or after January 1, 2020, because the individual:

(1) has attained age 65 on or after January 2020; or

(2) although under age 65, is entitled to or deemed eligible for benefits under Medicare Part A by reason of disability or otherwise.

Subd. 18b. **Open enrollment period.** "Open enrollment period" means the time period described in Code of Federal Regulations, title 42, section 422.62, paragraph (a), clauses (2) to (4), as amended.

Subd. 19. **Outpatient prescription drug.** "Outpatient prescription drug" means a prescription drug prescribed or administered under circumstances that qualify for coverage under Medicare Part D and not under Medicare Part A or Part B.

Subd. 20. **Physician.** "Physician" shall not be defined more restrictively than as defined in the Medicare program or section 62A.04, subdivision 1, or 62A.15, subdivision 3a.

Subd. 21. **Policy form.** "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

Subd. 22. **Secretary.** "Secretary" means the Secretary of the United States Department of Health and Human Services.

Subd. 23. **Sickness.** "Sickness" shall not be defined more restrictively than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under a workers' compensation, occupational disease, employer's liability, or similar law.

History: *1981 c 318 s 1; 1983 c 263 s 10; 1986 c 397 s 2; 1987 c 337 s 55; 1989 c 258 s 3,4; 1990 c 403 s 3; 1990 c 415 s 3; 1991 c 43 s 1; 1991 c 129 s 1; 1992 c 549 art 3 s 11; 1992 c 554 art 1 s 1-3; 1993 c 1 s 1; 1993 c 330 s 1-3,12; 1994 c 465 art 1 s 2; 1994 c 625 art 10 s 6; 1995 c 258 s 29,30; 1996 c 446 art 1 s 27-31; 1997 c 71 art 2 s 4; 1999 c 90 s 1-3; 2001 c 215 s 13-15; 2002 c 277 s 32; 2002 c 330 s 11; 1Sp2003 c 14 art 7 s 2-4; 2005 c 17 art 1 s 1-9,14; 2005 c 132 s 10; 2009 c 178 art 1 s 23; 2010 c 384 s 18,19; 2019 c 26 art 5 s 1,13; 2023 c 57 art 2 s 7*

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, including to supplement coverage under Medicare Advantage plans established under Medicare Part C, 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 1w are met.

Subd. 1a. **Minimum coverage.** The policy must provide a minimum of the coverage set out in subdivision 2 and for an extended basic plan, the additional requirements of section 62E.07.

Subd. 1b. **Preexisting condition coverage.** (a) 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.

(b) The policy must cover preexisting conditions if the insured meets the requirements under subdivision 1r, paragraph (c).

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 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 waiting period if the enrollee meets the requirements under subdivision 1r, paragraph (c), 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. If the suspended policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide coverage substantially equivalent to the coverage in effect before the date of 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.** (a) No health carrier issuing Medicare-related coverage in this state may impose preexisting condition limitations or otherwise deny or condition the issuance or effectiveness of any such coverage available for sale in this state, nor may it discriminate in the pricing of such coverage, because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant where an application for such coverage is submitted: (1) prior to or during the six-month period beginning with the first day of the month in which an individual first enrolled for benefits under Medicare Part B; or (2) during the open enrollment period if the applicant:

(i) is age 65 to 70 and the applicant is applying for coverage during the open enrollment period for the first time; and

(ii) meets the requirements under subdivision 1r, paragraph (c).

(b) Notwithstanding paragraph (a), the premium increases permitted under subdivision 1r are allowed.

(c) This subdivision applies to each Medicare-related coverage offered by a health carrier regardless of whether the individual has attained the age of 65 years.

(d) If an individual who is enrolled in Medicare Part B due to disability status is involuntarily disenrolled due to loss of disability status, the individual is eligible for another six-month enrollment period provided under this subdivision beginning the first day of the month in which the individual later becomes eligible for and enrolls again in Medicare Part B and during the open enrollment period. An individual who is or was previously enrolled in Medicare Part B due to disability status is eligible for another six-month enrollment period under this subdivision beginning the first day of the month in which the individual has attained the age of 65 years and either maintains enrollment in, or enrolls again in, Medicare Part B. If an individual enrolled in Medicare Part B voluntarily disenrolls from Medicare Part B because the individual becomes enrolled under an employee welfare benefit plan, the individual is eligible for another six-month enrollment period, as provided in this subdivision, beginning the first day of the month in which the individual later becomes eligible for and enrolls again in Medicare Part B.

Subd. 1i. **Replacement coverage.** If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the issuer of the replacing policy or certificate shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate for benefits to the extent the time was spent under the original policy or certificate. For purposes of this subdivision, "Medicare supplement policy or certificate" means all coverage described in section 62A.011, subdivision 3, clause (10).

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.3099 to 62A.44.

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

(a) Only the standards for renewability provided in this subdivision may be used in Medicare supplement insurance policy forms.

(b) 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.

(c) 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.

(d) 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.

(e) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the policy as modified for that purpose is deemed to satisfy the guaranteed renewal requirements of this subdivision.

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 co-payment 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.** (a) 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. Receipt of Medicare Part D benefits is not considered in determining a continuous loss.

(b) 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 form 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. This period of ineligibility to file a form for approval 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 and section 62A.3099. A change in the rating structure or methodology shall be considered a discontinuance under this section and section 62A.3099 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.** (a) 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 must appear as a separate paragraph of the policy or certificate and be labeled as "preexisting condition limitations."

(b) Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a "Guide to Health Insurance for People with Medicare" in the form developed by the Centers for Medicare and Medicaid Services and in a type size no smaller than 12-point type. Delivery of the 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 and section 62A.3099. Except in the case of direct response issuers, delivery of the guide must be made to the applicant at the time of application, and acknowledgment of receipt of the guide must be obtained by the issuer. Direct response issuers shall deliver the 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.** (a) Each health maintenance organization, health service plan corporation, insurer, or fraternal benefit society that sells Medicare-related coverage shall establish a separate community rate for that coverage. No Medicare-related coverage 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.

(b) 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;

(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; and

(4) for coverage that supplements Medicare, premium increases on an individual who enrolls in a Medicare supplement policy outside of the individual's initial enrollment period in Medicare Part B. This paragraph does not apply to individuals who enroll in a Medicare supplement policy pursuant to subdivision 1u, paragraph (b), clauses (1) to (8). The increases described in paragraph (c) apply each year an individual is enrolled in a Medicare supplement policy and are in addition to any standard increases in community rate.

(c) The premium increases permitted under paragraph (b), clause (4):

(1) apply to an individual age 65 to 70;

(2) apply to an individual who enrolls in a Medicare supplement policy pursuant to subdivision 1h, paragraph (a), clause (2);

(3) apply only the first time the individual enrolls;

(4) apply for the duration of time the policy is in force; and

(5) must equal:

(i) for an individual who enrolls during the 2026 open enrollment period, 15 percent;

(ii) for an individual who enrolls during the 2027 open enrollment period, 20 percent;

(iii) for an individual who enrolls during the 2028 open enrollment period, 25 percent;

(iv) for an individual who enrolls during the 2029 open enrollment period, 30 percent;

(v) for an individual who enrolls during the 2030 open enrollment period, 35 percent; and

(vi) for an individual who enrolls during an open enrollment period after 2029, 35 percent.

If an individual age 65 to 70 enrolls in a subsequent Medicare supplement policy that is not a replacement or renewal, the individual is not subject to the premium increases as described in paragraph (b), clause (4).

Subd. 1s. **Prescription drug coverage.** (a) Subject to subdivisions 1k, 1m, 1n, and 1p, a Medicare supplement policy with benefits for outpatient prescription drugs, in existence prior to January 1, 2006, must be renewed, at the option of the policyholder, for current policyholders who do not enroll in Medicare Part D.

(b) A Medicare supplement policy with benefits for outpatient prescription drugs must not be issued after December 31, 2005.

(c) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs must not be renewed after the policyholder enrolls in Medicare Part D unless:

(1) the policy is modified to eliminate outpatient prescription drug coverage for expenses of outpatient prescription drugs incurred on or after the effective date of the individual's coverage under Medicare Part D; and

(2) premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

(d) An issuer of a Medicare supplement policy or certificate must comply with the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended, including any federal regulations, as amended, adopted under that act. This paragraph does not require compliance with any provision of that act until the date upon which that act requires compliance with that provision. The commissioner has authority to enforce this paragraph.

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 by retaining existing coverage you may have or by enrolling in Medicare Part D. Please ask for further details."

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 described in paragraph (b), or of the date of Medicare Part D enrollment, 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 Advantage organization under a Medicare Advantage 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 Advantage 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 Advantage organization under a Medicare Advantage 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;

(6) the individual, upon first enrolling for benefits under Medicare Part B, enrolls in a Medicare Advantage 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;

(7) the individual enrolls in a Medicare Part D plan during the initial Part D enrollment period, as defined under United States Code, title 42, section 1395ss(v)(6)(D), and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (e), clause (4);

(8) the individual was enrolled in a state public program and is losing coverage due to the unwinding of the Medicaid continuous enrollment conditions, as provided by Code of Federal Regulations, title 45, section 155.420(d)(9) and (d)(1), and Public Law 117-328, section 5131 (2022); or

(9) the individual meets the requirements under subdivision 1r, paragraph (c), and enrolls during the open enrollment period.

(c)(1) In the case of an individual described in paragraph (b), clause (1), the guaranteed issue period begins on the later of: (i) 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; or (ii) the date that the applicable coverage terminates or ceases; and ends 63 days after the later of those two dates.

(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), clause (7), the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) 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.

(7) For an individual described in paragraph (b), clause (9), the guarantee issue period is the open enrollment period.

(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, except that after December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy to which the individual is entitled under paragraph (b), clause (5), is:

(i) the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) at the election of the policyholder, a policy described in clause (4), except that the policy may be one that is offered and available for issuance to new enrollees that is offered by any issuer;

(3) paragraph (b), clause (6), is any Medicare supplement policy offered by any issuer;

(4) paragraph (b), clause (7), is a Medicare supplement policy that has a benefit package classified as a basic plan under section 62A.316 if the enrollee's existing Medicare supplement policy is a basic plan or, if the enrollee's existing Medicare supplement policy is an extended basic plan under section 62A.315, a basic or extended basic plan at the option of the enrollee, provided that the policy is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage. The issuer must permit the enrollee to retain all optional benefits contained in the enrollee's existing coverage, other than outpatient prescription drugs, subject to the provision that the coverage be offered and available for issuance to new enrollees by the same 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.

Subd. 1v. **Medicare Part B deductible.** A Medicare supplemental policy or certificate must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

Subd. 1w. MS 2024 [Never effective, 1Sp2025 c 4 art 5 s 9]

Subd. 2. **General coverage.** For a policy to meet the requirements of this section and section 62A.3099 it must contain (1) a designation specifying whether the policy is an extended basic Medicare supplement plan or a basic Medicare supplement plan, (2) a caption stating that the commissioner has established two categories of Medicare supplement insurance and minimum standards for each, with the extended basic Medicare supplement being the most comprehensive and the basic Medicare supplement being the least comprehensive, and (3) the policy must provide the coverage prescribed in sections 62A.315 and 62A.316.

Subd. 3. [Renumbered 62A.3099]

Subd. 4. **Prohibited policy provisions.** (a) 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. Duplication of benefits is permitted to the extent permitted under subdivision 1s, paragraph (a), for benefits provided by Medicare Part D.

(b) 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 1h.

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.3099 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 chapter 62S, 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.

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.

Subd. 8. **Prohibition against use of genetic information and requests for genetic information.** This subdivision applies to all policies with policy years beginning on or after May 21, 2009.

(a) An issuer of a Medicare supplement policy or certificate:

(1) shall not deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to such individual; and

(2) shall not discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to such individual.

(b) Nothing in paragraph (a) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

(1) denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(2) increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

(c) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

(d) Paragraph (c) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated under Part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996 as they may be revised from time to time, and consistent with paragraph (a).

(e) For purposes of carrying out paragraph (d), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(f) Notwithstanding paragraph (c), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions are met:

(1) the request is made pursuant to research that complies with Code of Federal Regulations, title 45, part 46, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research;

(2) the issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(i) compliance with the request is voluntary; and

(ii) noncompliance will have no effect on enrollment status or premium or contribution amounts;

(3) no genetic information collected or acquired under this paragraph shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

(4) the issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted; and

(5) the issuer complies with such other conditions as the secretary may by regulation require for activities under this paragraph.

(g) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(h) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(i) An issuer of a Medicare supplement policy or certificate that obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (h) if such request, requirement, or purchase is not in violation of paragraph (g).

(j) For purposes of this subdivision only:

(1) "family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual;

(2) "genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic test of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such terms include, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term genetic information does not include information about the sex or age of any individual;

(3) "genetic services" means a genetic test or genetic counseling, including obtaining, interpreting, or assessing genetic information or genetic education;

(4) "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term genetic test does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved;

(5) "issuer of a Medicare supplement policy or certificate" includes a third-party administrator or other person acting for or on behalf of such issuer; and

(6) "underwriting purposes" means:

(i) rules for, or determination of, eligibility including enrollment and continued eligibility, for benefits under the policy;

(ii) the computation of premium or contribution amounts under the policy;

(iii) the application of any preexisting condition exclusion under the policy; and

(iv) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

History: *1981 c 318 s 1; 1983 c 263 s 10; 1986 c 397 s 2; 1987 c 337 s 55; 1989 c 258 s 3,4; 1990 c 403 s 3; 1990 c 415 s 3; 1991 c 43 s 1; 1991 c 129 s 1; 1992 c 549 art 3 s 11; 1992 c 554 art 1 s 1-3; 1993 c 1 s 1; 1993 c 330 s 1-3,12; 1994 c 465 art 1 s 2; 1994 c 625 art 10 s 6; 1995 c 258 s 29,30; 1996 c 446 art 1 s 27-31; 1997 c 71 art 2 s 4; 1999 c 90 s 1-3; 2001 c 215 s 13-15; 2002 c 277 s 32; 2002 c 330 s 11; 1Sp2003 c 14 art 7 s 2-4; 2005 c 17 art 1 s 1-9,14; 2005 c 132 s 10; 2009 c 178 art 1 s 24,25; 2019 c 26 art 5 s 2,3,13; 2023 c 57 art 2 s 8-14; 2025 c 20 s 290; 1Sp2025 c 4 art 5 s 1-7,9*

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

(a) 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. An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare supplement policy or certificate issued on or after January 1, 2006;

(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 not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer, including mammograms and pap smears;

(7) preventive medical care benefit: coverage for the following preventive health services not covered by Medicare:

(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) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically 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) coverage of cost sharing for all Medicare Part A eligible hospice care and respite care expenses; and

(9) coverage for cost sharing for Medicare Part A or B home health care services and medical supplies.

(b) An extended basic Medicare supplement plan must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

History: *1989 c 258 s 5; 1990 c 403 s 4; 1992 c 554 art 1 s 4; 1993 c 330 s 4; 1996 c 446 art 1 s 32; 1Sp2003 c 14 art 2 s 2; art 7 s 5; 2005 c 17 art 1 s 10; 2005 c 132 s 11; 2009 c 178 art 1 s 26,70; 2019 c 26 art 5 s 4,13*

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 not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer screening including mammograms and pap smears;

(7) 80 percent of coverage for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes not otherwise covered under Part D of the Medicare program. Coverage must include persons with gestational, type I, or type II diabetes. Coverage under this clause is subject to section 62A.3093, subdivision 2;

(8) coverage of cost sharing for all Medicare Part A eligible hospice care and respite care expenses; and

(9) coverage for cost sharing for Medicare Part A or B home health care services and medical supplies subject to the Medicare Part B deductible amount.

(b) The following benefit riders must be offered with this plan:

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

(2) 100 percent of the Medicare Part B excess charges coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;

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

(4) preventive medical care benefit coverage for the following preventative health services not covered by Medicare:

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

(ii) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically 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.

(c) A basic Medicare supplement plan must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

History: *1989 c 258 s 6; 1990 c 403 s 5; 1990 c 612 s 5; 1991 c 129 s 2; 1992 c 554 art 1 s 5; 1993 c 330 s 5; 1997 c 225 art 2 s 4; 1998 c 293 s 1; 1Sp2003 c 14 art 7 s 6; 2005 c 17 art 1 s 11; 2005 c 132 s 12; 2006 c 255 s 13; 2009 c 178 art 1 s 27,70; 2019 c 26 art 5 s 5,13*

62A.3161 MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT COVERAGE.

(a) The Medicare supplement plan with 50 percent coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (8);

(3) coverage for 50 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (8);

(4) coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (8);

(5) coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations, until the out-of-pocket limitation is met as described in clause (8);

(6) except for coverage provided in this clause, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B, after the policyholder pays the Medicare Part B deductible, until the out-of-pocket limitation is met as described in clause (8);

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible; and

(8) coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment by the secretary of the United States Department of Health and Human Services.

(b) A Medicare supplement plan with 50 percent coverage must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

History: *2006 c 255 s 14; 2019 c 26 art 5 s 6,13*

62A.3162 MEDICARE SUPPLEMENT PLAN WITH 75 PERCENT COVERAGE.

(a) The basic Medicare supplement plan with 75 percent coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 75 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (8);

(3) coverage for 75 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (8);

(4) coverage for 75 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (8);

(5) coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations until the out-of-pocket limitation is met as described in clause (8);

(6) except for coverage provided in this clause, coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in clause (8);

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible; and

(8) coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2,000 in 2006, indexed each year by the appropriate inflation adjustment by the Secretary of the United States Department of Health and Human Services.

(b) A Medicare supplement plan with 75 percent coverage must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

History: *2006 c 255 s 15; 2019 c 26 art 5 s 7,13*

62A.3163 MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT PART A DEDUCTIBLE COVERAGE.

(a) The Medicare supplement plan with 50 percent Medicare Part A deductible coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A;

(4) coverage for cost sharing for all Medicare Part A eligible hospice and respite care expenses;

(5) coverage under Medicare Part A or B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations;

(6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B, after the policyholder pays the Medicare Part B deductible;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

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

(9) coverage for 100 percent of the Medicare Part A or B home health care services and medical supplies after the policyholder pays the Medicare Part B deductible.

(b) A Medicare supplement plan with 50 percent Part A deductible coverage must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

History: *2009 c 178 art 1 s 28,70; 2019 c 26 art 5 s 8,13*

62A.3164 MEDICARE SUPPLEMENT PLAN WITH $20 AND $50 CO-PAYMENT MEDICARE PART B COVERAGE.

(a) The Medicare supplement plan with $20 and $50 co-payment Medicare Part B coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A;

(4) coverage for the cost sharing for all Medicare Part A eligible hospice and respite care expenses;

(5) coverage for Medicare Part A or B of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations;

(6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B except for the lesser of $20 or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit and the lesser of $50 or the Medicare Part B coinsurance or co-payment for each covered emergency room visit; however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

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

(9) coverage for Medicare Part A or B home health care services and medical supplies after the policyholder pays the Medicare Part B deductible.

(b) A Medicare supplement plan with $20 and $50 co-payment Medicare Part B coverage must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual. No portion of the co-payment referenced in this paragraph may be applied to a Medicare Part B deductible.

History: *2009 c 178 art 1 s 29,70; 2019 c 26 art 5 s 9,13*

62A.3165 MEDICARE SUPPLEMENT PLAN WITH HIGH DEDUCTIBLE COVERAGE.

(a) The Medicare supplement plan will pay 100 percent coverage upon payment of the annual high deductible. The annual deductible shall consist of out-of-pocket expenses, other than premiums, for services covered. This plan must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for 100 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A;

(4) coverage for 100 percent of cost sharing for all Medicare Part A eligible expenses and respite care;

(5) coverage for 100 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations;

(6) except for coverage provided in this clause, coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

(8) coverage of 100 percent of the hospital and medical expenses and supplies incurred during travel outside of the United States as a result of a medical emergency;

(9) coverage for 100 percent of Medicare Part A and B home health care services and medical supplies; and

(10) the basis for the deductible shall be $1,860 and shall be adjusted annually from 2010 by the secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(b) A Medicare supplement plan with high deductible coverage must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

History: *2009 c 178 art 1 s 30,70; 2019 c 26 art 5 s 10,13*

62A.317 STANDARDS FOR CLAIMS PAYMENT.

(a) An issuer shall comply with section 1882(c)(3) of the federal Social Security Act, as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA), Public Law 100-203, by:

(1) accepting a notice from a Medicare carrier on duly assigned claims submitted by Medicare participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the Medicare participating physician or supplier and the beneficiary of the payment determination;

(3) paying the Medicare participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy or certificate name, number, and a central mailing address to which notices from a Medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(b) Compliance with the requirements in paragraph (a) shall be certified on the Medicare supplement insurance experience reporting form.

History: *1992 c 554 art 1 s 6*

62A.318 MEDICARE SELECT POLICIES AND CERTIFICATES.

Subdivision 1. **Applicability and advertising limitation.** (a) This section applies to Medicare select policies and certificates, as defined in this section, including those issued by health maintenance organizations.

(b) No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

Subd. 2. **Definitions.** 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.

Subd. 3. **Review by commissioner.** 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 101-508, if the commissioner finds that the issuer has satisfied all of the requirements of Minnesota Statutes.

Subd. 4. **Approval; plan of operation.** 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.

Subd. 5. **Contents of plan of operation.** 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 subdivision 9; and

(7) any other information requested by the commissioner.

Subd. 6. **Filing of proposed changes; deemed approval.** 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.

Subd. 7. **Nonnetwork providers; limits on coverage restrictions.** 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.

Subd. 8. **Full payment; services not available in network.** 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.

Subd. 9. **Required disclosures.** 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.

Subd. 10. **Proof of disclosure.** 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.

Subd. 11. **Grievance procedures.** 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.

Subd. 12. **Offer of alternative product required.** 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.

Subd. 13. **Right to replace with nonnetwork coverage.** (a) 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 select 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.

(b) For the purposes of this subdivision, 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. Coverage for outpatient prescription drugs is not permitted in Medicare supplement policies or certificates issued on or after January 1, 2006.

Subd. 14. **Continuation of coverage under certain circumstances.** (a) 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.

(b) In the event of a determination under paragraph (a), 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.

(c) For the purposes of this subdivision, 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 subdivision, 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. Coverage for outpatient prescription drugs must not be included for sale or issuance of a Medicare supplement policy or certificate issued on or after January 1, 2006.

Subd. 15. **Provision of data required.** 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.

Subd. 16. **Regulation by Commerce Department.** Medicare select policies and certificates under this section shall be regulated and approved by the Department of Commerce.

Subd. 17. **Types of plans.** (a) Medicare select policies and certificates offered by the issuer must provide the coverages specified in sections 62A.315 to 62A.3165. Before a Medicare select policy or certificate is sold or issued in this state, the applicant must be provided with an explanation of coverage for each of the coverages specified in sections 62A.315 to 62A.3165 and must be provided with the opportunity of purchasing such coverage if offered by the issuer. 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.

(b) Medicare select policies and certificates must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

History: *1992 c 554 art 2 s 1; 1993 c 330 s 6; 1996 c 446 art 1 s 33; 2005 c 17 art 1 s 12; 2011 c 108 s 33; 2019 c 26 art 5 s 11,13; 2026 c 88 art 1 s 11*

62A.319 [Repealed, 2014 c 222 art 1 s 58]

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

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

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

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

62A.36 LOSS RATIO STANDARDS.

Subdivision 1. **Loss ratio standards and refund provisions.** (a) For purposes of this section, "Medicare supplement policy or certificate" has the meaning given in section 62A.3099 but also includes a policy, contract, or certificate issued under a contract under section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq. 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.

These ratios must be calculated based upon 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. For purposes of this calculation, "health care expenses" has the meaning given in section 62A.3099, subdivision 10. 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.

An application form for a Medicare supplement policy or certificate, as defined in this section, must prominently disclose the anticipated loss ratio and explain what it means.

(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.

(f) An issuer must file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

(g) Issuers are permitted to continue to issue currently approved policy and certificate forms as appropriate through December 31, 2005.

(h) Issuers must comply with any requirements to notify enrollees under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Subd. 1a. **Supplement to annual statements.** Each insurer that has Medicare supplement policies in force in this state shall, as a supplement to the annual statement required by section 60A.13, submit, in a form prescribed by the commissioner, data showing its incurred claims experience, its earned premiums, and the aggregate amount of premiums collected and losses incurred for each Medicare policy form in force. If the data submitted does not confirm that the insurer has satisfied the loss ratio requirements of this section, the commissioner shall notify the insurer in writing of the deficiency. The insurer shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the insurer fails to file amended rates within the prescribed time, the commissioner shall order that the insurer's filed rates for the nonconforming policy 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 insurer'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 insurer from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data as to premiums and loss ratios for the preceding three years available to the public at a cost not to exceed the cost of copying. The commissioner shall also provide the public with copies of the policies to which the loss ratios and premiums apply. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

Subd. 1b. **Penalties.** Each sale of a policy 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.

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

History: *1981 c 318 s 6; 1990 c 403 s 6-8; 1991 c 129 s 3; 1992 c 554 art 1 s 8; 1993 c 330 s 7; 1994 c 625 art 10 s 7; 2005 c 17 art 1 s 13,14*

62A.37 GOVERNMENT CERTIFICATIONS, APPROVALS, AND ENDORSEMENTS.

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

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

History: *1981 c 318 s 7*

62A.38 NOTICE OF FREE EXAMINATION.

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

History: *1981 c 318 s 8; 1992 c 554 art 1 s 9*

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 federal Social Security Act, section 1833 or 1876 (United States Code, title 42, section 1395, et seq.), disability income 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 "Guide to Health Insurance for People with Medicare" 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: *1981 c 318 s 9; 1983 c 263 s 11; 1992 c 554 art 1 s 10; 1993 c 330 s 8; 1996 c 446 art 1 s 34*

62A.40 REPLACEMENT REGULATED.

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

History: *1981 c 318 s 10; 1986 c 444*

62A.41 PENALTIES.

Subdivision 1. **Generally.** Any insurer, general agent, agent, or other person who knowingly or willfully, either directly or indirectly, makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to compliance of any policy with the standards and requirements set forth in this section; falsely assumes or pretends to be acting, or misrepresents in any way, including a violation of section 62A.37, that the person is acting, under the authority or in association with Medicare, or any federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value; or knowingly sells a health insurance policy to an individual entitled to benefits under part A or part B of Medicare with the knowledge that such policy substantially duplicates health benefits to which such individual is otherwise entitled under a requirement of state or federal law other than under Medicare shall be guilty of a felony and subject to a civil penalty of not more than $5,000 per violation, and the commissioner may revoke or suspend the license of any company, association, society, other insurer, or agent thereof.

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

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

Subd. 4. **Unlicensed sales.** Notwithstanding section 60K.32, a person who acts or assumes to act as an insurance producer without a valid license for the purpose of selling or attempting to sell Medicare supplement insurance, and the person who aids or abets the actor, is guilty of a felony and is subject to a civil penalty of not more than $5,000 per violation.

History: *1981 c 318 s 11; 1986 c 444; 1989 c 258 s 7; 1992 c 564 art 3 s 21; 2001 c 117 art 2 s 7*

62A.42 RULEMAKING AUTHORITY.

To carry out the purposes of sections 62A.3099 to 62A.44, the commissioner may promulgate rules pursuant to chapter 14. These rules may:

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

(b) prescribe uniform policy forms in order to give the insurance purchaser a reasonable opportunity to compare the cost of insuring with various insurers and may prescribe reasonable measures as necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations; and

(c) establish other reasonable standards to further the purpose of sections 62A.3099 to 62A.44.

History: *1981 c 318 s 12; 1982 c 424 s 130; 1983 c 263 s 12; 1992 c 554 art 1 s 11; 2005 c 17 art 1 s 14*

62A.421 DEMONSTRATION PROJECTS.

Subdivision 1. **Establishment.** The commissioner may establish demonstration projects to allow an issuer of Medicare supplement policies to extend coverage to individuals enrolled in part A or part B, or both, of the Medicare program, Title XVIII of the Social Security Act, United States Code, title 42, section 1395, et seq. For purposes of this section, the commissioner may waive compliance with the benefits described in sections 62A.315 and 62A.316 and other applicable statutes and rules if there is reasonable evidence that the statutes or rules prohibit the operation of the demonstration project, but may not waive the six-month guaranteed issue provision. The commissioner shall provide for public comment before any statute or rule is waived.

Subd. 2. **Benefits.** A demonstration project must provide health benefits equal to or exceeding the level of benefits provided in Title XVIII of the Social Security Act and an out-of-hospital prescription drug benefit. The out-of-hospital prescription drug benefit may be waived by the commissioner if the issuer presents evidence satisfactory to the commissioner that the inclusion of the benefit would restrict the operation of the demonstration project.

Subd. 3. **Application.** An issuer electing to participate in a demonstration project shall apply to the commissioner for approval on a form developed by the commissioner. The application shall include at least the following:

(1) a statement identifying the population that the project is designed to serve;

(2) a description of the proposed project including a statement projecting a schedule of costs and benefits for the policyholder;

(3) reference to the sections of Minnesota Statutes and Department of Commerce rules for which waiver is requested;

(4) evidence that application of the requirements of applicable Minnesota Statutes and Department of Commerce rules would, unless waived, prohibit the operation of the demonstration project;

(5) an estimate of the number of years needed to adequately demonstrate the project's effects; and

(6) other information the commissioner may reasonably require.

Subd. 4. **Timeline.** The commissioner shall approve, deny, or refer back to the issuer for modification, the application for a demonstration project within 60 days of the receipt of a complete application.

Subd. 5. **Period specified.** The commissioner may approve an application for a demonstration project for a period of six years, with an option to renew.

Subd. 6. **Annual report.** Each issuer for which a demonstration project is approved shall annually file a report with the commissioner summarizing the project's experience at the same time it files its annual report. The report shall be on a form developed by the commissioner and shall be separate from the annual report.

Subd. 7. **Rescission of approval.** The commissioner may rescind approval of a demonstration project if the commissioner makes any of the findings listed in section 60A.052 or 62D.15, subdivision 1, with respect to the project for which it has not been granted a specific exemption, or if the commissioner finds that the project's operation is contrary to the information contained in the approved application.

History: *2001 c 215 s 16*

62A.43 LIMITATIONS ON SALES.

Subdivision 1. **Duplicate coverage prohibited.** No agent shall sell a Medicare supplement plan, as defined in section 62A.3099, to a person who currently has one plan in effect; however, an agent may sell a replacement plan in accordance with section 62A.40, provided that the second plan is not made effective any sooner than necessary to provide continuous benefits for preexisting conditions. Every application for Medicare supplement insurance shall require a written statement signed by the applicant listing all health and accident insurance maintained by the applicant as of the date the application is taken and stating whether the applicant is entitled to any medical assistance. The written statement must be accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of the statement.

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

Subd. 3. **Action by commissioner.** If the commissioner determines after an investigation that an insurer has issued a Medicare supplement plan to a person who already has one plan, except as permitted in subdivision 1, the commissioner shall notify the insurer in writing of the determination. If the insurer thereafter fails to take reasonable action to prevent overselling, the commissioner may, in the manner prescribed in chapter 14, revoke or suspend the insurer's authority to sell accident and health insurance in this state or impose a civil penalty not to exceed $10,000, or both.

Subd. 4. **Other policies not prohibited.** The prohibition in this section or the requirements of section 62A.31, subdivision 1, against the sale of duplicate Medicare supplement coverage do not preclude the sale of a health insurance policy or certificate if it will pay benefits without regard to other health coverage and if prospective purchasers are provided, on or together with the application for the policy or certificate, the appropriate disclosure statement for health insurance policies sold to Medicare beneficiaries that duplicate Medicare as prescribed by the National Association of Insurance Commissioners. Notwithstanding this provision, if the commissioner determines that the coverage being sold is in fact Medicare supplement insurance, the commissioner shall notify the insurer in writing of the determination. If the insurer does not thereafter comply with sections 62A.3099 to 62A.44, the commissioner may, pursuant to chapter 14, revoke or suspend the insurer's authority to sell accident and health insurance in this state or impose a civil penalty not to exceed $10,000, or both.

History: *1983 c 263 s 13; 1986 c 444; 1987 c 337 s 56,57; 1991 c 129 s 4; 1994 c 485 s 31; 1999 c 90 s 4; 2005 c 17 art 1 s 14*

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: *1989 c 258 s 8; 1992 c 554 art 1 s 12; 1993 c 330 s 9*

62A.44 APPLICATIONS.

Subdivision 1. **Applicant copy.** No individual Medicare supplement plan shall be issued or delivered in this state unless a signed and completed copy of the application for insurance is left with the applicant at the time application is made.

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 purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy or certificate.

(4) The benefits and premiums under your Medicare supplement policy or certificate can be suspended, if requested, 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.

(5) Counseling services may be available in Minnesota to provide advice concerning medical assistance through state Medicaid, Qualified Medicare Beneficiaries (QMBs), and Specified Low-Income Medicare Beneficiaries (SLMBs).

To the best of your knowledge:

(1) Do you have another Medicare supplement policy or certificate in force?

(a) If so, with which company?

(b) If so, do you intend to replace your current Medicare supplement policy with this policy or certificate?

(2) Do you have any other health insurance policies that provide benefits which this Medicare supplement policy or certificate would duplicate?

(a) If so, please name the company.

(b) What kind of policy?

(3) Are you covered for medical assistance through the state Medicaid program? If so, which of the following programs provides coverage for you?

(a) Specified Low-Income Medicare Beneficiary (SLMB),

(b) Qualified Medicare Beneficiary (QMB), or

(c) full Medicaid Beneficiary?"

(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. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision you should terminate your present Medicare supplement policy. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, (BROKER OR OTHER REPRESENTATIVE): I have reviewed your current medical or health insurance coverage. To the best of my knowledge this Medicare supplement policy will not duplicate your existing Medicare supplement policy because you intend to terminate the existing Medicare supplement policy. The replacement policy or certificate is being purchased for the following reason(s) (check one):

..... Additional benefits

..... No change in benefits, but lower premiums

..... Fewer benefits and lower premiums

..... Other (please specify)

.....

.....

.....

(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.

.....

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

.....

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

.....

(Date)

.....

(Applicant's Signature)

.....

(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.

Subd. 3. **Electronic enrollment.** (a) For any Medicare supplement plan as defined in section 62A.3099, any requirement that a signature of an insured be obtained by an agent or insurer is satisfied if:

(1) the consent is obtained by telephonic or electronic enrollment by the group policyholder or insured. A verification of the enrollment information must be provided to the applicant;

(2) the telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention, and prompt retrieval of records; and

(3) the telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of individual information and privileged information as defined in section 72A.491, subdivision 19, is maintained.

(b) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage.

History: *1983 c 263 s 14; 1992 c 554 art 1 s 13; 1993 c 13 art 1 s 18; 1993 c 330 s 10; 1996 c 446 art 1 s 35; 2008 c 344 s 12; 2023 c 57 art 2 s 15; 1Sp2025 c 4 art 5 s 8*

62A.45 [Renumbered 62A.3093]

PRESCRIPTION DRUG PLANS

62A.451 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62A.451 to 62A.4528, the terms defined in this section have the meanings given.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 3. **Enrollee.** "Enrollee" means an individual who is entitled to limited health services under a contract with an entity authorized to provide or arrange for such services under sections 62A.451 to 62A.4528.

Subd. 4. **Evidence of coverage.** "Evidence of coverage" means the certificate, agreement, or contract issued under section 62A.4516 setting forth the coverage to which an enrollee is entitled.

Subd. 5. **Limited health service.** "Limited health service" means pharmaceutical services covered under Medicare Part D. Limited health service does not include hospital, medical, surgical, or emergency services.

Subd. 6. **Prepaid limited health service organization.** "Prepaid limited health service organization" means any corporation, partnership, or other entity that, in return for a prepayment, undertakes to provide or arrange for the provision of limited health services to enrollees. Prepaid limited health service organization does not include:

(1) an entity otherwise authorized under the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service;

(2) an entity that meets the requirements of section 62A.4514; or

(3) a provider or entity when providing or arranging for the provision of limited health services under a contract with a prepaid limited health service organization or with an entity described in clause (1) or (2).

Subd. 7. **Provider.** "Provider" means a physician, pharmacist, health facility, or other person or institution that is licensed or otherwise authorized to deliver or furnish limited health services under sections 62A.451 to 62A.4528.

Subd. 8. **Subscriber.** "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services under a contract with an entity authorized to provide or arrange for such services under sections 62A.451 to 62A.4528.

History: *2005 c 17 art 2 s 1*

62A.4511 CERTIFICATE OF AUTHORITY REQUIRED.

No person, corporation, partnership, or other entity may operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner under sections 62A.451 to 62A.4528.

History: *2005 c 17 art 2 s 2*

62A.4512 APPLICATION FOR CERTIFICATE OF AUTHORITY.

An application for a certificate of authority to operate a prepaid limited health service organization must be filed with the commissioner on a form prescribed by the commissioner. The application must be verified

by an officer or authorized representative of the applicant and must set forth, or be accompanied by, the following:

(1) a copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments to these documents;

(2) a copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs;

(3) a list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association;

(4) a statement generally describing the applicant, its facilities, personnel, and the limited health services to be offered;

(5) a copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees;

(6) a copy of the form of any contract made or to be made between the applicant and any person listed in clause (3);

(7) a copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any functions including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of limited health services to enrollees;

(8) a copy of the form of any group contract that is to be issued to employers, unions, trustees, or other organizations and a copy of any form of evidence of coverage to be issued to subscribers;

(9) a copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, satisfies this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of sections 62A.451 to 62A.4528;

(10) a copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

(11) a statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served in accordance with section 45.028;

(12) a description of how the applicant will comply with section 62A.4523; and

(13) such other information as the commissioner may reasonably require to make the determinations required by sections 62A.451 to 62A.4528.

History: *2005 c 17 art 2 s 3*

62A.4513 ISSUANCE OF CERTIFICATE OF AUTHORITY; DENIAL.

Subdivision 1. **Issuance.** Following receipt of an application filed under section 62A.4512, the commissioner shall review the application and notify the applicant of any deficiencies. The commissioner must approve or deny an application within 90 days after receipt of a substantially complete application, or the application is deemed approved. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:

(1) the requirements of section 62A.4512 have been fulfilled;

(2) the individuals responsible for conducting the applicant's affairs are competent, trustworthy, and possess good reputations, and have had appropriate experience, training, or education;

(3) the applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:

(i) the financial soundness of the applicant's arrangements for limited health services;

(ii) the adequacy of working capital, other sources of funding, and provisions for contingencies;

(iii) any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization; and

(iv) the manner in which the requirements of section 62A.4523 have been fulfilled; and

(4) any deficiencies identified by the commissioner have been corrected.

Subd. 2. **Denials.** If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The prepaid limited health service organization has 30 days from the date of receipt of the notice to request a hearing before the commissioner under chapter 14.

History: *2005 c 17 art 2 s 4*

62A.4514 FILING REQUIREMENTS FOR AUTHORIZED ENTITIES.

(a) An entity authorized under the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health service plan corporation, a fraternal benefit society, or a multiple employer welfare arrangement, and that is not otherwise authorized under the laws of this state to offer limited health services on a per capita or fixed prepayment basis, may do so by filing for approval with the commissioner the information requested by section 62A.4512, clauses (4), (5), (7), (8), and (10), and any subsequent material modification or addition to those provisions.

(b) If the commissioner disapproves the filing, the procedures provided in section 62A.4513, subdivision 2, must be followed.

History: *2005 c 17 art 2 s 5*

62A.4515 MATERIAL MODIFICATIONS.

Subdivision 1. **Material modifications.** A prepaid limited health service organization shall file with the commissioner prior to use, a notice of any material modification of any matter or document furnished under section 62A.4512, together with supporting documents necessary to fully explain the modification. If the commissioner does not disapprove the filing within 60 days of its filing, the filing is deemed approved.

Subd. 2. **Procedure for disapproval.** If a filing under this section is disapproved, the commissioner shall notify the prepaid limited health service organization and specify the reasons for disapproval in the notice. The prepaid limited health service organization has 30 days from the date of receipt of notice to request a hearing before the commissioner under chapter 14.

History: *2005 c 17 art 2 s 6*

62A.4516 EVIDENCE OF COVERAGE.

Every subscriber must be issued an evidence of coverage consistent with the requirements of Medicare Part D.

History: *2005 c 17 art 2 s 7*

62A.4517 CONSTRUCTION WITH OTHER LAWS.

Subdivision 1. **Application of other insurance laws.** (a) A prepaid limited health service organization organized under the laws of this state is deemed to be a domestic insurer for purposes of chapter 60D unless specifically exempted in writing from one or more of the provisions of that chapter by the commissioner, based upon a determination that the provision is not applicable to the organization or to providing coverage under Medicare Part D.

(b) No other provision of chapters 60 to 72C applies to a prepaid limited health service organization unless such an organization is specifically mentioned in the provision.

Subd. 2. **Not a healing art.** The provision of limited health services by a prepaid limited health service organization or other entity under sections 62A.451 to 62A.4528 must not be deemed to be the practice of medicine or other healing arts.

Subd. 3. **Solicitation and advertising.** Solicitation to arrange for or provide limited health services in accordance with sections 62A.451 to 62A.4528 shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

History: *2005 c 17 art 2 s 8*

62A.4518 NONDUPLICATION OF COVERAGE.

Notwithstanding any other law of this state, a prepaid limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health service plan corporation, or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services, whether in the form of services, supplies, or reimbursement, insofar as the coverage or service is provided in accordance with sections 62A.451 to 62A.4528 under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service

organization, a health maintenance organization, an accident and health insurance company, a nonprofit health service corporation, or a fraternal benefit society.

History: *2005 c 17 art 2 s 9*

62A.4519 COMPLAINT SYSTEM.

Every prepaid limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers, consistent with the requirements of Medicare Part D.

History: *2005 c 17 art 2 s 10*

62A.4520 EXAMINATION OF ORGANIZATION.

(a) The commissioner may examine the affairs of any prepaid limited health service organization as often as is reasonably necessary to protect the interests of the people of this state, but not less frequently than once every three years.

(b) Every prepaid limited health service organization shall make its relevant books and records available for an examination and in every way cooperate with the commissioner to facilitate an examination.

(c) In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state.

History: *2005 c 17 art 2 s 11*

62A.4521 INVESTMENTS.

The funds of a prepaid limited health service organization shall be invested only in accordance with the guidelines under chapter 62D for investments by health maintenance organizations.

History: *2005 c 17 art 2 s 12*

62A.4522 AGENTS.

No individual may apply, procure, negotiate, or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license or is otherwise authorized to sell accident and health insurance policies, nonprofit health service plan contracts, or health maintenance organization contracts.

History: *2005 c 17 art 2 s 13*

62A.4523 PROTECTION AGAINST INSOLVENCY; DEPOSIT.

Subdivision 1. **Net equity.** (a) Except as approved in accordance with subdivision 4, each prepaid limited health service organization shall at all times have and maintain tangible net equity equal to the greater of:

(1) $100,000; or

(2) two percent of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

(b) A prepaid limited health service organization that has uncovered expenses in excess of $100,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible

net equity equal to 25 percent of the uncovered expense in excess of $100,000 in addition to the tangible net equity required by paragraph (a).

Subd. 2. **Definitions.** For the purpose of this section:

(1) "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner; and

(2) "tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; start-up costs; long-term prepayments of deferred charges; nonreturnable deposits; and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates and that are not past due.

Subd. 3. **Deposit.** (a) Each prepaid limited health service organization shall deposit with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the commissioner, in an amount equal to $50,000 plus 25 percent of the tangible net equity required in subdivision 1; provided, however, that the deposit must not be required to exceed $200,000.

(b) The deposit is an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.

(c) All income from deposits is an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or any part of it after making a substitute deposit of equal amount and value. Any securities must be approved by the commissioner before being substituted.

(d) The deposit must be used to protect the interests of the prepaid limited health service organization's enrollees and to ensure continuation of limited health care services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit is an asset subject to provisions of chapter 60B.

(e) The commissioner may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

Subd. 4. **Waiver of net equity requirement.** Upon application by a prepaid limited health service organization, the commissioner may waive some or all of the requirements of subdivision 1 for any period of time the commissioner deems proper upon a finding that either:

(1) the prepaid limited health service organization has a net equity of at least $10,000,000; or

(2) an entity having a net equity of at least $10,000,000 furnishes to the commissioner a written commitment, acceptable to the commissioner, to provide for the uncovered expenses of the prepaid limited health service organization.

Subd. 5. **Definition; uncovered expenses.** For the purposes of this section, "uncovered expense" means the cost of health care services that are the obligation of a prepaid limited health organization (1) for which an enrollee may be liable in the event of the insolvency of the organization and (2) for which alternative arrangements acceptable to the commissioner have not been made to cover the costs. Costs incurred by a

provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, must be considered a covered expense.

History: *2005 c 17 art 2 s 14*

62A.4524 OFFICER'S AND EMPLOYEE'S FIDELITY BOND.

(a) A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than $20,000,000 or in any other amount prescribed by the commissioner. Except as otherwise provided by this paragraph, the bond must be issued by an insurance company that is licensed to do business in this state or, if the fidelity bond required by this paragraph is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed surplus lines agent resident in this state in compliance with sections 60A.195 to 60A.2095 satisfies the requirements of this paragraph.

(b) In lieu of the bond specified in paragraph (a), a prepaid limited health service organization may deposit with the commissioner cash or securities or other investments of the types set forth in section 62A.4521. Such a deposit must be maintained by the commissioner in the amount and subject to the same conditions required for a bond under this paragraph.

History: *2005 c 17 art 2 s 15*

62A.4525 REPORTS.

(a) Every prepaid limited health service organization shall file with the commissioner annually, on or before April 1, a report verified by at least two principal officers covering the preceding calendar year.

(b) The report must be on forms prescribed by the commissioner and must include:

(1) a financial statement of the organization, including its balance sheet, income statement, and statement of changes in financial position for the preceding year, certified by an independent public accountant, or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which must be consolidating financial statements of the prepaid limited health service organization;

(2) the number of subscribers at the beginning of the year, the number of subscribers at the end of the year, and the number of enrollments terminated during the year; and

(3) such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out the commissioner's duties under sections 62A.451 to 62A.4528.

(c) The commissioner may require more frequent reports containing information necessary to enable the commissioner to carry out the commissioner's duties under sections 62A.451 to 62A.4528.

(d) The commissioner may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

History: *2005 c 17 art 2 s 16*

62A.4526 SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY.

Subdivision 1. **Grounds for suspension or revocation.** The commissioner may suspend or revoke the certificate of authority issued to a prepaid limited health service organization under sections 62A.451 to 62A.4528 upon determining that any of the following conditions exist:

(1) the prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62A.4512, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the prepaid limited health service organization issues an evidence of coverage that does not comply with the requirements of section 62A.4516;

(3) the prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services;

(4) the prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(5) the tangible net equity of the prepaid limited health service organization is less than that required by section 62A.4523 or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

(6) the prepaid limited health service organization has failed to implement in a reasonable manner the complaint system required by section 62A.4519;

(7) the continued operation of the prepaid limited health service organization would be hazardous to its enrollees; or

(8) the prepaid limited health service organization has otherwise failed to comply with sections 62A.451 to 62A.4528.

Subd. 2. **Procedure for suspension or revocation.** If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than 60 days after the date of notification for a hearing on the matter in accordance with chapter 14.

Subd. 3. **Winding up after revocation.** When the certificate of authority of a prepaid limited health service organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

History: *2005 c 17 art 2 s 17*

62A.4527 PENALTIES.

In lieu of any penalty specified elsewhere in sections 62A.451 to 62A.4528, or when no penalty is specifically provided, whenever a prepaid limited health service organization or other person, corporation, partnership, or entity subject to those sections has been found, pursuant to chapter 14, to have violated any provision of sections 62A.451 to 62A.4528, the commissioner may:

(1) issue and cause to be served upon the organization, person, or entity charged with the violation a copy of the findings and an order requiring the organization, person, or entity to cease and desist from engaging in the act or practice that constitutes the violation; and

(2) impose a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $10,000.

History: *2005 c 17 art 2 s 18*

62A.4528 REHABILITATION, CONSERVATION, OR LIQUIDATION.

(a) Any rehabilitation, conservation, or liquidation of a prepaid limited health service organization must be deemed to be the rehabilitation, conservation, or liquidation of an insurance company and must be conducted under chapter 60B.

(b) A prepaid limited health service organization is not subject to the laws and rules governing insurance insolvency guaranty funds, nor shall any insurance insolvency guaranty fund provide protection to individuals entitled to receive limited health services from a prepaid limited health service organization.

History: *2005 c 17 art 2 s 19*

LONG-TERM CARE POLICIES

62A.46 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to sections 62A.46 to 62A.56.

Subd. 2. **Long-term care policy.** (a) "Long-term care policy" means an individual or group policy, certificate, subscriber contract, or other evidence of coverage that provides benefits for prescribed long-term care, including nursing facility services or home care services, or both nursing facility services and home care services, pursuant to the requirements of sections 62A.46 to 62A.56. Long-term care policy does not include short-term home health and nursing care insurance under section 62A.70.

(b) Sections 62A.46, 62A.48, and 62A.52 to 62A.56 do not apply to a long-term care policy issued to: (1) 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; or (2) a labor union or similar employee organization.

Subd. 3. **Nursing facility.** "Nursing facility" means (1) a facility that is licensed as a nursing home under chapter 144A; (2) a facility that is both licensed as a boarding care home under sections 144.50 to 144.56 and certified as an intermediate care facility for purposes of the medical assistance program; and (3) in states other than Minnesota, a facility that meets licensing and certification standards comparable to those that apply to the facilities described in clauses (1) and (2).

Subd. 4. **Home care services.** "Home care services" means one or more of the following prescribed services for the long-term care and treatment of an insured that are provided by a home health agency in a noninstitutional setting according to a written diagnosis or assessment and plan of care:

(1) nursing and related personal care services under the direction of a registered nurse, including the services of a home health aide;

(2) physical therapy;

(3) speech therapy;

(4) respiratory therapy;

(5) occupational therapy;

(6) nutritional services provided by a licensed dietitian;

(7) homemaker services, meal preparation, and similar nonmedical services;

(8) medical social services; and

(9) other similar medical services and health-related support services.

Subd. 5. **Prescribed long-term care.** "Prescribed long-term care" means a service, type of care, or procedure that could not be omitted without adversely affecting the patient's illness or condition and is specified in a plan of care prepared by either: (1) a physician and a registered nurse and is appropriate and consistent with the diagnosis; or (2) a registered nurse or licensed social worker based on an assessment of the insured's ability to perform the activities of daily living and to perform basic cognitive functions appropriately.

Subd. 6. **Qualified insurer.** "Qualified insurer" means an entity licensed under chapter 62A or 62C.

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

Subd. 8. **Plan of care.** "Plan of care" means a written document prepared and signed by either: (1) a physician and registered nurse that specifies medically prescribed long-term care services or treatment that are consistent with the diagnosis; or (2) by a registered nurse or licensed social worker that specifies prescribed long-term care services or treatment that are consistent with an assessment of the insured's ability to perform the activities of daily living and to perform basic cognitive functions appropriately. The plan of care must be prepared in accordance with accepted standards of practice and must contain services or treatment that could not be omitted without adversely affecting the patient's illness or condition.

Subd. 9. **Insured.** "Insured" means a person covered under a long-term care policy.

Subd. 10. **Home health agency.** "Home health agency" means an entity that provides home care services and is (1) certified for participation in the Medicare program; or (2) licensed as a home health agency where a state licensing statute exists, or is otherwise acceptable to the insurer if licensing is not required.

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

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

Subd. 13. **Benefit day.** "Benefit day" means each day of confinement in a nursing facility or each visit for home care services. For purposes of section 62A.48, subdivision 1, if the policyholder receives more than one home care service visit within a 24-hour period, each visit constitutes one benefit day.

History: *1986 c 397 s 3; 1987 c 337 s 58; 1989 c 330 s 18; 1990 c 551 s 1-4; 1993 c 21 s 1; 1995 c 258 s 31,32; 1996 c 446 art 1 s 36; 2005 c 17 art 1 s 14; 2017 c 40 art 1 s 7; 2026 c 124 art 1 s 36*

62A.48 LONG-TERM CARE POLICIES.

Subdivision 1. **Policy requirements.** No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long-term care services shall be offered, issued, delivered, or renewed in this state, whether or not the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long-term care policy must cover prescribed long-term care in nursing facilities or the prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. A long-term care policy may cover both prescribed long-term care in nursing facilities and the prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long-term care policy, other than one that covers only nursing facility services, must include: a minimum lifetime benefit limit of at least $25,000 for services. A long-term care policy that covers only nursing facility services must include a minimum lifetime benefit limit of not less than one year of nursing facility services. Nursing facility and home care coverages under a long-term care policy must not be subject to separate lifetime maximums for policies that cover both nursing facility and home health care. Prior hospitalization may not be required under a long-term care policy.

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. Coverage under the policy may include a waiting period of up to 180 days before benefits are paid, but there must be no more than one waiting period per benefit period; for purposes of this sentence, "days" can mean calendar or benefit days. If benefit days are used, an appropriate premium reduction and disclosure must be made. If benefit days are used in connection with coverage for home care services, the waiting period for home care services must not be longer than 90 benefit days. No policy may exclude coverage for mental or nervous disorders which have a demonstrable organic cause, such as Alzheimer's and related dementias. No policy may require the insured to be homebound or house confined to receive home care services. The policy must include a provision that the plan will not be canceled or renewal refused except on the grounds of nonpayment of the premium, provided that the insurer may change the premium rate on a class basis on any policy anniversary date. A provision that the policyholder may elect to have the premium paid in full at age 65 by payment of a higher premium up to age 65 may be offered. A provision that the premium would be waived during any period in which benefits are being paid to the insured during confinement in a nursing facility must be included. A nongroup policyholder may return a policy within 30 days of its delivery and have the premium refunded in full, less any benefits paid under the policy, if the policyholder is not satisfied for any reason.

No individual long-term care policy shall be offered or delivered in this state until the insurer has received from the insured a written designation of at least one person, in addition to the insured, who is to receive notice of cancellation of the policy for nonpayment of premium. The insured has the right to designate up to a total of three persons who are to receive the notice of cancellation, in addition to the insured. The form used for the written designation must inform the insured that designation of one person is required and that designation of up to two additional persons is optional and must provide space clearly designated for listing between one and three persons. The designation shall include each person's full name, home address, and telephone number. Each time an individual policy is renewed or continued, the insurer shall notify the insured of the right to change this written designation.

The insurer may file a policy form that utilizes a plan of care prepared as provided under section 62A.46, subdivision 5, clause (1) or (2).

Subd. 2. **Per diem coverage.** If benefits are provided on a per diem basis, the minimum daily benefit for care in a nursing facility must be the lesser of $40 or actual charges under a long-term care policy and

the minimum benefit per visit for home care under a long-term care policy must be the lesser of $25 or actual charges. The home care services benefit must cover at least seven paid visits per week.

Subd. 3. **Expense-incurred coverage.** If benefits are provided on an expense-incurred basis, a benefit of not less than 80 percent of covered charges for prescribed long-term care must be provided.

Subd. 4. **Loss ratio.** The anticipated loss ratio for long-term care policies must not be less than 65 percent for policies issued on a group basis or 60 percent for policies issued on an individual or mass-market basis. This subdivision does not apply to policies issued on or after January 1, 2002, that comply with sections 62S.021 and 62S.081.

Subd. 5. **Solicitations by mail or media advertisement.** For purposes of this section, long-term care policies issued as a result of solicitations of individuals through mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

Subd. 6. **Coordination of benefits.** A long-term care policy may be secondary coverage for services provided under sections 62A.46 to 62A.56. Nothing in sections 62A.46 to 62A.56 shall require the secondary payor to pay the obligations of the primary payor nor shall it prevent the secondary payor from recovering from the primary payor the amount of any obligation of the primary payor that the secondary payor elects to pay.

There shall be no coordination of benefits between a long-term care policy and a policy designed primarily to provide coverage payable on a per diem, fixed indemnity or non-expense-incurred basis, or a policy that provides only accident coverage.

Subd. 7. **Existing policies.** Nothing in sections 62A.46 to 62A.56 prohibits the renewal of 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.3099 to 62A.44 under section 62A.31, subdivision 6.

Subd. 8. **Cancellation for nonpayment of premium.** No individual long-term care policy shall be canceled for nonpayment of premium unless the insurer, at least 30 days before the effective date of the cancellation, has given notice to the insured and to those persons designated pursuant to section 62A.48, subdivision 1, at the address provided by the insured for purposes of receiving notice of cancellation.

Subd. 9. **Qualified long-term care.** Sections 62A.46 to 62A.56 do not apply to policies marketed as qualified long-term care insurance policies under chapter 62S.

Subd. 10. **Regulation of premiums and premium increases.** Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with sections 62S.021, 62S.081, 62S.265, and 62S.266 to the same extent as policies issued under chapter 62S.

Subd. 11. **Nonforfeiture benefits.** Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with section 62S.02, subdivision 2, to the same extent as policies issued under chapter 62S.

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: *1986 c 397 s 4; 1987 c 337 s 59-62; 1988 c 689 art 2 s 8; 1989 c 209 art 2 s 1; 1989 c 330 s 19; 1990 c 551 s 5-7; 1993 c 330 s 12; 1994 c 625 art 8 s 4; 1995 c 258 s 33,34; 1996 c 389 s 1; 1996 c 446 art 1 s 37; 1997 c 71 art 2 s 5; 1Sp2001 c 9 art 8 s 1-3; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 3; 2005 c 17 art 1 s 14*

62A.49 HOME CARE SERVICES COVERAGE.

Subdivision 1. **Generally.** Section 62A.48 does not prohibit the sale of policies, certificates, subscriber contracts, or other evidences of coverage that provide home care services only. Home care services only policies may be sold, provided that they meet the requirements set forth in sections 62A.46 to 62A.56, except that they do not have to meet those conditions that relate to long-term care in nursing facilities. Disclosures and representations regarding these policies must be adjusted accordingly to remove references to coverage for nursing home care.

Subd. 2. **Provider networks and managed care.** Home health care services issued pursuant to this section may be provided through a limited provider network and may employ managed care practices. If these methods are used, they must be adequately disclosed within the policy and any advertisements or representations regarding coverage. Policies may not be sold in areas where there are not sufficient providers to meet the needs of the policyholders located in that area.

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: *1994 c 485 s 32; 1996 c 446 art 1 s 38; 1Sp2003 c 14 art 2 s 4*

62A.50 DISCLOSURES AND REPRESENTATIONS.

Subdivision 1. **Seal or emblems.** No graphic seal or emblem shall be displayed on any policy, or in connection with promotional materials on policy solicitations, that may reasonably be expected to convey to the purchaser that the policy form is approved, endorsed, or certified by a state or local unit of government or agency, the federal government, or a federal agency.

Subd. 2. **Cancellation notice.** Long-term care policies issued on a nongroup basis must have a notice prominently printed on the first page of the policy stating that the policyholder may return the policy within 30 days of its delivery and have the premium refunded in full if the policyholder is not satisfied for any reason. A solicitation for a long-term care policy to be issued on a nongroup basis pursuant to a direct-response solicitation must state in substance that the policyholder may return the policy within 30 days of its delivery and have the premium refunded in full if the policyholder is not satisfied for any reason.

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

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

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

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

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

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

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

(7) the following language, in bold print: "YOUR PREMIUMS CAN BE INCREASED IN THE FUTURE. THE RATE SCHEDULE THAT LISTS YOUR PREMIUM NOW CAN CHANGE.";

(8) the following language in bold print, with any provisions that are inapplicable to the particular policy omitted or crossed out: "THIS POLICY HAS A WAITING PERIOD OF ..... (CALENDAR OR BENEFIT) DAYS FOR NURSING CARE SERVICES AND A WAITING PERIOD OF ..... (CALENDAR OR BENEFIT) DAYS FOR HOME CARE SERVICES. THIS MEANS THAT THIS POLICY WILL NOT COVER YOUR CARE FOR THE FIRST ..... (CALENDAR OR BENEFIT) DAYS AFTER YOU ENTER A NURSING HOME, OR THE FIRST ..... (CALENDAR OR BENEFIT) DAYS AFTER YOU BEGIN TO USE HOME CARE SERVICES. YOU WOULD NEED TO PAY FOR YOUR CARE FROM OTHER SOURCES FOR THOSE WAITING PERIODS."; and

(9) a signed and completed copy of the application for insurance is left with the applicant at the time the application is made.

Subd. 4. **Policies other than qualified long-term care insurance policies.** A policy that is not intended to be a qualified long-term care insurance policy as defined under section 62S.01, subdivision 24, must include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long-term care insurance policy. The disclosure must be prominently displayed and read as follows: This long-term care insurance policy (certificate) is not intended to be a qualified long-term care insurance contract as defined under section 7702 (B)(b) of the Internal Revenue Code of 1986. You should consult with your attorney, accountant, or tax advisor regarding the tax implications of purchasing long-term care insurance.

History: *1986 c 397 s 5; 1987 c 337 s 63; 1988 c 689 art 2 s 9; 1995 c 258 s 35; 1996 c 389 s 2; 1997 c 71 art 2 s 6; 1999 c 177 s 39*

62A.52 REVIEW OF PLAN OF CARE.

The insurer may review an insured's plan of care at reasonable intervals, but not more frequently than once every 30 days.

History: *1986 c 397 s 6*

62A.54 PROHIBITED PRACTICES.

Unless otherwise provided for in sections 62A.46 to 62A.56, the solicitation or sale of long-term care policies is subject to the requirements and penalties applicable to the sale of Medicare supplement insurance policies as set forth in sections 62A.3099 to 62A.44.

It is misconduct for any agent or company to make any misstatements concerning eligibility or coverage under the medical assistance program, or about how long-term care costs will or will not be financed if a person does not have long-term care insurance. Any agent or company providing information on the medical

assistance program shall also provide information about how to contact the county human services department or the state Department of Human Services.

History: *1986 c 397 s 7; 1988 c 689 art 2 s 10; 1992 c 564 art 1 s 33; 2005 c 17 art 1 s 14*

62A.56 RULEMAKING.

Subdivision 1. **Permissive.** The commissioner may adopt rules pursuant to chapter 14 to carry out the purposes of sections 62A.46 to 62A.56. The rules may:

(1) establish additional disclosure requirements for long-term care policies designed to adequately inform the prospective insured of the need and extent of coverage offered;

(2) prescribe uniform policy forms in order to give the purchaser of long-term care policies a reasonable opportunity to compare the cost of insuring with various insurers; and

(3) establish other reasonable minimum standards as needed to further the purposes of sections 62A.46 to 62A.56.

Subd. 2. **Mandatory.** The commissioner shall adopt rules under chapter 14 establishing general standards to ensure that assessments used in the prescribing of long-term care are reliable, valid, and clinically appropriate.

History: *1986 c 397 s 8; 1990 c 551 s 8*

62A.59 COVERAGE OF SERVICE; PRIOR AUTHORIZATION.

Subdivision 1. **Service for which prior authorization not required.** A health carrier must not retrospectively deny or limit coverage of a health care service for which prior authorization was not required by the health carrier, unless there is evidence that the health care service was provided based on fraud or misinformation.

Subd. 2. **Service for which prior authorization required but not obtained.** A health carrier must not deny or limit coverage of a health care service which the enrollee has already received solely on the basis of lack of prior authorization if the service would otherwise have been covered had the prior authorization been obtained.

History: *2024 c 127 art 57 s 7*

DENIAL OF EXPENSES

62A.60 RETROACTIVE DENIAL OF EXPENSES.

In cases where the subscriber or insured is liable for costs beyond applicable co-payments or deductibles, no insurer may retroactively deny payment to a person who is covered when the services are provided for health care services that are otherwise covered, if the insurer or its representative failed to provide prior or concurrent review or authorization for the expenses when required to do so under the policy, plan, or certificate. If prior or concurrent review or authorization was provided by the insurer or its representative, and the preexisting condition limitation provision, the general exclusion provision and any other coinsurance, or other policy requirements have been met, the insurer may not deny payment for the authorized service or time period except in cases where fraud or substantive misrepresentation occurred.

History: *1989 c 330 s 20; 1996 c 446 art 1 s 39*

DISCLOSURES

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 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 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.

(e) "Usual and customary" means the normal charge, in the absence of insurance, of the provider for a service or article, but not more than the prevailing charge in the area for like service or article. A "like service" is the same nature and duration, requires the same skill, and is performed by a provider of similar training and experience. A "like article" is one that is identically or substantially equivalent. "Area" means the municipality or, in the case of a large city, a subdivision of the city, in which the service or article is actually provided or a greater area as is necessary to obtain a representative cross-section of charges for like service or article.

History: *1993 c 345 art 8 s 3; 1997 c 225 art 2 s 5; 1999 c 177 s 40*

62A.615 [Repealed, 2013 c 84 art 1 s 94]

NURSING HOME COVERAGE FOR TERMINALLY ILL

62A.616 COVERAGE FOR NURSING HOME CARE FOR TERMINALLY ILL AND OTHER SERVICES.

An insurer may offer a health plan that covers nursing home care for the terminally ill, personal care attendants, and hospice care. For the purposes of this section, "terminally ill" means a diagnosis certified by a physician that a person has less than six months to live.

History: *1995 c 258 s 36*

PROJECT TO EXPAND HEALTH INSURANCE COVERAGE

62A.62 DEMONSTRATION PROJECT.

Subdivision 1. **Establishment.** The commissioner shall establish demonstration projects to allow health insurers regulated under this chapter and nonprofit health service plan corporations regulated under chapter 62C to extend coverage for health and services to individuals or groups currently unable to afford such coverage. For purposes of this section, the commissioner may recommend legislation granting an exemption from minimum benefits required under chapter 62A, and any applicable rules if there is reasonable evidence that the rules prohibit the operation of the demonstration project. The commissioner shall provide for public comment before recommending an exemption from any statute or rule.

Subd. 2. **Application and approval.** An insurer or health service plan corporation electing to participate in a demonstration project shall apply to the commissioner for approval on a form developed by the commissioner. The application shall include at least the following:

(1) a statement identifying the population that the project is designed to serve;

(2) a description of the proposed project including a statement projecting a schedule of costs and benefits for the enrollee;

(3) reference to the sections of Minnesota Statutes and Department of Commerce rules for which waiver is requested;

(4) evidence that application of the requirements of applicable Minnesota Statutes and Department of Commerce rules would, unless waived, prohibit the operation of the demonstration project;

(5) an estimate of the number of years needed to adequately demonstrate the project's effects; and

(6) other information the commissioner may reasonably require.

Subd. 3. **Commissioner's review of application for demonstration project.** The commissioner shall approve, deny, or refer back to the insurer or health service plan corporation for modification, the application for a demonstration project within 60 days of receipt from the insurer or health service plan corporation. If the commissioner approves a project that requires legislation exempting the project from minimum benefit requirements, the commissioner shall make the approval contingent on enactment of the required legislation.

Subd. 4. **Length of project.** The commissioner may approve an application for a demonstration project for a maximum of six years, with an option to renew.

Subd. 5. **Report required.** Each insurer or health service plan corporation for which a demonstration project is approved shall annually file a report with the commissioner summarizing the project's experience at the same time it files its annual report. The report shall be on a form developed by the commissioner and shall be separate from the annual report.

Subd. 6. **Approval may be rescinded.** The commissioner may rescind approval of a demonstration project if the commissioner finds that the project's operation is contrary to the information contained in the approved application.

Subd. 7. **Applicability.** This section does not apply to the demonstration project established under section 256B.73.

History: *1990 c 568 art 3 s 2*

PROHIBITED AGREEMENTS

62A.63 DEFINITIONS.

Subdivision 1. **Application.** For purposes of section 62A.64, the terms defined in this section have the meanings given them.

Subd. 2. **Health care provider.** "Health care provider" means a person, hospital, or health care facility, organization, or corporation that is licensed, certified, or otherwise authorized by the laws of this state to provide health care.

Subd. 3. **Insurer.** "Insurer" means a health insurer regulated under this chapter, service plan corporation as defined under section 62C.02, subdivision 6, and health maintenance organization as defined under section 62D.02, subdivision 4.

History: *1991 c 109 s 1*

62A.64 HEALTH INSURANCE; PROHIBITED AGREEMENTS.

An agreement between an insurer and a health care provider may not:

(1) prohibit, or grant the insurer an option to prohibit, the provider from contracting with other insurers or payors to provide services at a lower price than the payment specified in the contract;

(2) require, or grant the insurer an option to require, the provider to accept a lower payment in the event the provider agrees to provide services to any other insurer or payor at a lower price; or

(3) require, or grant the insurer an option of, termination or renegotiation of the existing contract in the event the provider agrees to provide services to any other insurer or payor at a lower price.

History: *1991 c 109 s 2*

INDIVIDUAL MARKET REGULATION

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.

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. A health carrier is prohibited from refusing to renew a Minnesota resident's individual health plan unless:

(1) the enrollee has failed to pay premiums in accordance with the health plan's terms, including any timeliness requirements;

(2) the enrollee has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the health plan's terms;

(3) the enrollee no longer lives in the area where the issuer is authorized to operate;

(4) a health carrier discontinues an individual health plan under subdivision 2a; or

(5) a health carrier discontinues issuing new individual health plans and refuses to renew all of the health carrier's existing individual health plans issued in Minnesota as provided under subdivision 8.

Subd. 2a. **Discontinuing individual health plan.** (a) In order to discontinue a particular type of individual health plan in Minnesota for purposes of subdivision 2, clause (4), a health carrier must:

(1) provide written notice to the commissioner that approves the individual health plan's policy forms and filings, in a form and manner approved by the commissioner, regarding the health carrier's intent to discontinue a particular type of individual health plan in Minnesota. The notice must be provided no later than May 1 of the year before the date the individual health plan intends to discontinue the particular type of individual health plan;

(2) provide written notice to each individual enrolled in the individual health plan no later than 90 days before the date the coverage is discontinued;

(3) offer to each individual covered by the individual health plan that the health carrier intends to discontinue the option to purchase on a guaranteed issue basis any other individual health plan currently offered by the health carrier for individuals in the individual market; and

(4) act uniformly without regard to any health status factor of a covered individual or a dependent of a covered individual who may become eligible for coverage.

(b) Subject to paragraph (d), the commissioner may disapprove a health carrier discontinuing a particular type of individual health plan within 60 days after receiving notice under paragraph (a) if the commissioner determines discontinuing the plan is not in Minnesota policyholders' best interest. When making the determination under this paragraph, the commissioner may consider the plan's enrollment size, the availability of comparable individual health plan options offered by the health carrier in Minnesota, or any other factor the commissioner deems relevant.

(c) A health carrier may appeal the commissioner's determination made under paragraph (b) to disapprove the health carrier's plan to discontinue a particular type of individual health plan in Minnesota. An appeal under this paragraph is subject to the contested case procedures under chapter 14 and must be made within 30 days of the date the commissioner makes a written determination under paragraph (b).

(d) A health carrier may discontinue an individual health plan without commissioner approval if the individual health plan is not a catastrophic or platinum-level health plan, as defined in United States Code, title 42, section 18022, and the plan:

(1) has fewer than 25 enrollees; or

(2) is a grandfathered plan, as defined in section 62A.011, subdivision 1b.

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 following requirements:

(a) Premium rates may vary based upon the ages of covered persons in accordance with the provisions of the Affordable Care Act.

(b) Premium rates may vary based upon geographic rating area. The commissioner shall grant approval if the following conditions are met:

(1) the areas are established in accordance with the Affordable Care Act;

(2) each geographic region must be composed of no fewer than seven counties that create a contiguous region; and

(3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in premium rates for each area, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

(c) Premium rates may vary based upon tobacco use, in accordance with the provisions of the Affordable Care Act.

(d) In developing its premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (c); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (b).

(e) The premium charged with respect to any particular individual health plan shall not be adjusted more frequently than annually or January 1 of the year following initial enrollment, except that the premium rates may be changed to reflect:

(1) changes to the family composition of the policyholder;

(2) changes in geographic rating area of the policyholder, as provided in paragraph (b);

(3) changes in age, as provided in paragraph (a);

(4) changes in tobacco use, as provided in paragraph (c);

(5) transfer to a new health plan requested by the policyholder; or

(6) other changes required by or otherwise expressly permitted by state or federal law or regulations.

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect and actuarially valid changes in risks associated with the enrollee populations.

(i) A health carrier may, as part of a minimum lifetime loss ratio guarantee filing under section 62A.02, subdivision 3a, include a rating practices guarantee as provided in this paragraph. The rating practices guarantee must be in writing and must guarantee that the policy form will be offered, sold, issued, and renewed only with premium rates and premium rating practices that comply with subdivisions 2, 3, 4, and 5. The rating practices guarantee must be accompanied by an actuarial memorandum that demonstrates that the premium rates and premium rating system used in connection with the policy form will satisfy the guarantee. The guarantee must guarantee refunds of any excess premiums to policyholders charged premiums that exceed those permitted under subdivision 2, 3, 4, or 5. A health carrier that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs (b), (f), and (h).

(j) The commissioner may establish regulations to implement the provisions of this subdivision.

Subd. 3a. **Disclosure.** (a) In connection with the offering for sale of a health plan in the individual market, a health carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) the provisions of the coverage concerning the health carrier's right to change premium rates and the factors that may affect changes in premium rates; and

(2) a listing of and descriptive information, including benefits and premiums, about all individual health plans actively marketed by the health carrier and the availability of the individual health plans for which the individual is qualified.

(b) Paragraph (a), clause (2), may be satisfied by referring individuals to the Health and Human Services web portal, as defined under the Affordable Care Act.

Subd. 3b. **Single risk pool.** A health carrier shall consider all enrollees in all health plans, other than short-term and grandfathered plan coverage, offered by the health carrier in the individual market, including those enrollees who enroll in qualified health plans offered through MNsure, to be members of a single risk pool.

Subd. 4. **Gender rating prohibited.** (a) 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, through a method that is in any way based upon the gender of any person covered or to be covered under the health plan. This subdivision prohibits the use of marital status or generalized differences in expected costs between principal insureds and their spouses.

(b) No health carrier may refuse to initially offer, sell, or issue an individual health plan to a Minnesota resident solely on the basis that the individual had a previous cesarean delivery.

Subd. 5. **Portability and conversion of coverage.** (a) For plan years beginning on or after January 1, 2014, no individual health plan may be offered, sold, issued, or renewed, to a Minnesota resident that contains a preexisting condition limitation, preexisting condition exclusion, or exclusionary rider. An individual age 19 or older may be subjected to an 18-month preexisting condition limitation during plan years beginning prior to January 1, 2014, unless the individual has maintained continuous coverage as defined in section 62L.02. The individual must not be subjected to an exclusionary rider. During plan years beginning prior to January 1, 2014, an individual who is age 19 or older and who has maintained continuous coverage may be subjected to a onetime preexisting condition limitation of up to 12 months, with credit for time covered under qualifying coverage as defined in section 62L.02, at the time that the individual first is covered under an individual health plan by any health carrier. Credit must be given for all qualifying coverage with respect

to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. The individual must not be subjected to an exclusionary rider. Thereafter, the individual who is age 19 or older must not be subject to any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider 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 as defined in section 62L.02. The prohibition on preexisting condition limitations for children age 18 or under does not apply to individual health plans that are grandfathered plans. The prohibition on preexisting condition limitations for adults age 19 and over beginning for plan years on or after January 1, 2014, does not apply to individual health plans that are grandfathered plans.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in section 62L.02. If the individual has available any continuation coverage provided under sections 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or 62D.105, or continuation coverage provided under federal law, the health carrier need not offer coverage under this paragraph until the individual has exhausted the continuation coverage. The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this paragraph must be a qualified plan as defined in section 62E.02 and must not contain any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The offer of coverage by the health carrier must inform the individual that the coverage, including what is covered and the health care providers from whom covered care may be obtained, may not be the same as the individual's coverage under the group health plan. The offer of coverage by the health carrier must also inform the individual that the individual, if a Minnesota resident, may be eligible to obtain coverage from (i) other private sources of health coverage, or (ii) the Minnesota Comprehensive Health Association, without a preexisting condition limitation, and must provide the telephone number used by that association for enrollment purposes. 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 100 percent of the premium charged for comparable individual coverage by the Minnesota Comprehensive Health Association, and the premium rate must be less than that amount if necessary to otherwise comply with this section. Coverage issued under this paragraph must provide that it cannot be canceled or nonrenewed as a result of the health carrier's subsequent decision to leave the individual, small employer, or other group market. Section 72A.20, subdivision 28, applies to this paragraph.

Subd. 6. [Repealed, 2013 c 84 art 1 s 94]

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.

Subd. 7a. **Short-term coverage; applicability.** Notwithstanding subdivision 3, paragraph (g), and subdivision 7, paragraph (c), short-term coverage is not subject to section 62A.021.

Subd. 8. **Cessation of individual business.** Notwithstanding the provisions of subdivisions 1 to 7, a health carrier may elect to cease doing business in the individual health plan market in this state if it complies with the requirements of this subdivision. For purposes of this section, "cease doing business" means to discontinue issuing new individual health plans and to refuse to renew all of the health carrier's existing individual health plans issued in this state whose terms permit refusal to renew under the circumstances specified in this subdivision. This subdivision does not permit cancellation of an individual health plan, unless the terms of the health plan permit cancellation under the circumstances specified in this subdivision. A health carrier electing to cease doing business in the individual health plan market in this state shall notify the commissioner 180 days prior to the effective date of the cessation. Within 30 days after the termination, the health carrier shall submit to the commissioner a complete list of policyholders that have been terminated. The cessation of business does not include the failure of a health carrier to offer or issue new business in the individual health plan market or continue an existing product line in that market, provided that a health carrier does not terminate, cancel, or fail to renew its current individual health plan business. A health carrier electing to cease doing business in the individual health plan market shall provide 120 days' written notice to each policyholder covered by an individual health plan issued by the health carrier. This notice must also inform each policyholder of the existence of the Minnesota Comprehensive Health Association, the requirements for being accepted, the procedures for applying for coverage, and the telephone numbers at the Department of Health and the Department of Commerce for information about private individual or family health coverage. A health carrier that ceases to write new business in the individual health plan market shall continue to be governed by this section with respect to continuing individual health plan business

conducted by the health carrier. A health carrier that ceases to do business in the individual health plan market after July 1, 1994, is prohibited from writing new business in the individual health plan market in this state for a period of five years from the date of notice to the commissioner. This subdivision applies to any health maintenance organization that ceases to do business in the individual health plan market in one service area with respect to that service area only. Nothing in this subdivision prohibits an affiliated health maintenance organization from continuing to do business in the individual health plan market in that same service area. The right to refuse to renew an individual health plan under this subdivision does not apply to individual health plans issued on a guaranteed renewable basis that does not permit refusal to renew under the circumstances specified in this subdivision.

History: *1992 c 549 art 3 s 12; 1993 c 247 art 3 s 6; 1993 c 345 art 8 s 4; 1994 c 506 s 1; 1994 c 625 art 10 s 8-12; 1995 c 234 art 7 s 4,5; 1998 c 407 art 8 s 1; 1998 c 408 s 25; 1999 c 177 s 41; 2001 c 215 s 17; 2002 c 330 s 12; 1Sp2003 c 14 art 7 s 7; 2004 c 268 s 1,9; 2006 c 255 s 16; 2009 c 159 s 1; 2010 c 384 s 20; 2013 c 84 art 1 s 26-31; 2013 c 108 art 1 s 67; 2013 c 144 s 21; 2018 c 182 art 1 s 109; 1Sp2025 c 4 art 3 s 3-5*

62A.651 [Repealed, 2000 c 483 s 55]

62A.66 [Expired, 1992 c 549 art 5 s 21]

62A.661 MS 2002 [Expired, 2002 c 378 s1]

TELEMEDICINE COVERAGE

62A.67 MS 2020 [Repealed, 1Sp2021 c 7 art 6 s 29]

62A.671 MS 2020 [Repealed, 1Sp2021 c 7 art 6 s 29]

62A.672 MS 2020 [Repealed, 1Sp2021 c 7 art 6 s 29]

62A.673 COVERAGE OF SERVICES PROVIDED THROUGH TELEHEALTH.

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Telehealth Act."

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional under section 245I.04, subdivision 2; a mental health practitioner under section 245I.04, subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

(d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward technology, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) "Store-and-forward technology" means the asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, 2027, telehealth also includes audio-only communication between a health care provider and a patient if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication or if, for substance use disorder treatment services and mental health care services delivered through telehealth by means of audio-only communication, the communication was initiated by the enrollee while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response. Telehealth does not include communication between health care providers that consists solely of a telephone conversation, email, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an email or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

(i) "Telemonitoring services" means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee's health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee's medical condition or status.

[See Note.]

Subd. 3. **Coverage of telehealth.** (a) A health plan sold, issued, or renewed by a health carrier in Minnesota must (1) cover benefits delivered through telehealth in the same manner as any other benefits covered under the health plan, and (2) comply with this section.

(b) Coverage for services delivered through telehealth must not be limited on the basis of geography, location, or distance for travel subject to the health care provider network available to the enrollee through the enrollee's health plan.

(c) A health carrier must not create a separate provider network to deliver services through telehealth that does not include network providers who provide in-person care to patients for the same service or require an enrollee to use a specific provider within the network to receive services through telehealth.

(d) A health carrier may require a deductible, co-payment, or coinsurance payment for a health care service provided through telehealth, provided that the deductible, co-payment, or coinsurance payment is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable for the same service provided through in-person contact.

(e) Nothing in this section:

(1) requires a health carrier to provide coverage for services that are not medically necessary or are not covered under the enrollee's health plan; or

(2) prohibits a health carrier from:

(i) establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service through telehealth for which the health carrier does not already reimburse other health care providers for delivering the service through telehealth;

(ii) establishing reasonable medical management techniques, provided the criteria or techniques are not unduly burdensome or unreasonable for the particular service; or

(iii) requiring documentation or billing practices designed to protect the health carrier or patient from fraudulent claims, provided the practices are not unduly burdensome or unreasonable for the particular service.

(f) Nothing in this section requires the use of telehealth when a health care provider determines that the delivery of a health care service through telehealth is not appropriate or when an enrollee chooses not to receive a health care service through telehealth.

Subd. 4. **Parity between telehealth and in-person services.** (a) A health carrier must not restrict or deny coverage of a health care service that is covered under a health plan solely:

(1) because the health care service provided by the health care provider through telehealth is not provided through in-person contact; or

(2) based on the communication technology or application used to deliver the health care service through telehealth, provided the technology or application complies with this section and is appropriate for the particular service.

(b) Prior authorization may be required for health care services delivered through telehealth only if prior authorization is required before the delivery of the same service through in-person contact.

(c) A health carrier may require a utilization review for services delivered through telehealth, provided the utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for the same services delivered through in-person contact.

(d) A health carrier or health care provider shall not require an enrollee to pay a fee to download a specific communication technology or application.

Subd. 5. **Reimbursement for services delivered through telehealth.** (a) A health carrier must reimburse the health care provider for services delivered through telehealth on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered by the health care provider through in-person contact.

(b) A health carrier must not deny or limit reimbursement based solely on a health care provider delivering the service or consultation through telehealth instead of through in-person contact.

(c) A health carrier must not deny or limit reimbursement based solely on the technology and equipment used by the health care provider to deliver the health care service or consultation through telehealth, provided the technology and equipment used by the provider meets the requirements of this section and is appropriate for the particular service.

(d) Nothing in this subdivision prohibits a health carrier and health care provider from entering into a contract that includes a value-based reimbursement arrangement for the delivery of covered services that may include services delivered through telehealth, and such an arrangement shall not be considered a violation of this subdivision.

Subd. 6. **Telehealth equipment.** (a) A health carrier must not require a health care provider to use specific telecommunications technology and equipment as a condition of coverage under this section, provided the health care provider uses telecommunications technology and equipment that complies with current industry interoperable standards and complies with standards required under the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and regulations promulgated under that Act, unless authorized under this section.

(b) A health carrier must provide coverage for health care services delivered through telehealth by means of the use of audio-only communication if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. Substance use disorder treatment services and mental health care services delivered through telehealth by means of audio-only communication may be covered without a scheduled appointment if the communication was initiated by the enrollee while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response. This paragraph expires July 1, 2023.

Subd. 7. **Telemonitoring services.** A health carrier must provide coverage for telemonitoring services if:

(1) the telemonitoring service is medically appropriate based on the enrollee's medical condition or status;

(2) the enrollee is cognitively and physically capable of operating the monitoring device or equipment, or the enrollee has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(3) the enrollee resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

Subd. 8. **Exception.** This section does not apply to coverage provided to state public health care program enrollees under chapter 256B or 256L.

History: *1Sp2021 c 7 art 6 s 1; 2022 c 98 art 4 s 1; 2023 c 70 art 2 s 4; 1Sp2025 c 3 art 8 s 1*

NOTE: The amendment to subdivision 2 by Laws 2022, chapter 98, article 4, section 1, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2022, chapter 98, article 4, section 1, the effective date.

62A.70 SHORT-TERM HOME HEALTH AND NURSING CARE INSURANCE.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Activities of daily living" has the meaning given in section 62S.01, subdivision 2.

(c) "Cognitive impairment" has the meaning given in section 62S.01, subdivision 9.

(d) "Free-look period" means a period with a duration of at least 30 days, beginning the date the policy, certificate, contract, or other evidence of coverage is issued and delivered to the insured, during which an

insured may cancel the policy, certificate, contract, or other evidence of coverage and receive a full refund of all paid insurance premiums.

(e) "Home health agency" has the meaning given in section 62A.46, subdivision 10.

(f) "Insured" means a person covered under a short-term home health and nursing care insurance policy.

(g) "Nursing facility" has the meaning given in section 62A.46, subdivision 3.

(h) "Plan of care" has the meaning given in section 62A.46, subdivision 8.

(i) "Qualified insurer" means an entity licensed under chapter 62A or 62C.

(j) "Short-term home health and nursing care insurance" means an individual or group policy, certificate, subscriber contract, or other evidence of coverage that provides benefits for short-term home health services or short-term nursing care services. Short-term home health and nursing care insurance does not include:

(1) a long-term care policy, as defined in section 62A.46, subdivision 2;

(2) long-term care insurance, as defined in section 62S.01, subdivision 18;

(3) Medicare supplement policies, as defined in section 62A.3099, subdivision 18; or

(4) major medical, disability income, or hospital confinement indemnity policies.

(k) "Short-term home health services" means one or more of the following services to care for and treat an insured that are provided by a home health agency in a noninstitutional setting pursuant to a written diagnosis or assessment and a plan of care:

(1) nursing and related personal care services under the direction of a registered nurse, including the services of a home health aide;

(2) physical therapy;

(3) speech therapy;

(4) respiratory therapy;

(5) occupational therapy;

(6) nutritional services provided by a licensed dietitian;

(7) homemaker services, meal preparation, and similar nonmedical services;

(8) medical social services; and

(9) other similar medical services and health-related support services.

(l) "Short-term nursing care services" means services to care for and treat an insured that are provided by a nursing facility pursuant to a written diagnosis or assessment and a plan of care.

(m) "Waiting period" means a specified time period that an insured must wait before some or all of the insured's coverage becomes effective.

Subd. 2. **Short-term home health and nursing care insurance approval.** (a) A qualified insurer may offer, issue, deliver, and renew short-term home health and nursing care insurance if the insurance meets the requirements of this section.

(b) Short-term home health and nursing care insurance may be offered, issued, delivered, or renewed only by a qualified insurer.

(c) Short-term home health and nursing care insurance must not be offered, issued, delivered, or renewed until the short-term home health and nursing care insurance is approved by the commissioner as necessary under sections 62A.02 and 62A.135.

Subd. 3. **Policy requirements.** (a) Short-term home health and nursing care insurance must provide benefits upon:

(1) cognitive impairment; or

(2) the insured's inability to perform at least two activities of daily living without substantial assistance.

(b) Short-term home health and nursing care insurance must not provide coverage for a period exceeding 360 days.

(c) Short-term home health and nursing care insurance must provide a free-look period.

(d) Short-term home health and nursing care insurance must not be canceled due to an insured's deterioration in health status or use of benefits.

(e) An insurer may deny the renewal of a policy, certificate, contract, or other evidence of coverage of short-term home health and nursing care insurance only for:

(1) nonpayment of a premium by the insured;

(2) fraud or misrepresentation by the insured;

(3) termination of the insurer's authority to transact business in the state; or

(4) the insured's exhaustion of the maximum benefit period.

(f) Upon the conversion or replacement by an insurer of a policy, certificate, contract, or other evidence of coverage containing a waiting period, the insurer is prohibited from establishing a waiting period that differs from the original waiting period.

Subd. 4. **Required disclosures.** Short-term home health and nursing care insurance must not be offered or issued without providing the following written disclosures:

(1) a statement, in bold text, that the policy, certificate, contract, or other evidence of coverage is supplemental health insurance; is not long-term care insurance; and is not a policy under the Minnesota partnership for long-term care program;

(2) a clear and understandable explanation of the free-look period; and

(3) a clear and understandable explanation of all renewability and continuity provisions.

History: *2026 c 124 art 1 s 37*