CHAPTER 554—S.F.No. 2743

An act relating to insurance; regulating Medicare supplement; making various changes in state law required by the federal government; regulating coverages and practices; regulating the Minnesota comprehensive health association; increasing the maximum lifetime benefit amounts of certain state plan coverages; extending the effective date of the authorization of use of experimental delivery methods; amending Minnesota Statutes 1990, sections 62A.31, by adding subdivisions; 62A.315; 62A.36, subdivision 1; 62A.38; 62A.39; 62A.42; 62A.436; 62A.44; and 62E.07; Minnesota Statutes 1991 Supplement, sections 62A.31, subdivision 1; 62A.316; 62E.10, subdivision 9; and 62E.12; proposing coding for new law in Minnesota Statutes, chapter 62A.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

Section 1. Minnesota Statutes 1991 Supplement, section 62A.31, subdivision 1, is amended to read:

Subdivision 1. **POLICY REQUIREMENTS.** No individual or group policy, certificate, subscriber contract or other evidence of accident and health insurance the effect or purpose of which is to supplement Medicare coverage issued or delivered in this state or offered to a resident of this state shall be sold or issued to an individual covered by Medicare unless the following requirements are met:

(a) The policy must provide a minimum of the coverage set out in subdivision 2~~;~~ and section 62E.07.

(b) The policy must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage~~;~~.

(c) The policy must contain a provision that the plan will not be canceled or nonrenewed on the grounds of the deterioration of health of the insured~~;~~.

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

(e) An outline of coverage as provided in section 62A.39 must be delivered at the time of application and prior to payment of any premium~~;~~.

(f)(1) The policy must provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period, not to exceed 24 months, in which the policyholder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act,

but only if the policyholder notifies the issuer of the policy within 90 days after the date the individual becomes entitled to this assistance;

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

(3) the policy must provide that upon reinstatement (i) there is no additional waiting period with respect to treatment of preexisting conditions, (ii) coverage is provided which is substantially equivalent to coverage in effect before the date of the suspension, and (iii) 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~~;~~.

(g) 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~~;~~.

(h) No issuer of Medicare supplement policies, including policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., in this state may impose preexisting condition limitations or otherwise deny or condition the issuance or effectiveness of any Medicare supplement insurance policy form available for sale in this state, nor may it discriminate in the pricing of such a policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such insurance is submitted during the six-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B~~;~~.

(i) If a Medicare supplement policy replaces another Medicare supplement policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for ~~similar~~ benefits to the extent the time was spent under the original policy~~;~~.

(j) The policy has been filed with and approved by the department as meeting all the requirements of sections 62A.31 to 62A.44~~;~~ ~~and~~.

(k) The policy guarantees renewability.

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

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

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

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

(l) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

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

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

(1) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

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

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

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

(n) 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 certifi-

cate benefit period, if any, or payment of the maximum benefits. The extension of benefits does not apply when the termination is based on fraud, misrepresentation, or nonpayment of premium. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days before discontinuing the availability of the form of the policy or certificate. An issuer that discontinues the availability of a policy form or certificate shall not file for approval a new policy form or certificate form of the same type for the same Medicare supplement benefit plan as the discontinued form for five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section. A change in the rating structure or methodology shall be considered a discontinuance under this section unless the issuer complies with the following requirements:

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

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

(o)(1) Except as provided in clause (2), 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;

(2) 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.

(p) 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 and any automatic renewal premium increases based on the policyholder's age. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy or certificate, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy or certificate after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy or

certificate shall require a signed acceptance by the insured. After the date of policy or certificate issue, a rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy or certificate term shall be agreed to in writing and signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, declaration page, or certificate. If a Medicare supplement policy or certificate contains limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "preexisting condition limitations."

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

(q)(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 paragraph;

(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.

(r) Each health maintenance organization, health service plan corporation, insurer, or fraternal benefit society that sells coverage that supplements Medicare coverage shall establish a separate community rate for that coverage. Beginning January 1, 1993, no coverage that supplements Medicare or that is governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., may be offered, issued, sold, or renewed to a Minnesota resident, except at the community rate required by this paragraph.

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

(1) actuarially valid differences in benefit designs or provider networks;

(2) geographic variations in rates if preapproved by the commissioner of commerce; and

(3) premium reductions in recognition of healthy lifestyle behaviors, including but not limited to, refraining from the use of tobacco. Premium reductions must be actuarially valid and must relate only to those healthy lifestyle behaviors that have a proven positive impact on health. Factors used by the health carrier making this premium reduction must be filed with and approved by the commissioner of commerce.

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

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

(2) offers the coverage described in clause (1) as an optional rider that may be purchased separately from other optional coverages. Each contract issued without prescription drug coverage by any insurer, health service plan corporation, health maintenance organization, or fraternal benefit society must contain, displayed prominently by type or other appropriate means, on the first page of the contract, the following:

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

Sec. 2. Minnesota Statutes 1990, section 62A.31, is amended by adding a subdivision to read:

Subd. 3. **DEFINITIONS.** (a) "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.

(b) "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.

(c) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

(d) "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.

(e) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(f) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

(g) "Health care expenses" means 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.

(h) "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.

(i) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, 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.

(j) "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 Number 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.

(k) "Medicare eligible expenses" means health care expenses covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

(l) "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 a policy 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., or an issued policy under a demonstration project authorized 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.

(m) "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.

(n) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(o) "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.

Sec. 3. Minnesota Statutes 1990, section 62A.31, is amended by adding a subdivision to read:

Subd. 4. **PROHIBITED POLICY PROVISIONS.** A Medicare supplement policy or certificate in force in the state shall not contain benefits that duplicate benefits provided by Medicare.

Sec. 4. Minnesota Statutes 1990, section 62A.315, is amended to read:

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

The extended basic Medicare supplement plan must have a level of coverage so that it will be certified as a qualified plan pursuant to ~~chapter 62E~~ 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 for the calendar year;

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

(3) coverage for the 20 percent copayment amount of Medicare eligible expenses excluding outpatient prescription drugs under Medicare part B regard-

less of hospital confinement for Medicare part B and coverage of the Medicare deductible amount;

(4) 80 percent of usual and customary hospital and medical expenses, supplies, and prescription drug expenses, not covered by Medicare's eligible expenses;

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

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

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

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

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

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

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

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

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

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

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

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

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

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

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

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

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

(ii) coverage requirements and limitations:

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

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

(C) coverage is limited to:

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

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

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

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

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

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

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

(iii) coverage is excluded for:

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

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

Sec. 5. Minnesota Statutes 1991 Supplement, section 62A.316, is amended to read:

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 for the calendar year, after satisfying the Medicare part A deductible;

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

(3) coverage for the 20 percent copayment amount of Medicare eligible expenses excluding outpatient prescription drugs under Medicare part B regardless of hospital confinement for Medicare part B after the Medicare deductible amount;

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

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

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

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

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

(2) a minimum of 80 percent of usual and customary eligible medical

expenses, not to exceed any charge limitation established by the Medicare program, and supplies not covered by Medicare part B. This does not include outpatient prescription drugs;

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

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

~~Nothing in this section prohibits the plan from requiring that services be received from providers designated as preferred providers or participating providers in order to receive coverage under optional benefit riders.~~

(5) coverage for the following preventive health services:

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

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

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

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

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

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

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

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

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

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

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

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

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

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

(ii) Coverage requirements and limitations:

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

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

(C) Coverage is limited to:

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

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

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

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

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

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

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

(iii) Coverage is excluded for:

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

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

Sec. 6. **[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 Number 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.

Sec. 7. **[62A.319] REPORTING OF MULTIPLE POLICIES.**

Subdivision 1. **ANNUAL REPORT.** On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

(1) the policy and certificate number; and

(2) the date of issuance.

Subd. 2. **NAIC REPORT FORMS.** The items in subdivision 1 must be grouped by individual policyholder and be on the National Association of Insurance Commissioners Reporting Medicare Supplement Policies form.

Sec. 8. Minnesota Statutes 1990, section 62A.36, subdivision 1, is amended to read:

Subdivision 1. ~~MINIMUM~~ LOSS ~~RATIOS~~ RATIO STANDARDS. ~~Notwithstanding section 62A.02, subdivision 3, relating to loss ratios,~~ (a) A Medicare supplement ~~policies~~ policy form or certificate form shall not be ~~required~~ 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 ~~Minnesota~~ policyholders and certificate holders in the form of aggregate benefits ~~under the policy, for each year excluding the year of issuance and the first year thereafter, on the basis of incurred claims experience and earned premiums in Minnesota and in accordance with accepted actuarial principles and practices,~~ not including anticipated refunds or credits, provided under the policy form or certificate form:

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

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

All filings of rates and rating schedules shall demonstrate that 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 or certificate shall equal or exceed the appropriate loss ratio standards.

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

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

A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the

end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week treasury bills. A refund or credit against premiums due shall be made by September 30 following the experience year on which the refund or credit is based.

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 1990, section 62A.38, is amended to read:

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.

Sec. 10. Minnesota Statutes 1990, section 62A.39, is amended to read:

62A.39 **DISCLOSURE.**

No individual Medicare supplement plan shall be delivered or issued in this state and no certificate shall be delivered ~~pursuant to~~ under a group Medicare supplement plan delivered or issued in this state unless 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. If the premium is based on the increasing age of the insured, information specifying when premiums will change must be included;

(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; ~~and~~

(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; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy; or other policy, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first

page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

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

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

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

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

Sec. 11. Minnesota Statutes 1990, section 62A.42, is amended to read:

62A.42 **RULEMAKING AUTHORITY.**

To carry out the purposes of sections 62A.31 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.31 to 62A.44.

Sec. 12. Minnesota Statutes 1990, section 62A.436, is amended to read:

62A.436 **COMMISSIONS.**

The commission, sales allowance, service fee, or compensation to an agent

for the sale of a Medicare supplement plan must be the same for each of the first four years of the policy. The commissioner may grant a waiver of this restriction on commissions when the commissioner believes that the insurer's fee structure does not encourage deceptive practices.

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

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.

Sec. 13. Minnesota Statutes 1990, section 62A.44, is amended to read:

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

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

To the best of your knowledge:

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

(2) Do you have any other health insurance policies that provide benefits that this Medicare supplement policy or certificate would duplicate? (a) If so, with which company?

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

(4) Are you covered by Medicaid?"

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

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

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

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

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

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

"NOTICE TO APPLICANT REGARDING REPLACEMENT

OF MEDICARE SUPPLEMENT INSURANCE

(Insurance company's name and address)

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

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement insurance and replace it with a policy or certificate to be issued by (Company Name) Insurance Company.

Your new policy or certificate will provide 30 days within which you may decide without cost whether you desire to keep the policy or certificate.

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

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

_____Additional benefits

_____No change in benefits, but lower premiums

_____Fewer benefits and lower premiums

_____Other (please specify)

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

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

(3) If you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, review it carefully

to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Do not cancel your present policy or certificate until you have received your new policy or certificate and are you 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.

Sec. 14. Minnesota Statutes 1990, section 62E.07, is amended to read:

62E.07 **QUALIFIED MEDICARE SUPPLEMENT PLAN.**

Any plan which provides benefits ~~to persons over the age of 65 years~~ may be

certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 100 percent of the deductibles required under Medicare and 80 percent of the charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by Medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services. ~~The coverage may be subject to a maximum lifetime benefit of not less than $500,000.~~

Sec. 15. Minnesota Statutes 1991 Supplement, section 62E.10, subdivision 9, is amended to read:

Subd. 9. **EXPERIMENTAL DELIVERY METHOD.** The association may petition the commissioner of commerce for a waiver to allow the experimental use of alternative means of health care delivery. The commissioner may approve the use of the alternative means the commissioner considers appropriate. The commissioner may waive any of the requirements of this chapter and chapters 60A, 62A, and 62D in granting the waiver. The commissioner may also grant to the association any additional powers as are necessary to facilitate the specific waiver, including the power to implement a provider payment schedule.

This subdivision is effective until August 1, ~~1992~~ 1993.

Sec. 16. Minnesota Statutes 1991 Supplement, section 62E.12, is amended to read:

62E.12 **MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLAN.**

The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan, and a number two qualified plan, except that the maximum lifetime benefit on these plans shall be $1,000,000, and ~~basic and~~ an extended basic plan and a basic Medicare ~~supplement plans~~ plan as described in sections 62A.31 to 62A.44 and 62E.07. The requirement that a policy issued by the association must be a qualified plan is satisfied if the association contracts with a preferred provider network and the level of benefits for services provided within the network satisfies the requirements of a qualified plan. If the association uses a preferred provider network, payments to nonparticipating providers must meet the minimum requirements of section 72A.20, subdivision 15. They shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier. Notwithstanding the provisions of section 62E.06 the state plan shall exclude coverage of services of a private duty nurse other than on an inpatient basis and any charges for treatment in a hospital located outside of the state of Minnesota in which the covered person is receiving treatment for a mental or nervous disorder, unless similar treatment for the mental or nervous disorder is medically necessary, unavailable in Minnesota and provided upon referral by a licensed Minnesota medical practitioner.

Sec. 17. **FEDERAL CHANGES.**

If the federal government requires additions or changes for compliance with any provisions of this act that are required by the federal Omnibus Budget Reconciliation Act of 1990, Public Law Number 101-508, the commissioner may by order make those additions or changes. Before issuing an order, the commissioner shall notify the appropriate policy committees of the legislature of the additions or changes.

Sec. 18. **EFFECTIVE DATE.**

Sections 1 to 14 and 17 are effective the day following final enactment and apply to policies or certificates issued before and after that date. Sections 15 and 16 are effective the day following final enactment.

ARTICLE 2

Section 1. **[62A.318] MEDICARE SELECT POLICIES AND CERTIFICATES.**

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

(b) For the purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) to make appropriate referrals;

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

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

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

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

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

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

(i) the formal organizational structure;

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

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

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

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

(7) any other information requested by the commissioner.

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

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

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

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

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

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

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

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

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

(ii) other Medicare select policies or certificates;

(2) a description, including address, phone number, and hours of operation,

of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

New language is indicated by underline, deletions by ~~strikeout~~.

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

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

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

Sec. 2. **EFFECTIVE DATE.**

Section 1 is effective July 30, 1992, and applies to policies or certificates issued on or after that date.

Presented to the governor April 17, 1992

Signed by the governor April 29, 1992, 8:08 a.m.

CHAPTER 555—S.F.No. 2662

An act relating to commerce; regulating real estate brokers and salespersons and the real estate, education, research, and recovery fund; temporarily changing the interest rate required on a rental deposit; amending Minnesota Statutes 1990, sections 82.19, by adding a subdivision; and 82.34, subdivisions 3, 4, 7, 9, 11, 13, and 14; 504.20, subdivision 2; Minnesota Statutes 1991 Supplement, section 82.22, subdivision 13; proposing coding for new law in Minnesota Statutes, chapter 80A; repealing Minnesota Statutes 1990, section 82.34, subdivision 20.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

Section 1. **[80A.041] EXEMPTION.**

A real estate broker or agent licensed under chapter 82 who arranges for the sale of a contract for deed is exempt from the license requirement of section 80A.04 if the real estate broker or agent receives no compensation in addition to the brokerage commission or fee and represents the seller, buyer, lessor, or lessee in the sale, lease, or exchange of the subject property.

Sec. 2. Minnesota Statutes 1990, section 82.19, is amended by adding a subdivision to read: