CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

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62A.02 POLICY FORMS.

[For text of subds 1 to 5, see M.S.1982]

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

History: *1983 c 247 s 31*

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) husband,

(b) wife,

(c) dependent children,

(d) any children under a specified age of 19 years or less, or

(e) any other person dependent upon the policyholder.

(4) **Appearance.** The style, arrangement, and over-all 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 lower case 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.

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(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) **Osteopath, 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 osteopath, 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, osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, licensed under the laws of this state.

[For text of subd 2, see M.S.1982]

History: *1983 c 221 s 1*

62A.141 COVERAGE FOR HANDICAPPED DEPENDENTS.

No group policy or plan of health and accident insurance regulated under this chapter, chapter 62C, or chapter 62D, which provides for dependent coverage may be issued or renewed in this state after August 1, 1983, unless it covers the handicapped dependents of the insured, subscriber, or enrollee of the policy or plan.

History: *1983 c 263 s 8*

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

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 or renewed after August 1, 1973 for chiropractic services, after August 1, 1976, for optometric services, and which are issued or renewed after the effective date of this section for services of a registered nurse meeting the requirements of subdivision 3a, by accident and health insurance companies regulated under this

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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.

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 by the profession to engage in advanced nursing practice. "Advanced nursing practice" means the performance of health services by professional nurses who have gained additional knowledge and skills through an organized program of study and clinical experience preparing nurses for advanced practice roles as nurse anesthetists or nurse midwives. The program of study must be beyond the education required for registered nurse licensure and must meet criteria established by the professional nursing organization having authority to certify the registered nurse in advanced nursing practice, and appear on a list established and maintained by the board of nursing through rulemaking.

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

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

History: *1983 c 221 s 2*

62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES.

[For text of subds 1 and 2, see M.S.1982]

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

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed consulting psychologist in a

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hospital and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

History: *1983 c 354 s 1*

62A.17 TERMINATION OF OR LAY OFF FROM EMPLOYMENT.

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 eligible employee who is terminated or laid off from his 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 himself and his dependents.

Subd. 2. **Responsibility of employee.** Every eligible employee electing to continue coverage shall pay his former employer, on a monthly basis, the cost of the continued coverage. If the policy, contract, or health care plan is administered by a trust, every eligible employee electing to continue coverage shall pay the trust the cost of continued coverage according to the eligibility rules established by the trust. The employee shall be eligible to continue the coverage until he becomes re-employed and eligible for health care coverage under a group policy, contract, or plan sponsored by the same or another employer, or for a period of 12 months after the termination of or lay off from employment, whichever is shorter.

Subd. 3. **Eligibility for continued coverage.** An employee shall be eligible to make the election for himself and his dependents provided for in subdivision 1 if:

(a) In the period preceding the termination of or lay off from his employment, he and his dependents were covered through his employment by a group insurance policy, subscriber's contract, or health care plan included within the provisions of section 62A.16;

(b) The termination of or lay off from employment was for reasons other than the discontinuance of the business, bankruptcy, or the employee's disability or retirement.

Subd. 4. **Responsibility of employer.** After timely receipt of the monthly payment from an eligible 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.

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 ten days after termination or lay off of:

(a) his right to elect to continue the coverage;

(b) the amount he must pay monthly to the employer to retain the coverage;

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

(d) 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 (a) to (d). The trust shall inform the employee of the information required by clauses (a) to (d).

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Notice may 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. If the employer or trust fails to so notify the employee who is properly enrolled in the program, the employee shall have the option to retain coverage if he makes this election within 60 days of the date he is terminated or laid off by making the proper payment to the employer or trust to provide continuous coverage.

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 12 months. To do so you must notify your former employer within ten days 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. 6. **Conversion to individual policy.** A group insurance policy that provides post termination or lay off coverage as required by this section shall also include a provision allowing a covered employee, surviving spouse, or dependent at the expiration of the post termination or lay off coverage provided by subdivision 2 to obtain from the insurer offering the group policy or group subscriber contract, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual policy of insurance or an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, and a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3. A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, the spouse, or a dependent in lieu of the optional coverage otherwise required by this subdivision.

The individual policy 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, up to age 65 or to the day before the date of eligibility for coverage under title XVIII of the Social Security Act, as amended. 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 policies issued by the insurer.

History: *1983 c 44 s 1,2; 1983 c 263 s 9*

62A.27 COVERAGE FOR ADOPTED CHILDREN.

No individual or group policy or plan of health and accident insurance regulated under this chapter or chapter 64A, subscriber contract regulated under chapter 62C, or health maintenance contract regulated under chapter 62D, providing coverage for more than one person may be issued or renewed in this state after August 1, 1983, unless the policy, plan, or contract covers adopted children of the insured, subscriber, or enrollee on the same basis as other dependents.

The coverage required by this section is effective from the date of placement for the purpose of adoption and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement.

History: *1983 c 56 s 1*

62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.

Subdivision 1. **Policy requirements.** No individual or group policy, certificate, subscriber contract or other evidence of accident and health insurance issued

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or delivered in this state shall be sold or issued to an individual age 65 or older covered by medicare unless the following requirements are met:

(a) The policy must provide a minimum of the coverage set out in subdivision 2;

(b) The policy must cover pre-existing 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; and

(d) 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.

The requirements of sections 62A.31 to 62A.44 shall not apply to disability income protection insurance policies 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 by-laws 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, and (3) the members have voting privileges and representation on the governing board and committees.

Subd. 2. **General coverage.** For a policy to meet the requirements of this section it must contain (1) a designation specifying whether the policy is a medicare supplement 1+, 1, 2, or 3, (2) a caption stating that the commissioner has established four categories of medicare supplement insurance and minimum standards for each, with medicare supplement 1+ being the most comprehensive and medicare supplement 3 being the least comprehensive, and (3) the policy must provide the minimum coverage prescribed in sections 62A.32 to 62A.35 for the supplement specified, provided that an annual deductible of not more than $200 is permissible for those covered charges not paid by medicare or otherwise included in paragraph (f) of sections 62A.32 and 62A.33.

History: *1983 c 263 s 10*

62A.32 MEDICARE SUPPLEMENT 1+; COVERAGE.

Medicare supplement 1+ must have a level of coverage so that it will be certified as a qualified plan pursuant to chapter 62E, and will provide:

(a) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare to at least 50 percent of the deductible and co-payment required under medicare for the first 60 days of any medicare benefit period;

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(b) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period;

(c) Coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days to the extent not covered by medicare;

(d) Upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional 365 days;

(e) Coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of 100 percent of the medicare calendar year part B deductible;

(f) 80 percent of charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by medicare or pursuant to paragraphs (a) to (e); and

(g) A limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services. The coverage must be subject to a maximum lifetime benefit of not less than $100,000.

History: *1983 c 340 s 17*

62A.39 DISCLOSURE.

No individual medicare supplement plan shall be delivered or issued in this state and no certificate shall be delivered pursuant to a group medicare supplement plan delivered or issued in this state unless an outline containing at least the following information 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;

(d) 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; 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."

History: *1983 c 263 s 11*

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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

(c) establish other reasonable standards to further the purpose of sections 62A.31 to 62A.44.

History: *1983 c 263 s 12*

62A.43 LIMITATIONS ON SALES.

Subdivision 1. **Duplicate coverage prohibited.** No agent shall sell a medicare supplement plan, as defined in section 62A.31, 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 listing of all health and accident insurance maintained by the applicant as of the date the application is taken.

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.

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 his or her 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.

History: *1983 c 263 s 13*

62A.44 APPLICATIONS.

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.

History: *1983 c 263 s 14*

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