CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

62A.135 NONCOMPREHENSIVE POLICIES; MINIMUM LOSS RATIOS.

(a) This section applies to individual or group policies, certificates, or other evidence of coverage designed primarily to provide coverage for hospital or medical expenses on a per diem, fixed indemnity, or nonexpense incurred basis offered, issued, or renewed, to provide coverage to a Minnesota resident.

(b) Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, policies must return to Minnesota policyholders in the form of aggregate benefits under the policy, for each year, on the basis of incurred claims experience and earned premiums in Minnesota and in accordance with accepted actuarial principles and practices:

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

(2) at least 65 percent of the aggregate amount of premiums earned in the case of individual policies.

(c) An insurer may only issue or renew an individual policy on a guaranteed renewable or noncancelable basis.

(d) Noncomprehensive policies, certificates, or other evidence of coverage subject to the provisions of this section are also subject to the requirements, penalties, and remedies applicable to medicare supplement policies, as set forth in section 62A.36, subdivisions 1a, 1b, and 2.

The first supplement to the annual statement required to be filed pursuant to this paragraph must be for the annual statement required to be submitted on or after January 1, 1993.

History: *1991 c 325 art 21 s 5*

62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES.

[For text of subd 1, see M.S.1990]

Subd. 2. **Minimum benefits.** (a) All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage on the same basis as coverage for other benefits for at least 80 percent of the cost of the usual and customary charges of the first ten hours of treatment incurred over a 12-month benefit period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient in a hospital, and at least 75 percent of the cost of the usual and customary charges for any additional hours of treatment during the same 12-month benefit period for serious or persistent mental or nervous disorders, if the services are furnished by (1) a licensed or accredited hospital, (2) a community mental health center or mental health clinic approved or licensed by the commissioner of human services or other authorized state agency, (3) a psychological practitioner licensed under the provisions of sections 148.88 to 148.98, (4) a licensed psychologist licensed under the provisions of sections 148.88 to 148.98, or (5) a psychiatrist licensed under chapter 147. Prior authorization from an accident and health insurance company, or a nonprofit health service corporation,

shall be required for an extension of coverage beyond ten hours of treatment. This prior authorization must be based upon the severity of the disorder, the patient's risk of deterioration without ongoing treatment and maintenance, degree of functional impairment, and a concise treatment plan. Authorization for extended treatment may be limited to a maximum of 30 visit hours during any 12-month benefit period.

(b) For purposes of this section, covered treatment for a minor includes treatment for the family if family therapy is recommended by a provider listed in paragraph (a). For purposes of determining benefits under this section, "hours of treatment" means treatment rendered on an individual or single-family basis. If treatment is rendered on a group basis, the hours of covered group treatment must be provided at a ratio of no less than two group treatment sessions to one individual treatment hour.

Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services if performed by a psychological practitioner or a licensed psychologist to the extent that the services and treatment are within the scope of psychological practitioner or licensed psychologist licensure.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a psychological practitioner or a licensed psychologist in a hospital and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

History: *1991 c 255 s 1,2*

62A.19 PROHIBITION AGAINST NONDIAGNOSTIC X-RAYS.

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

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

History: *1991 c 101 s 1*

62A.301 COVERAGE FOR FULL-TIME STUDENTS.

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

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

History: *1991 c 95 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 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;

(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 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.

[For text of subds 1a and 2, see M.S.1990]

History: *1991 c 43 s 1; 1991 c 129 s 1*

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.

(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 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.

History: *1991 c 129 s 2*

62A.36 LOSS RATIO STANDARDS.

[For text of subd 1, see M.S.1990]

Subd. 1a. **Supplement to annual statements.** Each insurer that has Medicare supplement policies in force in this state shall, as a supplement to the annual statement

required by section 60A.13, submit, in a form prescribed by the commissioner, data showing its incurred claims experience, its earned premiums, and the aggregate amount of premiums collected and losses incurred for each Medicare policy form in force. If the data submitted does not confirm that the insurer has satisfied the loss ratio requirements of this section, the commissioner shall notify the insurer in writing of the deficiency. The insurer shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the insurer fails to file amended rates within the prescribed time, the commissioner shall order that the insurer's filed rates for the nonconforming policy be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The insurer's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the insurer from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data as to premiums and loss ratios for the preceding three years available to the public at a cost not to exceed the cost of copying. The commissioner shall also provide the public with copies of the policies to which the loss ratios and premiums apply. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

[For text of subds 1b and 2, see M.S.1990]

History: *1991 c 129 s 3*

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 written statement signed by the applicant listing all health and accident insurance maintained by the applicant as of the date the application is taken and stating whether the applicant is entitled to any medical assistance. The written statement must be accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of the statement.

[For text of subds 2 to 4, see M.S.1990]

History: *1991 c 129 s 4*

PROHIBITED AGREEMENTS

62A.63 DEFINITIONS.

Subdivision 1. **Application.** For purposes of section 62A.64, the terms defined in this section have the meanings given them.

Subd. 2. **Health care provider.** "Health care provider" means a person, hospital, or health care facility, organization, or corporation that is licensed, certified, or otherwise authorized by the laws of this state to provide health care.

Subd. 3. **Insurer.** "Insurer" means a health insurer regulated under this chapter, service plan corporation as defined under section 62C.02, subdivision 6, and health maintenance organization as defined under section 62D.02, subdivision 4.

History: *1991 c 109 s 1*

62A.64 HEALTH INSURANCE; PROHIBITED AGREEMENTS.

An agreement between an insurer and a health care provider may not:

(1) prohibit, or grant the insurer an option to prohibit, the provider from contracting with other insurers or payors to provide services at a lower price than the payment specified in the contract;

(2) require, or grant the insurer an option to require, the provider to accept a lower payment in the event the provider agrees to provide services to any other insurer or payor at a lower price; or

(3) require, or grant the insurer an option of, termination or renegotiation of the existing contract in the event the provider agrees to provide services to any other insurer or payor at a lower price.

History: *1991 c 109 s 2*