CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

62A.023 NOTICE OF RATE CHANGE.

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

History: *1995 c 258 s 21*

62A.04 STANDARD PROVISIONS.

[For text of subd 1, see M.S.1994]

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

(1) A provision as follows:

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

(2) A provision as follows:

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

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

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

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

(3) A provision as follows:

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

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

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

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

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

(4) A provision as follows:

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

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

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

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

(5) A provision as follows:

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

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

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

(6) A provision as follows:

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

(7) A provision as follows:

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

(8) A provision as follows:

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

(9) A provision as follows:

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

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

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

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

person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

(10) A provision as follows:

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

(11) A provision as follows:

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

(12) A provision as follows:

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

[For text of subds 3 to 10, see M.S.1994]

History: *1995 c 75 s 1*

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

Subdivision 1. **Individual family policies; renewals.** (a) No policy of individual accident and sickness insurance which provides for insurance for more than one person under section 62A.03, subdivision 1, clause (3), and no individual health maintenance contract which provides for coverage for more than one person under chapter 62D, shall be renewed to insure or cover any person in this state or be delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered members of the family any newborn infants, including dependent grandchildren who reside with a covered grandparent, immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth.

(b) The coverage under paragraph (a) includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision.

Subd. 2. **Group policies; renewals.** (a) No group accident and sickness insurance policy and no group health maintenance contract which provide for coverage of family members or other dependents of an employee or other member of the covered group shall be renewed to cover members of a group located in this state or delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered family members or dependents any newborn infants, including dependent grandchildren who reside with a covered grandparent, immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth.

(b) The coverage under paragraph (a) includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental

or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision.

History: *1995 c 258 s 22*

62A.045 PAYMENTS ON BEHALF OF WELFARE RECIPIENTS.

(a) No health plan issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256; 256B; or 256D or services pursuant to section 252.27; 256.9351 to 256.9361; 260.251, subdivision 1a; or 393.07, subdivision 1 or 2. No health carrier providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

(b) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state and/or its authorized agent.

(c) Notwithstanding any law to the contrary, when a person covered by a health plan receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the department of human services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health carrier for those services. If the commissioner of human services notifies the health carrier that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health carrier must be issued directly to the commissioner. Submission by the department to the health carrier of the claim on a department of human services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the health carrier relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health carrier to the provider or the commissioner as required by this section.

(d) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health carrier, the health carrier shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

(e) For the purpose of this section, health plan includes coverage offered by integrated service networks, community integrated service networks, any plan governed under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461, and coverage offered under the exclusions listed in section 62A.011, subdivision 3, clauses (2), (6), (9), (10), and (12).

History: *1995 c 207 art 10 s 1*

NOTE: The amendment to this section by Laws 1995, chapter 207, article 10, section 1, is effective retroactive to August 10, 1993. See Laws 1995, chapter 207, article 10, section 26.

62A.046 COORDINATION OF BENEFITS.

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

Subd. 2. **Dependent coverage.** A group contract which provides coverage of a claimant as a dependent of a parent who has legal responsibility for the dependent's medical care pursuant to a court order under section 518.171 must make payments directly to the provider of care, the custodial parent, or the department of human services pursuant to section 62A.045.

In such cases, liability to the insured is satisfied to the extent of benefit payments made under this section.

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

Subd. 4. **Deductible provision.** Payments made by an enrollee or by the commissioner on behalf of an enrollee in the MinnesotaCare program under sections 256.9351 to 256.9361, or a person receiving benefits under chapter 256B or 256D, for services that are covered by the policy or plan of health insurance shall, for purposes of the deductible, be treated as if made by the insured.

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

Subd. 6. **Coordination of benefits.** Insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations may coordinate benefits to prohibit greater than 100 percent coverage when an insured, subscriber, or enrollee is covered by both an individual and a group contract providing coverage for hospital and medical treatment or expenses. Benefits coordinated under this paragraph must provide for 100 percent coverage of an insured, subscriber, or enrollee. To the extent appropriate, all coordination of benefits provisions currently applicable by law or rule to insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations, shall apply to coordination of benefits between individual and group contracts, except that the group contract shall always be the primary plan. This paragraph does not apply to specified accident, hospital indemnity, specified disease, or other limited benefit insurance policies.

History: *1995 c 207 art 10 s 2; 1995 c 234 art 8 s 56*

NOTE: The amendment to this section by Laws 1995, chapter 207, article 10, section 2, is effective retroactive to August 10, 1993. See Laws 1995, chapter 207, article 10, section 26.

62A.048 DEPENDENT COVERAGE.

(a) A health plan that covers a Minnesota resident must, if it provides dependent coverage, allow dependent children who do not reside with the participant to be covered on the same basis as if they reside with the participant. Every health plan must provide coverage in accordance with section 518.171 to dependents covered by a qualified court or administrative order meeting the requirements of section 518.171, and enrollment of a child cannot be denied on the basis that the child was born out of wedlock, the child is not claimed as a dependent on a parent's federal income tax return, or the child does not reside with the parent or in the health carrier's service area.

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

History: *1995 c 207 art 10 s 3*

NOTE: The amendment to this section by Laws 1995, chapter 207, article 10, section 3, is effective retroactive to August 10, 1993. See Laws 1995, chapter 207, article 10, section 26.

62A.095 SUBROGATION CLAUSES REGULATED.

Subdivision 1. **Applicability.** No health plan shall be offered, sold, or issued to a resident of this state, or to cover a resident of this state, unless the health plan complies with subdivision 2.

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

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

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

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

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

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

Subd. 3. **Retroactive amendments regulated.** No addition of, or amendment of, a subrogation, reimbursement, or similar clause in a health plan shall be applied to the disadvantage of a covered person with respect to benefits provided by the health carrier in connection with an injury, illness, condition, or other covered situation that originated prior to the addition of or amendment to the clause.

History: *1995 c 219 s 1*

62A.096 NOTICE OF SUBROGATION CLAIM REQUIRED.

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

History: *1995 c 219 s 2*

62A.10 GROUP INSURANCE.

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

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

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

Subd. 4. **Policy forms.** No policy or certificate of group accident and health insurance may be issued or delivered in this state unless the same has been approved by the commissioner in accordance with section 62A.02, subdivisions 1 to 6. These forms shall contain the

standard provisions relating and applicable to health and accident insurance and shall conform with the other requirements of law relating to the contents and terms of policies of accident and sickness insurance insofar as they may be applicable to group accident and health insurance, and also the following provisions:

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

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

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

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

History: *1995 c 234 art 7 s 2,3; 1995 c 258 s 23*

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

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

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

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

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

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

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

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

(1) as shown in the following table:

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

or

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

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

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

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

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

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

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

Subd. 7. **Solicitations by mail or media advertisement.** For purposes of this section, fixed indemnity policies issued without the use of an agent as a result of solicitations of indi-

viduals through the mail or mass media advertising, including both print and broadcast advertising, must be treated as group policies.

History: *1995 c 258 s 24*

62A.136 DENTAL AND VISION PLAN COVERAGE.

The following provisions do not apply to health plans providing dental or vision coverage only: sections 62A.041; 62A.047; 62A.149; 62A.151; 62A.152; 62A.154; 62A.155; 62A.21, subdivision 2b; 62A.26; 62A.28; and 62A.30.

History: *1995 c 258 s 25*

62A.14 HANDICAPPED CHILDREN.

Subdivision 1. **Individual family policies.** An individual hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, or an individual health maintenance contract delivered or issued for delivery in this state after August 1, 1984, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self–sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap and (b) chiefly dependent upon the policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or health maintenance organization by the policyholder or enrollee within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two–year period following the child's attainment of the limiting age.

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

History: *1995 c 258 s 26*

62A.141 COVERAGE FOR HANDICAPPED DEPENDENTS.

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

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

History: *1995 c 258 s 27*

62A.27 COVERAGE FOR ADOPTED CHILDREN.

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

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

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

History: *1995 c 207 art 10 s 4*

NOTE: The amendment to this section by Laws 1995, chapter 207, article 10, section 4, is effective retroactive to August 10, 1993. See Laws 1995, chapter 207, article 10, section 26.

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

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

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

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

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

Subd. 2. **Requirement.** Coverage described in subdivision 1 that covers prescription drugs must provide the same coverage for a prescription written by a health care provider authorized to prescribe the particular drug covered by the health coverage described in subdivision 1, regardless of the type of health care provider that wrote the prescription. This section is intended to prohibit denial of coverage based on the prescription having been written by an advanced practice nurse under section 148.235, a physician assistant under section 147.34, or any other nonphysician health care provider authorized to prescribe the particular drug.

History: *1995 c 69 s 1*

62A.308 HOSPITALIZATION AND ANESTHESIA FOR DENTAL PROCEDURES.

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

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

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

History: *1995 c 91 s 1*

62A.309 BREAST CANCER COVERAGE.

Subdivision 1. **Scope of coverage.** This section applies to all health plans as defined in section 62A.011.

Subd. 2. **Required coverage.** Every health plan included in subdivision 1 must provide to each covered person who is a resident of Minnesota coverage for the treatment of breast cancer by high–dose chemotherapy with autologous bone marrow transplantation and for expenses arising from the treatment.

Subd. 3. **Greater coinsurance or copayment prohibited.** Coverage under this section shall not be subject to any greater coinsurance or copayment than that applicable to any other coverage provided by the health plan.

Subd. 4. **Greater deductible prohibited.** Coverage under this section shall not be subject to any greater deductible than that applicable to any other coverage provided by the health plan.

History: *1995 c 183 s 1; 1995 c 258 s 28*

62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.

[For text of subds 1 to 1g, see M.S.1994]

Subd. 1h. **Limitations on denials, conditions, and pricing of coverage.** 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, medical condition, or age 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. This paragraph applies regardless of whether the individual has attained the age of 65 years. If an individual who is enrolled in Medicare Part B due to disability status is involuntarily disenrolled due to loss of disability status, the individual is eligible for the six–month enrollment period provided under this subdivision if the individual later becomes eligible for and enrolls again in Medicare Part B.

Subd. 1i. **Replacement coverage.** If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the issuer of the replacing policy or certificate shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate for benefits to the extent the time was spent under the original policy or certificate. For purposes of this subdivision, "Medicare supplement policy or certificate" means all coverage described in section 62A.011, subdivision 4, clause (10).

[For text of subds 1j to 6, see M.S.1994]

History: *1995 c 258 s 29,30*

62A.45 COVERAGE FOR EQUIPMENT AND SUPPLIES FOR DIABETES.

A health plan, including a plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), must provide coverage for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes. Coverage must include persons with gestational, type I or type II diabetes. Coverage required under this section is subject to the same deductible or coinsurance provisions applicable to the plan's hospital, medical expense, medical equipment, or prescription drug benefits. A health carrier may not reduce or eliminate coverage due to this requirement.

History: *1995 c 52 s 1*

62A.46 DEFINITIONS.

[For text of subd 1, see M.S.1994]

Subd. 2. **Long–term care policy.** "Long–term care policy" means an individual or group policy, certificate, subscriber contract, or other evidence of coverage that provides

benefits for prescribed long–term care, including nursing facility services and home care services, pursuant to the requirements of sections 62A.46 to 62A.56.

Sections 62A.46, 62A.48, and 62A.52 to 62A.56 do not apply to a long–term care policy issued to (a) an employer or employers or to the trustee of a fund established by an employer where only employees or retirees, and dependents of employees or retirees, are eligible for coverage or (b) to a labor union or similar employee organization. The associations exempted from the requirements of sections 62A.31 to 62A.44 under 62A.31, subdivision 1, clause (c) shall not be subject to the provisions of sections 62A.46 to 62A.56 until July 1, 1988.

[For text of subds 3 to 12, see M.S.1994]

Subd. 13. **Benefit day.** "Benefit day" means each day of confinement in a nursing facility or each visit for home care services. For purposes of section 62A.48, subdivision 1, if the policyholder receives more than one home care service visit within a 24–hour period, each visit constitutes one benefit day.

History: *1995 c 258 s 31,32*

62A.48 LONG–TERM CARE POLICIES.

Subdivision 1. **Policy requirements.** No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long–term care services shall be offered, issued, delivered, or renewed in this state, whether or not the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long–term care policy must cover prescribed long–term care in nursing facilities and at least the prescribed long–term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long–term care policy must include: a minimum lifetime benefit limit of at least $25,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums. Prior hospitalization may not be required under a long–term care policy.

The policy must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage. Coverage under the policy may include a waiting period of up to 90 days before benefits are paid, but there must be no more than one waiting period per benefit period; for purposes of this sentence, "days" can mean calendar or benefit days. If benefit days are used, an appropriate premium reduction and disclosure must be made. No policy may exclude coverage for mental or nervous disorders which have a demonstrable organic cause, such as Alzheimer's and related dementias. No policy may require the insured to be homebound or house confined to receive home care services. The policy must include a provision that the plan will not be canceled or renewal refused except on the grounds of nonpayment of the premium, provided that the insurer may change the premium rate on a class basis on any policy anniversary date. A provision that the policyholder may elect to have the premium paid in full at age 65 by payment of a higher premium up to age 65 may be offered. A provision that the premium would be waived during any period in which benefits are being paid to the insured during confinement in a nursing facility must be included. A nongroup policyholder may return a policy within 30 days of its delivery and have the premium refunded in full, less any benefits paid under the policy, if the policyholder is not satisfied for any reason.

No individual long–term care policy shall be offered or delivered in this state until the insurer has received from the insured a written designation of at least one person, in addition to the insured, who is to receive notice of cancellation of the policy for nonpayment of premium. The insured has the right to designate up to a total of three persons who are to receive the notice of cancellation, in addition to the insured. The form used for the written designation must inform the insured that designation of one person is required and that designation of up to two additional persons is optional and must provide space clearly designated for listing between one and three persons. The designation shall include each person's full name, home address, and telephone number. Each time an individual policy is renewed or continued, the insurer shall notify the insured of the right to change this written designation.

The insurer may file a policy form that utilizes a plan of care prepared as provided under section 62A.46, subdivision 5, clause (1) or (2).

Subd. 2. **Per diem coverage.** If benefits are provided on a per diem basis, the minimum daily benefit for care in a nursing facility must be the lesser of $40 or actual charges under a long–term care policy and the minimum benefit per visit for home care under a long–term care policy must be the lesser of $25 or actual charges. The home care services benefit must cover at least seven paid visits per week.

[For text of subds 3 to 8, see M.S.1994]

History: *1995 c 258 s 33,34*

62A.50 DISCLOSURES AND REPRESENTATIONS.

[For text of subds 1 and 2, see M.S.1994]

Subd. 3. **Disclosures.** No long–term care policy shall be offered or delivered in this state, whether or not the policy is issued in this state, and no certificate of coverage under a group long–term care policy shall be offered or delivered in this state, unless a statement containing at least the following information is delivered to the applicant at the time the application is made:

(1) a description of the benefits and coverage provided by the policy and the differences between this policy, a supplemental Medicare policy and the benefits to which an individual is entitled under parts A and B of Medicare;

(2) a statement of the exceptions and limitations in the policy including the following language, as applicable, in bold print: "THIS POLICY DOES NOT COVER ALL NURSING CARE FACILITIES OR NURSING HOME, HOME CARE, OR ADULT DAY CARE EXPENSES AND DOES NOT COVER RESIDENTIAL CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.";

(3) a statement of the renewal provisions including any reservation by the insurer of the right to change premiums;

(4) a statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions;

(5) an explanation of the policy's loss ratio including at least the following language: "This means that, on the average, policyholders may expect that $..... of every $100 in premium will be returned as benefits to policyholders over the life of the contract.";

(6) a statement of the out–of–pocket expenses, including deductibles and copayments for which the insured is responsible, and an explanation of the specific out–of–pocket expenses that may be accumulated toward any out–of–pocket maximum as specified in the policy;

(7) the following language, in bold print: "YOUR PREMIUMS CAN BE INCREASED IN THE FUTURE. THE RATE SCHEDULE THAT LISTS YOUR PREMIUM NOW CAN CHANGE.";

(8) the following language, if applicable, in bold print: "IF YOU ARE NOT HOSPITALIZED PRIOR TO ENTERING A NURSING HOME OR NEEDING HOME CARE, YOU WILL NOT BE ABLE TO COLLECT ANY BENEFITS UNDER THIS PARTICULAR POLICY."; and

(9) a signed and completed copy of the application for insurance is left with the applicant at the time the application is made.

History: *1995 c 258 s 35*

NURSING HOME COVERAGE FOR TERMINALLY ILL

62A.616 COVERAGE FOR NURSING HOME CARE FOR TERMINALLY ILL AND OTHER SERVICES.

An insurer may offer a health plan that covers nursing home care for the terminally ill, personal care attendants, and hospice care. For the purposes of this section, "terminally ill" means a diagnosis certified by a physician that a person has less than six months to live.

History: *1995 c 258 s 36*

62A.65 INDIVIDUAL MARKET REGULATION.

[For text of subds 1 to 4, see M.S.1994]

Subd. 5. **Portability of coverage.** (a) No individual health plan may be offered, sold, issued, or with respect to children age 18 or under renewed, to a Minnesota resident that contains a preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, unless the limitation or exclusion is permitted under this subdivision, provided that, except for children age 18 or under, underwriting restrictions may be retained on individual contracts that are issued without evidence of insurability as a replacement for prior individual coverage that was sold before May 17, 1993. The individual may be subjected to an 18–month preexisting condition limitation, unless the individual has maintained continuous coverage as defined in section 62L.02. The individual must not be subjected to an exclusionary rider. An individual who has maintained continuous coverage may be subjected to a one–time preexisting condition limitation of up to 12 months, with credit for time covered under qualifying coverage as defined in section 62L.02, at the time that the individual first is covered under an individual health plan by any health carrier. Credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. The individual must not be subjected to an exclusionary rider. Thereafter, the individual must not be subject to any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage as defined in section 62L.02.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in section 62L.02. The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this paragraph must be a qualified plan as defined in section 62E.02 and must not contain any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. In no event shall the premium rate exceed 90 percent of the premium charged for comparable individual coverage by the Minnesota comprehensive health association, and the premium rate must be less than that amount if necessary to otherwise comply with this section. An individual health plan offered under this paragraph to a person satisfies the health carrier's obligation to offer conversion coverage under section 62E.16, with respect to that person. Coverage issued under this paragraph must provide that it cannot be canceled or nonrenewed as a result of the health carrier's subsequent decision to leave the individual, small employer, or other group market. Section 72A.20, subdivision 28, applies to this paragraph.

[For text of subds 6 and 7, see M.S.1994]

Subd. 8. **Cessation of individual business.** Notwithstanding the provisions of subdivisions 1 to 7, a health carrier may elect to cease doing business in the individual health plan market in this state if it complies with the requirements of this subdivision. For purposes of

this section, "cease doing business" means to discontinue issuing new individual health plans and to refuse to renew all of the health carrier's existing individual health plans issued in this state whose terms permit refusal to renew under the circumstances specified in this subdivision. This subdivision does not permit cancellation of an individual health plan, unless the terms of the health plan permit cancellation under the circumstances specified in this subdivision. A health carrier electing to cease doing business in the individual health plan market in this state shall notify the commissioner 180 days prior to the effective date of the cessation. The cessation of business does not include the failure of a health carrier to offer or issue new business in the individual health plan market or continue an existing product line in that market, provided that a health carrier does not terminate, cancel, or fail to renew its current individual health plan business. A health carrier electing to cease doing business in the individual health plan market shall provide 120 days' written notice to each policyholder covered by an individual health plan issued by the health carrier. A health carrier that ceases to write new business in the individual health plan market shall continue to be governed by this section with respect to continuing individual health plan business conducted by the health carrier. A health carrier that ceases to do business in the individual health plan market after July 1, 1994, is prohibited from writing new business in the individual health plan market in this state for a period of five years from the date of notice to the commissioner. This subdivision applies to any health maintenance organization that ceases to do business in the individual health plan market in one service area with respect to that service area only. Nothing in this subdivision prohibits an affiliated health maintenance organization from continuing to do business in the individual health plan market in that same service area. The right to refuse to renew an individual health plan under this subdivision does not apply to individual health plans issued on a guaranteed renewable basis that does not permit refusal to renew under the circumstances specified in this subdivision.

History: *1995 c 234 art 7 s 4,5*