CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

62A.011 DEFINITIONS.

[For text of subds 1 and 2, see M.S.1996]

Subd. 3. **Health plan.** "Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self–insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified. Health plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or non–expense–incurred basis;

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

(6) designed solely to provide dental or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident–only coverage;

(9) a long–term care policy as defined in section 62A.46 or 62S.01;

(10) issued as a supplement to Medicare, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended;

(11) workers' compensation insurance; or

(12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health plan.

History: *1997 c 71 art 2 s 3*

62A.021 HEALTH CARE POLICY RATES.

Subdivision 1. **Loss ratio standards.** (a) Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, health care policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the

form of aggregate benefits not including anticipated refunds or credits, provided under the policies or certificates, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27, calculated on an aggregate basis; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of each policy form or certificate form issued in the individual market; calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. Assessments by the reinsurance association created in chapter 62L and all types of taxes, surcharges, or assessments created by Laws 1992, chapter 549, or created on or after April 23, 1992, are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for policies and certificates issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until a 72 percent loss ratio is reached on July 1, 2000. A health carrier that enters a market after July 1, 1993, does not start at the beginning of the phase–in schedule and must instead comply with the loss ratio requirements applicable to other health carriers in that market for each time period. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

(b) All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy form or certificate form shall equal or exceed the appropriate loss ratio standards.

(c) A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner shall order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

(d) Each sale of a policy or certificate that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

(e)(1) For purposes of this section, health care policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

(2) For purposes of this section, (i) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and (ii) "health carrier" has the meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

(f) The loss ratio phase–in as described in paragraph (a) does not apply to individual policies and small employer policies issued by a health plan company that is assessed less than three percent of the total annual amount assessed by the Minnesota comprehensive health association. These policies must meet a 68 percent loss ratio for individual policies, a 71 percent loss ratio for small employer policies with fewer than ten employees, and a 75 percent loss ratio for all other small employer policies.

(g) The commissioners of commerce and health shall each annually issue a public report listing, by health plan company, the actual loss ratios experienced in the individual and small employer markets in this state by the health plan companies that the commissioners respectively regulate. The commissioners shall coordinate release of these reports so as to release them as a joint report or as separate reports issued the same day. The report or reports shall be released no later than June 1 for loss ratios experienced for the preceding calendar year. Health plan companies shall provide to the commissioners any information requested by the commissioners for purposes of this paragraph.

[For text of subd 2, see M.S.1996]

Subd. 3. **Loss ratio disclosure.** (a) Each health care policy form or health care certificate form for which subdivision 1 requires compliance with a loss ratio requirement shall prominently display the disclosure provided in paragraph (b) on its declarations sheet if it has one and, if not, on its front page. The disclosure must also be prominently displayed in any marketing materials used in connection with it.

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

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

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

History: *1997 c 225 art 2 s 2,3*

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; 256L.01 to 256L.10; 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 com-

missioner 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 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: *1997 c 225 art 2 s 62*

62A.046 COORDINATION OF BENEFITS.

[For text of subds 1 to 3, see M.S.1996]

Subd. 4. **Deductible provision.** Payments made by an enrollee or by the commissioner on behalf of an enrollee in the MinnesotaCare program under sections 256L.01 to 256L.10, or a person receiving benefits under chapter 256B 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.

[For text of subds 5 and 6, see M.S.1996]

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 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: *1997 c 225 art 2 s 62*

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 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: *1997 c 225 art 2 s 62*

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

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

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

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

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

[For text of subd 2, see M.S.1996]

History: *1997 c 225 art 2 s 62*

62A.3091 NONDISCRIMINATE COVERAGE OF TESTS.

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

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

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

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

[For text of subd 2, see M.S.1996]

History: *1997 c 225 art 2 s 62*

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

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

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

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

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

[For text of subd 2, see M.S.1996]

History: *1997 c 225 art 2 s 62*

62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.

[For text of subds 1 to 5, see M.S.1996]

Subd. 6. **Application to certain policies.** The requirements of sections 62A.31 to 62A.44 shall not apply to disability income protection insurance policies, long–term care policies issued pursuant to sections 62A.46 to 62A.56 or chapter 62S, or group policies of accident and health insurance which do not purport to supplement Medicare issued to any of the following groups:

(a) A policy issued to an employer or employers or to the trustee of a fund established by an employer where only employees or retirees, and dependents of employees or retirees, are eligible for coverage.

(b) A policy issued to a labor union or similar employee organization.

(c) A policy issued to an association, a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 100 persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have a constitution and bylaws which provide that (1) the association or associations hold regular meetings not less frequently than annually to further purposes of the members, (2) except for credit unions, the association or associations collect dues or solicit contributions from members, (3) the members have voting privileges and representation on the governing board and committees, and (4) the members are not, within the first 30 days of membership, directly solicited, offered, or sold a long–term care policy or Medicare supplement policy if the policy is available as an association benefit. This clause does not prohibit direct solicitations, offers, or sales made exclusively by mail.

An association may apply to the commissioner for a waiver of the 30–day waiting period as to that association. The commissioner may grant the waiver upon a finding of all of the following: (1) that the association is in full compliance with this section; (2) that sanctions have not been imposed against the association as a result of significant disciplinary action by the department of commerce; and (3) that at least 90 percent of the association's income comes from dues, contributions, or sources other than income from the sale of insurance.

History: *1997 c 71 art 2 s 4*

62A.316 BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.

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

(1) coverage for all of the Medicare part A inpatient hospital coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare, after satisfying the Medicare part A deductible;

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

(3) coverage for the copayment amount of Medicare eligible expenses under Medicare part B regardless of hospital confinement, subject to the Medicare part B deductible amount;

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

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

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

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

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

(2) a minimum of 80 percent of eligible medical expenses and supplies not covered by Medicare part B, not to exceed any charge limitation established by the Medicare program or state law;

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

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

(5) coverage for the following preventive health services:

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

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

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

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

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

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

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

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

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

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

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

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

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

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

(ii) Coverage requirements and limitations:

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

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

(C) coverage is limited to:

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

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

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

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

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

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

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

(iii) Coverage is excluded for:

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

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

(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses to a maximum of $1,200 paid by the issuer annually under this

benefit. An issuer of Medicare supplement insurance policies that elects to offer this benefit rider shall also make available coverage that contains the rider specified in clause (4).

History: *1997 c 225 art 2 s 4*

62A.45 COVERAGE FOR DIABETES.

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

History: *1997 c 57 s 1*

62A.48 LONG–TERM CARE POLICIES.

[For text of subds 1 to 8, see M.S.1996]

Subd. 9. **Qualified long–term care.** Sections 62A.46 to 62A.56 do not apply to policies marketed as qualified long–term care insurance policies under chapter 62S.

History: *1997 c 71 art 2 s 5*

62A.50 DISCLOSURES AND REPRESENTATIONS.

[For text of subds 1 to 3, see M.S.1996]

Subd. 4. **Policies other than qualified long–term care insurance policies.** A policy that is not intended to be a qualified long–term care insurance policy as defined under section 62S.01, subdivision 24, must include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long–term care insurance policy. The disclosure must be prominently displayed and read as follows: This long–term care insurance policy (certificate) is not intended to be a qualified long–term care insurance contract as defined under section 7702 (B)(b) of the Internal Revenue Code of 1986. You should consult with your attorney, accountant, or tax advisor regarding the tax implications of purchasing long–term care insurance.

History: *1997 c 71 art 2 s 6*

62A.61 DISCLOSURE OF METHODS USED BY HEALTH CARRIERS TO DETERMINE USUAL AND CUSTOMARY FEES.

(a) A health carrier that bases reimbursement to health care providers upon a usual and customary fee must maintain in its office a copy of a description of the methodology used to calculate fees including at least the following:

(1) the frequency of the determination of usual and customary fees;

(2) a general description of the methodology used to determine usual and customary fees; and

(3) the percentile of usual and customary fees that determines the maximum allowable reimbursement.

(b) A health carrier must provide a copy of the information described in paragraph (a) to the commissioner of health or the commissioner of commerce, upon request.

(c) The commissioner of health or the commissioner of commerce, as appropriate, may use to enforce this section any enforcement powers otherwise available to the commissioner with respect to the health carrier. The commissioner of health or commerce, as appropriate,

may require health carriers to provide the information required under this section and may use any powers granted under other laws relating to the regulation of health carriers to enforce compliance.

(d) For purposes of this section, "health carrier" has the meaning given in section 62A.011.

History: *1997 c 225 art 2 s 5*