CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

62A.095 SUBROGATION CLAUSES REGULATED.

Subdivision 1. **Applicability.** (a) 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.

(b) Health plans providing benefits under health care programs administered by the commissioner of human services are not subject to the limits described in subdivision 2 but are subject to the right of subrogation provisions under section 256B.37 and the lien provisions under section 256.015; 256B.042; 256D.03, subdivision 8; or 256L.03, subdivision 6.

[For text of subds 2 and 3, see M.S.2000]

History: *1Sp2001 c 9 art 2 s 1*

62A.17 TERMINATION OF OR LAYOFF FROM EMPLOYMENT; CONTINUATION AND CONVERSION RIGHTS.

Subdivision 1. **Continuation of coverage.** Every group insurance policy, group subscriber contract, and health care plan included within the provisions of section 62A.16, except policies, contracts, or health care plans covering employees of an agency of the federal government, shall contain a provision which permits every covered employee who is voluntarily or involuntarily terminated or laid off from employment, if the policy, contract, or health care plan remains in force for active employees of the employer, to elect to continue the coverage for the employee and dependents.

An employee shall be considered to be laid off from employment if there is a reduction in hours to the point where the employee is no longer eligible under the policy, contract, or health care plan. Termination shall not include discharge for gross misconduct.

Upon request by the terminated or laid off employee, a health carrier must provide the instructions necessary to enable the employee to elect continuation of coverage.

[For text of subds 2 to 6, see M.S.2000]

History: *2001 c 215 s 9*

62A.20 CONTINUATION COVERAGE OF CURRENT SPOUSE AND CHILDREN.

Subdivision 1. **Requirement.** Every policy of accident and health insurance providing coverage of hospital or medical expense on either an expense-incurred basis or other than an expense-incurred basis, which in addition to covering the insured also provides coverage to the spouse and dependent children of the insured shall contain:

(1) a provision which allows the spouse and dependent children to elect to continue coverage when the insured becomes enrolled for benefits under Title XVIII of the Social Security Act (Medicare); and

(2) a provision which allows the dependent children to continue coverage when they cease to be dependent children under the generally applicable requirement of the plan.

Upon request by the insured or the insured's spouse or dependent child, a health carrier must provide the instructions necessary to enable the spouse or child to elect continuation of coverage.

[For text of subd 2, see M.S.2000]

History: *2001 c 215 s 10*

62A.21 CONTINUATION AND CONVERSION PRIVILEGES FOR INSURED FORMER SPOUSES AND CHILDREN.

[For text of subd 1, see M.S.2000]

Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's former spouse and dependent children upon entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

(a) the date the insured's former spouse becomes covered under any other group health plan; or

(b) the date coverage would otherwise terminate under the policy.

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. The policy must require the group policyholder to, upon request, provide the insured with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Upon request by the insured's former spouse or dependent child, a health carrier must provide the instructions necessary to enable the child or former spouse to elect continuation of coverage.

[For text of subds 2b and 3, see M.S.2000]

History: *2001 c 215 s 11*

62A.302 COVERAGE OF DEPENDENTS.

Subdivision 1. **Scope of coverage.** This section applies to:

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

(2) coverage described in section 62A.011, subdivision 3, clauses (4), (6), (7), (8), (9), and (10); and

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

Subd. 2. **Required coverage.** Every health plan included in subdivision 1 that provides dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02.

History: *2001 c 215 s 12*

62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.

[For text of subd 1, see M.S.2000]

Subd. 1a. **Minimum coverage.** The policy must provide a minimum of the coverage set out in subdivision 2 and for an extended basic plan, the additional requirements of section 62E.07.

[For text of subds 1b to 1h, see M.S.2000]

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 3, clause (10).

[For text of subds 1j to 2, see M.S.2000]

Subd. 3. **Definitions.** (a) The definitions provided in this subdivision apply to sections 62A.31 to 62A.44.

(b) "Accident," "accidental injury," or "accidental means" means to employ "result" language and does not include words that establish an accidental means test or use words such as "external," "violent," "visible wounds," or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under a workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(c) "Applicant" means:

(1) in the case of an individual Medicare supplement policy or certificate, the person who seeks to contract for insurance benefits; and

(2) in the case of a group Medicare supplement policy or certificate, the proposed certificate holder.

(d) "Bankruptcy" means a situation in which a Medicare + Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

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

(f) "Certificate" means a certificate delivered or issued for delivery in this state or offered to a resident of this state under a group Medicare supplement policy or certificate.

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

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

(i) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in United States Code, title 29, section 1002 (Employee Retirement Income Security Act).

(j) "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers. The expenses shall not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; and

(7) claims processing costs.

(k) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in the Medicare program.

(l) "Insolvency" means a situation in which an issuer, licensed to transact the business of insurance in this state, including the right to transact business as any type of issuer, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(m) "Issuer" includes insurance companies, fraternal benefit societies, health service plan corporations, health maintenance organizations, and any other entity delivering or issuing for delivery Medicare supplement policies or certificates in this state or offering these policies or certificates to residents of this state.

(n) "Medicare" shall be defined in the policy and certificate. Medicare may be defined as the Health Insurance for the Aged Act, title XVIII of the Social Security Amendments of 1965, as amended, or title I, part I, of Public Law Number 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as amended.

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

(p) "Medicare + Choice plan" means a plan of coverage for health benefits under Medicare part C as defined in section 1859 of the federal Social Security Act, United States Code, title 42, section 1395w-28, and includes:

(1) coordinated care plans which provide health care services, including, but not limited to, health maintenance organization plans, with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) medical savings account plans coupled with a contribution into a Medicare + Choice medical savings account; and

(3) Medicare + Choice private fee-for-service plans.

(q) "Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.31 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by section 1833 (known as "cost" or "HCPP" contracts) or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended; or Section 4001 of the Balanced Budget Act of 1997 (BBA)(Public Law Number 105-33), Sections 1851 to 1859 of the Social Security Act establishing part C of the Medicare program, known as the "Medicare + Choice program."

(r) "Medicare supplement policy or certificate" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, or those policies or certificates covered by section 1833 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., or an issued policy under a demonstration project specified under amendments to the federal Social Security Act, which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.

(s) "Physician" shall not be defined more restrictively than as defined in the Medicare program or section 62A.04, subdivision 1, or 62A.15, subdivision 3a.

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

(u) "Secretary" means the Secretary of the United States Department of Health and Human Services.

(v) "Sickness" shall not be defined more restrictively than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under a workers' compensation, occupational disease, employer's liability, or similar law.

[For text of subds 4 to 6, see M.S.2000]

History: *2001 c 215 s 13-15*

62A.41 PENALTIES.

[For text of subds 1 to 3, see M.S.2000]

Subd. 4. **Unlicensed sales.** Notwithstanding section 60K.32, a person who acts or assumes to act as an insurance producer without a valid license for the purpose of selling or attempting to sell Medicare supplement insurance, and the person who aids or abets the actor, is guilty of a felony and is subject to a civil penalty of not more than $5,000 per violation.

History: *2001 c 117 art 2 s 7*

NOTE: The amendment to subdivision 4 by Laws 2001, chapter 117, article 2, section 7, is effective July 1, 2002. Laws 2001, chapter 117, article 2, section 19.

62A.421 DEMONSTRATION PROJECTS.

Subdivision 1. **Establishment.** The commissioner may establish demonstration projects to allow an issuer of Medicare supplement policies to extend coverage to individuals enrolled in part A or part B, or both, of the Medicare program, Title XVIII of the Social Security Act, United States Code, title 42, section 1395, et seq. For purposes of this section, the commissioner may waive compliance with the benefits described in sections 62A.315 and 62A.316 and other applicable statutes and rules if there is reasonable evidence that the statutes or rules prohibit the operation of the demonstration project, but may not waive the six-month guaranteed issue provision. The commissioner shall provide for public comment before any statute or rule is waived.

Subd. 2. **Benefits.** A demonstration project must provide health benefits equal to or exceeding the level of benefits provided in Title XVIII of the Social Security Act and an out-of-hospital prescription drug benefit. The out-of-hospital prescription drug benefit may be waived by the commissioner if the issuer presents evidence satisfactory to the commissioner that the inclusion of the benefit would restrict the operation of the demonstration project.

Subd. 3. **Application.** An issuer electing to participate in a demonstration project shall apply to the commissioner for approval on a form developed by the commissioner. The application shall include at least the following:

(1) a statement identifying the population that the project is designed to serve;

(2) a description of the proposed project including a statement projecting a schedule of costs and benefits for the policyholder;

(3) reference to the sections of Minnesota Statutes and department of commerce rules for which waiver is requested;

(4) evidence that application of the requirements of applicable Minnesota Statutes and department of commerce rules would, unless waived, prohibit the operation of the demonstration project;

(5) an estimate of the number of years needed to adequately demonstrate the project's effects; and

(6) other information the commissioner may reasonably require.

Subd. 4. **Timeline.** The commissioner shall approve, deny, or refer back to the issuer for modification, the application for a demonstration project within 60 days of the receipt of a complete application.

Subd. 5. **Period specified.** The commissioner may approve an application for a demonstration project for a period of six years, with an option to renew.

Subd. 6. **Annual report.** Each issuer for which a demonstration project is approved shall annually file a report with the commissioner summarizing the project's experience at the same time it files its annual report. The report shall be on a form developed by the commissioner and shall be separate from the annual report.

Subd. 7. **Rescission of approval.** The commissioner may rescind approval of a demonstration project if the commissioner makes any of the findings listed in section 60A.052 or 62D.15, subdivision 1, with respect to the project for which it has not been granted a specific exemption, or if the commissioner finds that the project's operation is contrary to the information contained in the approved application.

History: *2001 c 215 s 16*

62A.48 LONG-TERM CARE POLICIES.

[For text of subds 1 to 3, see M.S.2000]

Subd. 4. **Loss ratio.** The anticipated loss ratio for long-term care policies must not be less than 65 percent for policies issued on a group basis or 60 percent for policies issued on an individual or mass-market basis. This subdivision does not apply to policies issued on or after January 1, 2002, that comply with sections 62S.021 and 62S.081.

[For text of subds 5 to 9, see M.S.2000]

Subd. 10. **Regulation of premiums and premium increases.** Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with sections 62S.021, 62S.081, 62S.265, and 62S.266 to the same extent as policies issued under chapter 62S.

Subd. 11. **Nonforfeiture benefits.** Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with section 62S.02, subdivision 2, to the same extent as policies issued under chapter 62S.

History: *1Sp2001 c 9 art 8 s 1-3*

62A.65 INDIVIDUAL MARKET REGULATION.

[For text of subds 1 to 7, see M.S.2000]

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. Within 30 days after the termination, the health carrier shall submit to the commissioner a complete list of policyholders that have been terminated. 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. This notice must also inform each policyholder of the existence of the Minnesota Comprehensive Health Association, the requirements for being accepted, the procedures for applying for coverage, and the telephone numbers at the department of health and the department

of commerce for information about private individual or family health coverage. 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: *2001 c 215 s 17*