CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

62A.136 DENTAL AND VISION PLAN COVERAGE.

The following provisions do not apply to health plans as defined in section 62A.011, subdivision 3, clause (6), providing dental or vision coverage only: sections 62A.041; 62A.0411; 62A.047; 62A.149; 62A.151; 62A.152; 62A.154; 62A.155; 62A.17, subdivision 6; 62A.21, subdivision 2b; 62A.26; 62A.28; 62A.285; 62A.30; 62A.304; 62A.3093; and 62E.16.

History: *2005 c 132 s 9*

62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.

[For text of subds 1 to 1e, see M.S.2004]

Subd. 1f. **Suspension based on entitlement to medical assistance.** (a) The policy or certificate must provide that benefits and premiums under the policy or certificate shall be suspended for any period that may be provided by federal regulation at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to this assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to this medical assistance, the policy or certificate shall be automatically reinstated, effective as of the date of termination of this entitlement, if the policyholder or certificate holder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) The policy must provide that upon reinstatement (1) there is no additional waiting period with respect to treatment of preexisting conditions, (2) coverage is provided which is substantially equivalent to coverage in effect before the date of the suspension. If the suspended policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide coverage substantially equivalent to the coverage in effect before the date of suspension, and (3) premiums are classified on terms that are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had coverage not been suspended.

[For text of subd 1g, see M.S.2004]

Subd. 1h. **Limitations on denials, conditions, and pricing of coverage.** No health carrier issuing Medicare-related coverage in this state may impose preexisting condition

limitations or otherwise deny or condition the issuance or effectiveness of any such coverage available for sale in this state, nor may it discriminate in the pricing of such coverage, because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant where an application for such coverage is submitted prior to or during the six-month period beginning with the first day of the month in which an individual first enrolled for benefits under Medicare Part B. This subdivision applies to each Medicare-related coverage offered by a health carrier 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 another six-month enrollment period provided under this subdivision beginning the first day of the month in which the individual later becomes eligible for and enrolls again in Medicare Part B. An individual who is or was previously enrolled in Medicare Part B due to disability status is eligible for another six-month enrollment period under this subdivision beginning the first day of the month in which the individual has attained the age of 65 years and either maintains enrollment in, or enrolls again in, Medicare Part B. If an individual enrolled in Medicare Part B voluntarily disenrolls from Medicare Part B because the individual becomes enrolled under an employee welfare benefit plan, the individual is eligible for another six-month enrollment period, as provided in this subdivision, beginning the first day of the month in which the individual later becomes eligible for and enrolls again in Medicare Part B.

[For text of subds 1i and 1j, see M.S.2004]

Subd. 1k. **Guaranteed renewability.** The policy must guarantee renewability.

(a) Only the standards for renewability provided in this subdivision may be used in Medicare supplement insurance policy forms.

(b) No issuer of Medicare supplement insurance policies may cancel or nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(c) If a group Medicare supplement insurance policy is terminated by the group policyholder and is not replaced as provided in this clause, the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder, provides for continuation of the benefits contained in the group policy; or provides for such benefits and benefit packages as otherwise meet the requirements of this clause.

(d) If an individual is a certificate holder in a group Medicare supplement insurance policy and the individual terminates membership in the group, the issuer of the policy shall offer the certificate holder the conversion opportunities described in this clause; or offer the certificate holder continuation of coverage under the group policy.

(e) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the policy as modified for that purpose is deemed to satisfy the guaranteed renewal requirements of this subdivision.

[For text of subds 1l and 1m, see M.S.2004]

Subd. 1n. **Termination of coverage.** (a) Termination by an issuer of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that began while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy or certificate was in force may be conditioned on the continuous total disability of the insured, limited to the duration of the policy or certificate benefit period, if any, or payment of the maximum benefits. The extension of benefits does not apply when the termination is based on fraud, misrepresentation, or nonpayment of premium. Receipt of Medicare Part D benefits is not considered in determining a continuous loss.

(b) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days before discontinuing the availability of the form of the policy or certificate. An issuer that discontinues the availability of a policy form or certificate form shall not file for approval a new policy form or certificate form of the same type for the same Medicare supplement benefit plan as the discontinued form for five years after the issuer provides notice to the commissioner of the discontinuance. This period of ineligibility to file a form for approval may be reduced if the commissioner determines that a shorter period is appropriate. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section. A change in the rating structure or methodology shall be considered a discontinuance under this section unless the issuer complies with the following requirements:

(1) the issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resulting rates differ from the existing rating methodology and resulting rates; and

(2) the issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

[For text of subds 1o to 1r, see M.S.2004]

Subd. 1s. **Prescription drug coverage.** (a) Subject to subdivisions 1k, 1m, 1n, and 1p, a Medicare supplement policy with benefits for outpatient prescription drugs, in existence prior to January 1, 2006, must be renewed, at the option of the policyholder, for current policyholders who do not enroll in Medicare Part D.

(b) A Medicare supplement policy with benefits for outpatient prescription drugs must not be issued after December 31, 2005.

(c) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs must not be renewed after the policyholder enrolls in Medicare Part D unless:

(1) the policy is modified to eliminate outpatient prescription drug coverage for expenses of outpatient prescription drugs incurred on or after the effective date of the individual's coverage under Medicare Part D; and

(2) premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

(d) An issuer of a Medicare supplement policy or certificate must comply with the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended, including any federal regulations, as amended, adopted under that act. This paragraph does not require compliance with any provision of that act until the date upon which that act requires compliance with that provision. The commissioner has authority to enforce this paragraph.

Subd. 1t. **Notice of lack of drug coverage.** Each policy or contract issued without prescription drug coverage by any insurer, health service plan corporation, health maintenance organization, or fraternal benefit society must contain, displayed prominently by type or other appropriate means, on the first page of the contract, the following:

"Notice to buyer: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to you by retaining existing coverage you may have or by enrolling in Medicare Part D. Please ask for further details."

Subd. 1u. **Guaranteed issue for eligible persons.** (a)(1) Eligible persons are those individuals described in paragraph (b) who seek to enroll under the policy during the period specified in paragraph (c) and who submit evidence of the date of termination

or disenrollment described in paragraph (b), or of the date of Medicare Part D enrollment, with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not: deny or condition the issuance or effectiveness of a Medicare supplement policy described in paragraph (c) that is offered and is available for issuance to new enrollees by the issuer; discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, medical condition, or age; or impose an exclusion of benefits based upon a preexisting condition under such a Medicare supplement policy.

(b) An eligible person is an individual described in any of the following:

(1) the individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(2) the individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the federal Social Security Act, and there are circumstances similar to those described in this clause that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan:

(i) the organization's or plan's certification under Medicare Part C has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(ii) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act, United States Code, title 42, section 1395w-21(g)(3)(b) (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the federal Social Security Act, United States Code, title 42, section 1395w-26), or the plan is terminated for all individuals within a residence area;

(iii) the individual demonstrates, in accordance with guidelines established by the Secretary, that:

(A) the organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(B) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(iv) the individual meets such other exceptional conditions as the secretary may provide;

(3)(i) the individual is enrolled with:

(A) an eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) an organization under an agreement under section 1833(a)(1)(A) of the federal Social Security Act, United States Code, title 42, section 1395l(a)(1)(A) (health care prepayment plan); or

(D) an organization under a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under clause (2);

(4) the individual is enrolled under a Medicare supplement policy, and the enrollment ceases because:

(i)(A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(B) of other involuntary termination of coverage or enrollment under the policy;

(ii) the issuer of the policy substantially violated a material provision of the policy; or

(iii) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5)(i) the individual was enrolled under a Medicare supplement policy and terminates that enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C; any eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare cost); any similar organization operating under demonstration project authority; any PACE provider under section 1894 of the federal Social Security Act, or a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the subsequent enrollment under item (i) is terminated by the enrollee during any period within the first 12 months of the subsequent enrollment during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the federal Social Security Act;

(6) the individual, upon first enrolling for benefits under Medicare Part B, enrolls in a Medicare Advantage plan under Medicare Part C, or with a PACE provider under section 1894 of the federal Social Security Act, and disenrolls from the plan by not later than 12 months after the effective date of enrollment; or

(7) the individual enrolls in a Medicare Part D plan during the initial Part D enrollment period, as defined under United States Code, title 42, section 1395ss(v)(6)(D), and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (e), clause (4).

(c)(1) In the case of an individual described in paragraph (b), clause (1), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, notice that a claim has been denied because of a termination or cessation; or (ii) the date that the applicable coverage terminates or ceases; and ends 63 days after the later of those two dates.

(2) In the case of an individual described in paragraph (b), clause (2), (3), (5), or (6), whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in paragraph (b), clause (4), item (i), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and (ii) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(4) In the case of an individual described in paragraph (b), clause (2), (4), (5), or (6), who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(5) In the case of an individual described in paragraph (b), clause (7), the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer

during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in paragraph (b) but not described in this paragraph, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(d)(1) In the case of an individual described in paragraph (b), clause (5), or deemed to be so described, pursuant to this paragraph, whose enrollment with an organization or provider described in paragraph (b), clause (5), item (i), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (5).

(2) In the case of an individual described in paragraph (b), clause (6), or deemed to be so described, pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (b), clause (6), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (6).

(3) For purposes of paragraph (b), clauses (5) and (6), no enrollment of an individual with an organization or provider described in paragraph (b), clause (5), item (i), or with a plan or in a program described in paragraph (b), clause (6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with the organization, provider, plan, or program.

(e) The Medicare supplement policy to which eligible persons are entitled under:

(1) paragraph (b), clauses (1) to (4), is any Medicare supplement policy that has a benefit package consisting of the basic Medicare supplement plan described in section 62A.316, paragraph (a), plus any combination of the three optional riders described in section 62A.316, paragraph (b), clauses (1) to (3), offered by any issuer;

(2) paragraph (b), clause (5), is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, any policy described in clause (1) offered by any issuer, except that after December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy to which the individual is entitled under paragraph (b), clause (5), is:

(i) the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) at the election of the policyholder, a policy described in clause (4), except that the policy may be one that is offered and available for issuance to new enrollees that is offered by any issuer;

(3) paragraph (b), clause (6), is any Medicare supplement policy offered by any issuer;

(4) paragraph (b), clause (7), is a Medicare supplement policy that has a benefit package classified as a basic plan under section 62A.316 if the enrollee's existing Medicare supplement policy is a basic plan or, if the enrollee's existing Medicare supplement policy is an extended basic plan under section 62A.315, a basic or extended basic plan at the option of the enrollee, provided that the policy is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage. The issuer must permit the enrollee to retain all optional benefits contained in the enrollee's existing coverage, other than outpatient prescription drugs, subject to the provision that the coverage be offered and available for issuance to new enrollees by the same issuer.

(f)(1) At the time of an event described in paragraph (b), because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer

terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in paragraph (b), because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated within ten working days of the issuer receiving notification of disenrollment.

(g) Reference in this subdivision to a situation in which, or to a basis upon which, an individual's coverage has been terminated does not provide authority under the laws of this state for the termination in that situation or upon that basis.

(h) An individual's rights under this subdivision are in addition to, and do not modify or limit, the individual's rights under subdivision 1h.

[For text of subd 2, see M.S.2004]

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 Advantage 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, for purposes of section 62A.36, 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 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 Part A or B, to the extent recognized as reasonable and medically necessary by Medicare.

(p) "Medicare Advantage 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 Advantage medical savings account; and

(3) Medicare Advantage 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 105-33), Sections 1851 to 1859 of the Social Security Act establishing Part C of the Medicare program, known as the "Medicare Advantage 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, other than 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. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan that provides benefits under an agreement under section 1833(a)(1)(A) of the Social Security Act.

(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.

(w) "Outpatient prescription drug" means a prescription drug prescribed or administered under circumstances that qualify for coverage under Medicare Part D and not under Medicare Part A or Part B.

Subd. 4. **Prohibited policy provisions.** (a) A Medicare supplement policy or certificate in force in the state shall not contain benefits that duplicate benefits provided by Medicare or contain exclusions on coverage that are more restrictive than those of Medicare. Duplication of benefits is permitted to the extent permitted under subdivision 1s, paragraph (a), for benefits provided by Medicare Part D.

(b) No Medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions, except as permitted under subdivision 1b.

[For text of subds 5 and 6, see M.S.2004]

Subd. 7. **Medicare prescription drug benefit.** If Congress enacts legislation creating a prescription drug benefit in the Medicare program, nothing in this section or any other section shall prohibit an issuer of a Medicare supplement policy from offering this prescription drug benefit consistent with the applicable federal law or regulations.

History: *2005 c 17 art 1 s 1-9; 2005 c 132 s 10*

62A.315 EXTENDED BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.

The extended basic Medicare supplement plan must have a level of coverage so that it will be certified as a qualified plan pursuant to section 62E.07, and will provide:

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

(2) coverage for the daily co-payment amount of Medicare Part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, and the Medicare Part B deductible amount;

(4) 80 percent of the usual and customary hospital and medical expenses and supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation established by the Medicare program or state law, the usual and customary hospital and medical expenses and supplies, described in section 62E.06, subdivision 1, while in a foreign country; and prescription drug expenses, not covered by Medicare. An outpa-

tient prescription drug benefit must not be included for sale or issuance in a Medicare supplement policy or certificate issued on or after January 1, 2006;

(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;

(6) 100 percent of the cost of immunizations not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer, including mammograms and pap smears;

(7) preventive medical care benefit: coverage for the following preventive health services not covered by Medicare:

(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) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically 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 any procedure covered by Medicare;

(8) at-home recovery benefit: 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 shall 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 aide, 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 medically necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $100 per visit;

(III) $4,000 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 unpaid volunteers or providers who are not care providers.

History: *2005 c 17 art 1 s 10; 2005 c 132 s 11*

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 co-payment amount of Medicare Part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the coinsurance amount, or in the case of outpatient department services paid under a prospective payment system, the co-payment 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;

(6) 100 percent of the cost of immunizations not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer screening including mammograms and pap smears; and

(7) 80 percent of coverage for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes not otherwise covered under Part D of the Medicare program. Coverage must include persons with gestational, type I, or type II diabetes.

(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. An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare policy or certificate issued on or after January 1, 2006;

(5) preventive medical care benefit coverage for the following preventative health services not covered by Medicare:

(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) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically 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). An outpatient prescription drug benefit must not be

included for sale or issuance in a Medicare policy or certificate issued on or after January 1, 2006.

History: *2005 c 17 art 1 s 11; 2005 c 132 s 12*

62A.318 MEDICARE SELECT POLICIES AND CERTIFICATES.

Subdivision 1. **Applicability and advertising limitation.** (a) This section applies to Medicare select policies and certificates, as defined in this section, including those issued by health maintenance organizations.

(b) No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

Subd. 2. **Definitions.** For the purposes of this section:

(1) "complaint" means any dissatisfaction expressed by an individual concerning a Medicare select issuer or its network providers;

(2) "grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare select issuer or its network providers;

(3) "Medicare select issuer" means an issuer offering, or seeking to offer, a Medicare select policy or certificate;

(4) "Medicare select policy" or "Medicare select certificate" means a Medicare supplement policy or certificate that contains restricted network provisions;

(5) "network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy or certificate;

(6) "restricted network provision" means a provision that conditions the payment of benefits, in whole or in part, on the use of network providers; and

(7) "service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare select policy or certificate.

Subd. 3. **Review by commissioner.** The commissioner may authorize an issuer to offer a Medicare select policy or certificate pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, Public Law 101-508, if the commissioner finds that the issuer has satisfied all of the requirements of Minnesota Statutes.

Subd. 4. **Approval; plan of operation.** A Medicare select issuer shall not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

Subd. 5. **Contents of plan of operation.** A Medicare select issuer shall file a proposed plan of operation with the commissioner, in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(i) the services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

(ii) the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(A) to deliver adequately all services that are subject to a restricted network provision; or

(B) to make appropriate referrals;

(iii) there are written agreements with network providers describing specific responsibilities;

(iv) emergency care is available 24 hours per day and seven days per week; and

(v) in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against an individual insured under a Medicare select policy or certificate. This section does not apply to supplemental charges or coinsurance amounts as stated in the Medicare select policy or certificate;

(2) a statement or map providing a clear description of the service area;

(3) a description of the grievance procedure to be used;

(4) a description of the quality assurance program, including:

(i) the formal organizational structure;

(ii) the written criteria for selection, retention, and removal of network providers; and

(iii) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted;

(5) a list and description, by specialty, of the network providers;

(6) copies of the written information proposed to be used by the issuer to comply with paragraph (i); and

(7) any other information requested by the commissioner.

Subd. 6. **Filing of proposed changes; deemed approval.** A Medicare select issuer shall file proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner before implementing the changes. The changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

An updated list of network providers shall be filed with the commissioner at least quarterly.

Subd. 7. **Nonnetwork providers; limits on coverage restrictions.** A Medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or condition; and

(2) it is not reasonable to obtain the services through a network provider.

Subd. 8. **Full payment; services not available in network.** A Medicare select policy or certificate shall provide payment for full coverage under the policy or certificate for covered services that are not available through network providers.

Subd. 9. **Required disclosures.** A Medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare select policy or certificate to each applicant. This disclosure must include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate with:

(i) other Medicare supplement policies or certificates offered by the issuer; and

(ii) other Medicare select policies or certificates;

(2) a description, including address, phone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are used;

(4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

(7) a description of the Medicare select issuer's quality assurance program and grievance procedure.

Subd. 10. **Proof of disclosure.** Before the sale of a Medicare select policy or certificate, a Medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to paragraph (i) and that the applicant understands the restrictions of the Medicare select policy or certificate.

Subd. 11. **Grievance procedures.** A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure must be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances must be considered in a timely manner and must be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action must be taken promptly.

(5) All concerned parties must be notified about the results of a grievance.

(6) The issuer shall report no later than March 31 of each year to the commissioner regarding the grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of the grievances.

Subd. 12. **Offer of alternative product required.** At the time of initial purchase, a Medicare select issuer shall make available to each applicant for a Medicare select policy or certificate the opportunity to purchase a Medicare supplement policy or certificate otherwise offered by the issuer.

Subd. 13. **Right to replace with nonnetwork coverage.** (a) At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare select policy or certificate has been in force for six months. If the issuer does not have available for sale a policy or certificate without restrictive network provisions, the issuer shall provide enrollment information for the Minnesota comprehensive health association Medicare supplement plans.

(b) For the purposes of this subdivision, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for Part B excess charges. Coverage for outpatient prescription drugs is not permitted in Medicare supplement policies or certificates issued on or after January 1, 2006.

Subd. 14. **Continuation of coverage under certain circumstances.** (a) Medicare select policies and certificates shall provide for continuation of coverage if the secretary of health and human services determines that Medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare select program to be reauthorized under law or its substantial amendment.

(b) In the event of a determination under paragraph (a), each Medicare select issuer shall make available to each individual insured under a Medicare select policy or certificate the opportunity to purchase a Medicare supplement policy or certificate

offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(c) For the purposes of this subdivision, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this subdivision, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for Part B excess charges. Coverage for outpatient prescription drugs must not be included for sale or issuance of a Medicare supplement policy or certificate issued on or after January 1, 2006.

Subd. 15. **Provision of data required.** A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare select program.

Subd. 16. **Regulation by Commerce Department.** Medicare select policies and certificates under this section shall be regulated and approved by the Department of Commerce.

Subd. 17. **Types of plans.** Medicare select policies and certificates must be either a basic plan or an extended basic plan. Before a Medicare select policy or certificate is sold or issued in this state, the applicant must be provided with an explanation of coverage for both a Medicare select basic and a Medicare select extended basic policy or certificate and must be provided with the opportunity of purchasing either a Medicare select basic or a Medicare select extended basic policy. The basic plan may also include any of the optional benefit riders authorized by section 62A.316. Preventive care provided by Medicare select policies or certificates must be provided as set forth in section 62A.315 or 62A.316, except that the benefits are as defined in chapter 62D.

History: *2005 c 17 art 1 s 12*

62A.36 LOSS RATIO STANDARDS.

Subdivision 1. **Loss ratio standards and refund provisions.** (a) For purposes of this section, "Medicare supplement policy or certificate" has the meaning given in section 62A.31, subdivision 3, but also includes a policy, contract, or certificate issued under a contract under section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

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

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

These ratios must be calculated based upon 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. For purposes of this calculation, "health care expenses" has the meaning given in section 62A.31, subdivision 3, paragraph (j). An insurer shall demonstrate that the third year loss ratio is greater than or equal to the applicable percentage.

All filings of rates and rating schedules shall demonstrate that 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 or certificate shall equal or exceed the appropriate loss ratio standards.

An application form for a Medicare supplement policy or certificate, as defined in this section, must prominently disclose the anticipated loss ratio and explain what it means.

(b) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the National Association of Insurance Commissioners Medicare Supplement Refund Calculating form, for each type of Medicare supplement benefit plan.

If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation must be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week treasury bills. A refund or credit against premiums due shall be made by September 30 following the experience year on which the refund or credit is based.

(c) An issuer of Medicare supplement policies and certificates in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy or certificate 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. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but before the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(1) a premium adjustment that is necessary to produce an expected loss ratio under the policy or certificate that will conform with minimum loss ratio standards for Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy or certificate other than the adjustments described herein shall be made with respect to a policy or certificate at any time other than on its renewal date or anniversary date;

(2) if an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits considered necessary to achieve the loss ratio required by this section;

(3) any appropriate riders, endorsements, or policy or certificate forms needed to accomplish the Medicare supplement insurance policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy or certificate forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(d) The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of a refund or credit for the reporting period. Public notice

of the hearing shall be furnished in a manner considered appropriate by the commissioner.

(e) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with, and approved by, the commissioner according to the filing requirements and procedures prescribed by the commissioner.

(f) An issuer must file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

(g) Issuers are permitted to continue to issue currently approved policy and certificate forms as appropriate through December 31, 2005.

(h) Issuers must comply with any requirements to notify enrollees under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[For text of subds 1a to 2, see M.S.2004]

History: *2005 c 17 art 1 s 13*

PRESCRIPTION DRUG PLANS

62A.451 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62A.451 to 62A.4528, the terms defined in this section have the meanings given.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 3. **Enrollee.** "Enrollee" means an individual who is entitled to limited health services under a contract with an entity authorized to provide or arrange for such services under sections 62A.451 to 62A.4528.

Subd. 4. **Evidence of coverage.** "Evidence of coverage" means the certificate, agreement, or contract issued under section 62A.4516 setting forth the coverage to which an enrollee is entitled.

Subd. 5. **Limited health service.** "Limited health service" means pharmaceutical services covered under Medicare Part D. Limited health service does not include hospital, medical, surgical, or emergency services.

Subd. 6. **Prepaid limited health service organization.** "Prepaid limited health service organization" means any corporation, partnership, or other entity that, in return for a prepayment, undertakes to provide or arrange for the provision of limited health services to enrollees. Prepaid limited health service organization does not include:

(1) an entity otherwise authorized under the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service;

(2) an entity that meets the requirements of section 62A.4514; or

(3) a provider or entity when providing or arranging for the provision of limited health services under a contract with a prepaid limited health service organization or with an entity described in clause (1) or (2).

Subd. 7. **Provider.** "Provider" means a physician, pharmacist, health facility, or other person or institution that is licensed or otherwise authorized to deliver or furnish limited health services under sections 62A.451 to 62A.4528.

Subd. 8. **Subscriber.** "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services under a contract with an entity authorized to provide or arrange for such services under sections 62A.451 to 62A.4528.

History: *2005 c 17 art 2 s 1*

62A.4511 CERTIFICATE OF AUTHORITY REQUIRED.

No person, corporation, partnership, or other entity may operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner under sections 62A.451 to 62A.4528.

History: *2005 c 17 art 2 s 2*

62A.4512 APPLICATION FOR CERTIFICATE OF AUTHORITY.

An application for a certificate of authority to operate a prepaid limited health service organization must be filed with the commissioner on a form prescribed by the commissioner. The application must be verified by an officer or authorized representative of the applicant and must set forth, or be accompanied by, the following:

(1) a copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments to these documents;

(2) a copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs;

(3) a list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association;

(4) a statement generally describing the applicant, its facilities, personnel, and the limited health services to be offered;

(5) a copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees;

(6) a copy of the form of any contract made or to be made between the applicant and any person listed in clause (3);

(7) a copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any functions including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of limited health services to enrollees;

(8) a copy of the form of any group contract that is to be issued to employers, unions, trustees, or other organizations and a copy of any form of evidence of coverage to be issued to subscribers;

(9) a copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, satisfies this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of sections 62A.451 to 62A.4528;

(10) a copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

(11) a statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served in accordance with section 45.028;

(12) a description of how the applicant will comply with section 62A.4523; and

(13) such other information as the commissioner may reasonably require to make the determinations required by sections 62A.451 to 62A.4528.

History: *2005 c 17 art 2 s 3*

62A.4513 ISSUANCE OF CERTIFICATE OF AUTHORITY; DENIAL.

Subdivision 1. **Issuance.** Following receipt of an application filed under section 62A.4512, the commissioner shall review the application and notify the applicant of any deficiencies. The commissioner must approve or deny an application within 90 days after receipt of a substantially complete application, or the application is deemed approved. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:

(1) the requirements of section 62A.4512 have been fulfilled;

(2) the individuals responsible for conducting the applicant's affairs are competent, trustworthy, and possess good reputations, and have had appropriate experience, training, or education;

(3) the applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:

(i) the financial soundness of the applicant's arrangements for limited health services;

(ii) the adequacy of working capital, other sources of funding, and provisions for contingencies;

(iii) any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization; and

(iv) the manner in which the requirements of section 62A.4523 have been fulfilled; and

(4) any deficiencies identified by the commissioner have been corrected.

Subd. 2. **Denials.** If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The prepaid limited health service organization has 30 days from the date of receipt of the notice to request a hearing before the commissioner under chapter 14.

History: *2005 c 17 art 2 s 4*

62A.4514 FILING REQUIREMENTS FOR AUTHORIZED ENTITIES.

(a) An entity authorized under the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health service plan corporation, a fraternal benefit society, or a multiple employer welfare arrangement, and that is not otherwise authorized under the laws of this state to offer limited health services on a per capita or fixed prepayment basis, may do so by filing for approval with the commissioner the information requested by section 62A.4512, clauses (4), (5), (7), (8), and (10), and any subsequent material modification or addition to those provisions.

(b) If the commissioner disapproves the filing, the procedures provided in section 62A.4513, subdivision 2, must be followed.

History: *2005 c 17 art 2 s 5*

62A.4515 MATERIAL MODIFICATIONS.

Subdivision 1. **Material modifications.** A prepaid limited health service organization shall file with the commissioner prior to use, a notice of any material modification of any matter or document furnished under section 62A.4512, together with supporting documents necessary to fully explain the modification. If the commissioner does not disapprove the filing within 60 days of its filing, the filing is deemed approved.

Subd. 2. **Procedure for disapproval.** If a filing under this section is disapproved, the commissioner shall notify the prepaid limited health service organization and specify the reasons for disapproval in the notice. The prepaid limited health service organization has 30 days from the date of receipt of notice to request a hearing before the commissioner under chapter 14.

History: *2005 c 17 art 2 s 6*

62A.4516 EVIDENCE OF COVERAGE.

Every subscriber must be issued an evidence of coverage consistent with the requirements of Medicare Part D.

History: *2005 c 17 art 2 s 7*

62A.4517 CONSTRUCTION WITH OTHER LAWS.

Subdivision 1. **Application of other insurance laws.** (a) A prepaid limited health service organization organized under the laws of this state is deemed to be a domestic insurer for purposes of chapter 60D unless specifically exempted in writing from one or more of the provisions of that chapter by the commissioner, based upon a determination that the provision is not applicable to the organization or to providing coverage under Medicare Part D.

(b) No other provision of chapters 60 to 72C applies to a prepaid limited health service organization unless such an organization is specifically mentioned in the provision.

Subd. 2. **Not a healing art.** The provision of limited health services by a prepaid limited health service organization or other entity under sections 62A.451 to 62A.4528 must not be deemed to be the practice of medicine or other healing arts.

Subd. 3. **Solicitation and advertising.** Solicitation to arrange for or provide limited health services in accordance with sections 62A.451 to 62A.4528 shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

History: *2005 c 17 art 2 s 8*

62A.4518 NONDUPLICATION OF COVERAGE.

Notwithstanding any other law of this state, a prepaid limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health service plan corporation, or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services, whether in the form of services, supplies, or reimbursement, insofar as the coverage or service is provided in accordance with sections 62A.451 to 62A.4528 under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization, a health maintenance organization, an accident and health insurance company, a nonprofit health service corporation, or a fraternal benefit society.

History: *2005 c 17 art 2 s 9*

62A.4519 COMPLAINT SYSTEM.

Every prepaid limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers, consistent with the requirements of Medicare Part D.

History: *2005 c 17 art 2 s 10*

62A.4520 EXAMINATION OF ORGANIZATION.

(a) The commissioner may examine the affairs of any prepaid limited health service organization as often as is reasonably necessary to protect the interests of the people of this state, but not less frequently than once every three years.

(b) Every prepaid limited health service organization shall make its relevant books and records available for an examination and in every way cooperate with the commissioner to facilitate an examination.

(c) In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state.

History: *2005 c 17 art 2 s 11*

62A.4521 INVESTMENTS.

The funds of a prepaid limited health service organization shall be invested only in accordance with the guidelines under chapter 62D for investments by health maintenance organizations.

History: *2005 c 17 art 2 s 12*

62A.4522 AGENTS.

No individual may apply, procure, negotiate, or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license or is otherwise authorized to sell accident and health insurance policies, nonprofit health service plan contracts, or health maintenance organization contracts.

History: *2005 c 17 art 2 s 13*

62A.4523 PROTECTION AGAINST INSOLVENCY; DEPOSIT.

Subdivision 1. **Net equity.** (a) Except as approved in accordance with subdivision 4, each prepaid limited health service organization shall at all times have and maintain tangible net equity equal to the greater of:

(1) $100,000; or

(2) two percent of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

(b) A prepaid limited health service organization that has uncovered expenses in excess of $100,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to 25 percent of the uncovered expense in excess of $100,000 in addition to the tangible net equity required by paragraph (a).

Subd. 2. **Definitions.** For the purpose of this section:

(1) "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner; and

(2) "tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; start-up costs; long-term prepayments of deferred charges; nonreturnable deposits; and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates and that are not past due.

Subd. 3. **Deposit.** (a) Each prepaid limited health service organization shall deposit with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the commissioner, in an amount equal to $50,000 plus 25 percent of the tangible net equity required in subdivision 1; provided, however, that the deposit must not be required to exceed $200,000.

(b) The deposit is an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.

(c) All income from deposits is an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or

any part of it after making a substitute deposit of equal amount and value. Any securities must be approved by the commissioner before being substituted.

(d) The deposit must be used to protect the interests of the prepaid limited health service organization's enrollees and to ensure continuation of limited health care services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit is an asset subject to provisions of chapter 60B.

(e) The commissioner may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

Subd. 4. **Waiver of net equity requirement.** Upon application by a prepaid limited health service organization, the commissioner may waive some or all of the requirements of subdivision 1 for any period of time the commissioner deems proper upon a finding that either:

(1) the prepaid limited health service organization has a net equity of at least $10,000,000; or

(2) an entity having a net equity of at least $10,000,000 furnishes to the commissioner a written commitment, acceptable to the commissioner, to provide for the uncovered expenses of the prepaid limited health service organization.

Subd. 5. **Definition; uncovered expenses.** For the purposes of this section, "uncovered expense" means the cost of health care services that are the obligation of a prepaid limited health organization (1) for which an enrollee may be liable in the event of the insolvency of the organization and (2) for which alternative arrangements acceptable to the commissioner have not been made to cover the costs. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, must be considered a covered expense.

History: *2005 c 17 art 2 s 14*

62A.4524 OFFICER'S AND EMPLOYEE'S FIDELITY BOND.

(a) A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than $20,000,000 or in any other amount prescribed by the commissioner. Except as otherwise provided by this paragraph, the bond must be issued by an insurance company that is licensed to do business in this state or, if the fidelity bond required by this paragraph is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed surplus lines agent resident in this state in compliance with sections 60A.195 to 60A.2095 satisfies the requirements of this paragraph.

(b) In lieu of the bond specified in paragraph (a), a prepaid limited health service organization may deposit with the commissioner cash or securities or other investments of the types set forth in section 62A.4521. Such a deposit must be maintained by the commissioner in the amount and subject to the same conditions required for a bond under this paragraph.

History: *2005 c 17 art 2 s 15*

62A.4525 REPORTS.

(a) Every prepaid limited health service organization shall file with the commissioner annually, on or before April 1, a report verified by at least two principal officers covering the preceding calendar year.

(b) The report must be on forms prescribed by the commissioner and must include:

(1) a financial statement of the organization, including its balance sheet, income statement, and statement of changes in financial position for the preceding year, certified by an independent public accountant, or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which must be consolidating financial statements of the prepaid limited health service organization;

(2) the number of subscribers at the beginning of the year, the number of subscribers at the end of the year, and the number of enrollments terminated during the year; and

(3) such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out the commissioner's duties under sections 62A.451 to 62A.4528.

(c) The commissioner may require more frequent reports containing information necessary to enable the commissioner to carry out the commissioner's duties under sections 62A.451 to 62A.4528.

(d) The commissioner may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

History: *2005 c 17 art 2 s 16*

62A.4526 SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY.

Subdivision 1. **Grounds for suspension or revocation.** The commissioner may suspend or revoke the certificate of authority issued to a prepaid limited health service organization under sections 62A.451 to 62A.4528 upon determining that any of the following conditions exist:

(1) the prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62A.4512, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the prepaid limited health service organization issues an evidence of coverage that does not comply with the requirements of section 62A.4516;

(3) the prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services;

(4) the prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(5) the tangible net equity of the prepaid limited health service organization is less than that required by section 62A.4523 or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

(6) the prepaid limited health service organization has failed to implement in a reasonable manner the complaint system required by section 62A.4519;

(7) the continued operation of the prepaid limited health service organization would be hazardous to its enrollees; or

(8) the prepaid limited health service organization has otherwise failed to comply with sections 62A.451 to 62A.4528.

Subd. 2. **Procedure for suspension or revocation.** If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than 60 days after the date of notification for a hearing on the matter in accordance with chapter 14.

Subd. 3. **Winding up after revocation.** When the certificate of authority of a prepaid limited health service organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its

affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

History: *2005 c 17 art 2 s 17*

62A.4527 PENALTIES.

In lieu of any penalty specified elsewhere in sections 62A.451 to 62A.4528, or when no penalty is specifically provided, whenever a prepaid limited health service organization or other person, corporation, partnership, or entity subject to those sections has been found, pursuant to chapter 14, to have violated any provision of sections 62A.451 to 62A.4528, the commissioner may:

(1) issue and cause to be served upon the organization, person, or entity charged with the violation a copy of the findings and an order requiring the organization, person, or entity to cease and desist from engaging in the act or practice that constitutes the violation; and

(2) impose a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $10,000.

History: *2005 c 17 art 2 s 18*

62A.4528 REHABILITATION, CONSERVATION, OR LIQUIDATION.

(a) Any rehabilitation, conservation, or liquidation of a prepaid limited health service organization must be deemed to be the rehabilitation, conservation, or liquidation of an insurance company and must be conducted under chapter 60B.

(b) A prepaid limited health service organization is not subject to the laws and rules governing insurance insolvency guaranty funds, nor shall any insurance insolvency guaranty fund provide protection to individuals entitled to receive limited health services from a prepaid limited health service organization.

History: *2005 c 17 art 2 s 19*