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Checklist Guide: Minnesota Medicare Requirements

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The following information has been compiled as a Checklist Guide for Commerce Department analysts to use in reviewing Medicare product filings submitted to the Department for approval in Minnesota. The Checklist Guide is designed as an internal Commerce Department resource to outline certain state or federal laws that could apply to provisions typically found in major medical certificates or policy forms. It may be periodically updated to reflect statutory changes. Additional state or federal law requirements may exist to the extent they apply to provisions not typically found in policy forms or certificates. Compliance with these additional requirements, if applicable to the product filing, would still be required even though they are not listed in this Checklist Guide.

NOTE: While the Department is making this Checklist Guide publicly available, this is meant only to be a guide to assist you with your product filings. This list is in no way exhaustive or a complete statement of all requirements and provisions that might be applicable. Please note that the Checklist Guide may only include part of an applicable law or regulation. Therefore, Companies or health plans should refer to all relevant Minnesota Statutes and Rules as well as applicable Federal law in developing product filings that they submit to the Department for approval. To the extent the provisions in this Checklist Guide conflict with state or federal law, companies making filings should comply with the language of state or federal law. This Checklist Guide is a representation of general provisions and should not be construed as a legal opinion or advice.

Helpful information and definitions:

Medicare -- Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). *Medicare.gov*

Medicare open enrollment begins on October 15th and ends on December 7th. This is the only time of the year when everyone on Medicare can makes changes to their coverage for the upcoming year. New coverage will begin on January 1.

Medicare Advantage -- A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. *Medicare.gov* (***Special note:*** *These plans are filed as informational only. Currently no policy review.)*

Medicare Cost Plans --A Medicare Cost Plan is a type of Medicare health plan offered through a private insurance company. Cost Plans are not Medicare Advantage Plans. Plans contract with Medicare to cover the same services and benefits offered under Original Medicare within the plan's network. However, you can choose to see providers outside of the Cost Plan network. If you receive Medicare-approved services outside the plan network, Original Medicare will be billed. You may then be responsible for the cost-sharing (deductibles, co-insurance and co-payments) not covered under Original Medicare. *http://www.mnaging.net/hcc*

Medicare Supplement (Medigap) Insurance -- Private insurance policies that can be purchased to "fill-in the gaps" and pay for certain out-of-pocket expenses (like deductibles and coinsurance) not covered by original Medicare (Part A and Part B) *Medicare.gov* . All medigap plans offer the same basic benefits but some offeradditional benefits, so you can choose which one meets your needs.In Minnesota, the Medigap plans that are offered: Basic, extended basic, K, L, M, N, and high deductible F. Plans E,H, I and J are no longer sold. (*http://www.medicare.gov/supplement-other-insurance/compare-medigap/minnesota/medigap-minnesota.html*)

Medicare Select Plans -- A type of Medigap policy that may require the Medicare Beneficiary to use hospitals and, in some cases, doctors within its network to be eligible for full benefits. *Medicare.gov* Minn. Stat. 62A.318 governs Medicare Select plans.

Special note: *Any wording you see colored in "red" is a note. If you see the symbol " ◊", this denotes a mandate for which a specific contractual reference is required.*

MINNESOTA SPECIFIC REQUIREMENTS

60A.06 KINDS OF INSURANCE PERMITTED.

Subdivision 1.Statutory lines. Insurance corporations may be authorized to transact in any state or territory in the United States, in the Dominion of Canada, and in foreign countries, when specified in their charters or certificates of incorporation, either as originally granted or as thereafter amended, any of the following kinds of business, upon the stock plan, or upon the mutual plan when the formation of such mutual companies is otherwise authorized by law; and business trusts as authorized by law of this state shall only be authorized to transact in this state the following kind of business hereinafter specified in clause (7) hereof when specified in their "declaration of trust":

(4) To make contracts of life and endowment insurance, to grant, purchase, or dispose of annuities or endowments of any kind; and, in such contracts, or in contracts supplemental thereto to provide for additional benefits in event of death of the insured by accidental means, total permanent disability of the insured, or specific dismemberment or disablement suffered by the insured, or acceleration of life or endowment or annuity benefits in advance of the time they would otherwise be payable;

(5)(a) To insure against loss or damage by the sickness, bodily injury or death by accident of the assured or dependents, or those for whom the assured has assumed a portion of the liability for the loss or damage, including liability for payment of medical care costs or for provision of medical care;

Subd. 3.Limitation on combination policies.

(a) Unless specifically authorized by subdivision 1, clause (4), it is unlawful to combine in one policy coverage permitted by subdivision 1, clauses (4) and (5)(a). This subdivision does not prohibit the simultaneous sale of these products, but the sale must involve two separate and distinct policies.

(b) This subdivision does not apply to group policies.

(c) This subdivision does not apply to policies permitted by subdivision 1, clause (4), that contain benefits providing acceleration of life, endowment, or annuity benefits in advance of the time they would otherwise be payable, or to long term care policies as defined in section 62A.46, subdivision 2, or chapter 62S.

(d) This subdivision does not prohibit combining life coverage with one or more of the following coverages:
(1) specified disease or illness coverage;
(2) other limited benefit health coverage;
(3) hospital indemnity coverage;
(4) other fixed indemnity products, provided that the prescribed minimum standards applicable to those categories of coverage are met.

◊60A.08 CONTRACTS OF INSURANCE.

Subd. 5.Signatures required. All insurance policies shall be signed by the secretary or an assistant secretary, and by the president or vice-president, or in their absence, by two directors of the insurer. The signatures may be facsimile signatures.

62A.011 DEFINITIONS.

Subd. 2.Health carrier. "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a fraternal benefit society operating under chapter 64B; or a joint self-insurance employee health plan operating under chapter 62H.

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

(10) issued as a supplement to **Medicare**, as defined in sections 62A.3099 to 62A.44, or policies, contracts, or certificates that **supplement Medicare** issued by health maintenance organizations or those policies, contracts, **or certificates governed by section 1833 or 1876**, section 1851, et seq.; or section 1860D-1, et seq., of title XVIII of the federal Social Security Act, et seq., as amended;

◊62A.02 POLICY FORMS.

Subdivision 1.Filing. For purposes of this section, "health plan" means a health plan as defined in section 62A.011 or a policy of accident and sickness insurance as defined in section 62A.01. No health plan shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection with the health plan, until a copy of its form and of the classification of risks and the premium rates pertaining to the form have been filed with the commissioner. The filing for nongroup health plan forms shall include a statement of actuarial reasons and data to support the rate. For health benefit plans as defined in section 62L.02, and for health plans to be issued to individuals, the health carrier shall file with the commissioner the information required in section 62L.08, subdivision 8. For group health plans for which approval is sought for sales only outside of the small employer market as defined in section 62L.02, this section applies only to policies or contracts of accident and sickness insurance. All forms intended for issuance in the individual or small employer market must be accompanied by a statement as to the expected loss ratio for the form. Premium rates and forms relating to specific insureds or proposed insureds, whether individuals or groups, need not be filed, unless requested by the commissioner.

Subd. 2.Approval.

(a) The health plan form shall not be issued, nor shall any application, rider, endorsement, or rate be used in connection with it, until the expiration of 60 days after it has been filed unless the commissioner approves it before that time.

(b) Notwithstanding paragraph (a), a rate filed with respect to a policy of accident and sickness insurance as defined in section 62A.01 by an insurer licensed under chapter 60A, may be used on or after the date of filing with the commissioner. Rates that are not approved or disapproved within the 60-day time period are deemed approved. This paragraph does not apply to **Medicare-related coverage** as defined in section 62A.3099, subdivision 17.

◊62A.021 HEALTH CARE POLICY RATES.

Subdivision 1.Loss ratio standards. (a) Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, and except as otherwise authorized by section 62A.02, subdivision 3a, for individual policies or certificates, health care policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate benefits not including anticipated refunds or credits, provided under the policies or certificates, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27, calculated on an aggregate basis; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of each policy form or certificate form issued in the individual market; calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. Assessments by the reinsurance association created in chapter 62L and all types of taxes, surcharges, or assessments created by Laws 1992, chapter 549, or created on or after April 23, 1992, are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for policies and certificates issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until a 72 percent loss ratio is reached on July 1, 2000. A health carrier that enters a market after July 1, 1993, does not start at the beginning of the phase-in schedule and must instead comply with the loss ratio requirements applicable to other health carriers in that market for each time period. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

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

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

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

◊62A.03 GENERAL PROVISIONS OF POLICY. (Individual plans only)

Subdivision 1.Conditions.
No policy of individual accident and sickness insurance may be delivered or issued for delivery to a person in this state unless:
(1) Premium. The entire money and other considerations therefor are expressed therein.

(2) Time effective. The time at which the insurance takes effect and terminates is expressed therein.

(3) One person. It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family deemed the policyholder, any two or more eligible members of that family, including:
(a) husband,
(b) wife,
(c) dependent children as described in sections 62A.302 and 62A.3021, or
(d) any other person dependent upon the policyholder.

(4) Appearance. The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-face type of a style in general use. The type size must be uniform and not less than ten point with a lowercase unspaced alphabet length not less than 120 point. The "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, the reference to renewal or cancellation by a separate statement, if any, and the captions and subcaptions.

(5) Description of policy. The policy, on the first page, indicates or refers to its provisions for renewal or cancellation either in the brief description, if any, or by a separate statement printed in type not smaller than the type used for captions or a separate provision bearing a caption which accurately describes the renewability or cancelability of the policy.

(6) Exceptions in policy. The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 62A.04, printed, at the insurer's option, either with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS." However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(7) Form number. Each form, including riders and endorsements, is identified by a form number in the lower left hand corner of the first page thereof.

(8) No incorporation by reference. It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates, classification of risks, or short rate table filed with the commissioner.

(9) Medical benefits. If the policy contains a provision for medical expense benefits, the term "medical benefits" or similar terms as used therein includes treatments by all licensed practitioners of the healing arts unless, subject to the qualifications contained in clause (10), the policy specifically states the practitioners whose services are covered.

(10) Osteopath, optometrist, chiropractor, or registered nurse services. With respect to any policy of individual accident and sickness insurance issued or entered into subsequent to August 1, 1974, notwithstanding the provisions of the policy, if it contains a provision providing for reimbursement for any service which is in the lawful scope of practice of a duly licensed osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, the person entitled to benefits or person performing services under the policy is entitled to reimbursement on an equal basis for the service, whether the service is performed by a physician, osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, licensed under the laws of this state.

◊62A.04 STANDARD PROVISIONS.

Subd. 2.Required provisions.

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

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

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

(3)(a) Except as required for qualified health plans sold through MNsure to individuals receiving advance payments of the premium tax credit, a provision as follows:

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

A policy which contains a cancellation provision may add, at the end of the above provision, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

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

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

(b) For qualified health plans sold through MNsure to individuals receiving advance payments of the premium tax credit, a grace period provision must be included that complies with the Affordable Care Act and is no less restrictive than the grace period required by the Affordable Care Act.

(4) A provision as follows:
REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. **For health plans described in section 62A.011, subdivision 3, clause (10), an insurer must accept payment of a renewal premium and reinstate the policy, if the insured applies for reinstatement no later than 60 days after the due date for the premium payment, unless:**
(1) the insured has in the interim left the state or the insurer's service area; or
(2) the insured has applied for reinstatement on two or more prior occasions.

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 10.Return of premium.

A policy of accident and sickness insurance as defined in section 62A.01 may contain or may be amended by rider to provide for a return of premium benefit so long as:

(1) the return of premium benefit is not applicable until the policy has been in force for five years;

(2) the return of premium benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy;

(3) the return of premium benefit is not included in or used with a policy with benefits that are reduced based on an insured's age;

(4) the return of premium benefit is not payable in lieu of benefits at the option of the insurer;

(5) the insurer demonstrates that the reserve basis for such benefit is adequate; and

(6) the cost of the benefit is disclosed to the insured and the insured is given the option of the coverage.

◊62A.043 DENTAL AND PODIATRIC COVERAGE.

Subdivision 1.Policies and contracts covered.
The provisions of this section shall apply to all individual or group policies or subscriber contracts providing payment for care in this state, which policies or contracts are issued or renewed after August 1, 1976 by an accident and health insurance company regulated under this chapter, or a nonprofit health service plan corporation regulated under chapter 62C.

Subd. 2.Services covered.
Any policy or contract referred to in subdivision 1 which provides coverage for services which can be lawfully performed within the scope of the license of a duly licensed dentist or podiatrist, shall provide benefits for such services whether performed by a duly licensed physician, dentist or podiatrist.

Subd. 3.Disorders covered.
Except for policies which only provide coverage for specified diseases, no policy or certificate of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D, shall be issued, renewed, continued, delivered, issued for delivery, or executed in this state after August 1, 1987, unless the policy, plan, or contract specifically **provides coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder.** Coverage shall be the same as that for treatment to any other joint in the body, and shall apply if the treatment is administered or prescribed by a physician or dentist.

62A.044 PAYMENTS TO GOVERNMENTAL INSTITUTIONS.

No group or individual policy of accident and sickness insurance issued or renewed after May 22, 1973, pursuant to this chapter, no group or individual service plan or subscriber contract issued or renewed after May 22, 1973, pursuant to chapter 62C, and no group or individual health maintenance contract issued or renewed after August 1, 1984, pursuant to chapter 62D, shall contain any provision excluding, denying, or prohibiting payments for covered and authorized services rendered or paid by a hospital or medical institution owned or operated by the federal, state, or local government, including correctional facilities, or practitioners therein in any instance wherein charges for such services are imposed against the policyholder, subscriber, or enrollee. The unit of government operating the institution may maintain an action for recovery of such charges.

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256; 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

62A.046 COORDINATION OF BENEFITS.

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

Subd. 6.Coordination of benefits.

Insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations may coordinate benefits to prohibit greater than 100 percent coverage when an insured, subscriber, or enrollee is covered by both an individual and a group contract providing coverage for hospital and medical treatment or expenses. Benefits coordinated under this paragraph must provide for 100 percent coverage of an insured, subscriber, or enrollee. To the extent appropriate, all coordination of benefits provisions currently applicable by law or rule to insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations, shall apply to coordination of benefits between individual and group contracts. Notwithstanding the definition of "plan" in Minnesota Rules, parts 2742.0200, subpart 2, and 4685.0910, subpart 7, an individual contract must coordinate benefits with a group contract under this subdivision consistent with applicable coordination of benefit rules. When a covered person's other coverage is Medicare or TRICARE, a health plan company must determine primacy and coordinate benefits in accordance with the Medicare Secondary Payor or TRICARE provisions of federal law. This subdivision does not apply to specified accident, hospital indemnity, specified disease, or other limited benefit insurance policies.

62A.049 LIMITATION ON PREAUTHORIZATIONS; EMERGENCIES.

No policy of accident and sickness insurance or group subscriber contract regulated under chapter 62C issued or renewed in this state may contain a provision that makes an insured person ineligible to receive full benefits because of the insured's failure to obtain preauthorization, if that failure occurs because of the need for emergency confinement or emergency treatment. The insured or an authorized representative of the insured shall notify the insurer as soon after the beginning of emergency confinement or emergency treatment as reasonably possible. However, to the extent that the insurer suffers actual prejudice caused by the failure to obtain preauthorization, the insured may be denied all or part of the insured's benefits.

62A.081 PAYMENTS TO FACILITIES OPERATED BY STATE OR LOCAL GOVERNMENT.

Every group or individual policy of accident and sickness insurance issued or renewed after July 1, 1973 regulated by this chapter, and every group or individual service plan or subscriber contract issued or renewed after July 1, 1973 regulated by chapter 62C, providing care or payment for care in this state, shall provide payments for services rendered by a hospital or medical facility owned or operated by, or on behalf of, the state or any unit of local government, or practitioners therein, on the same basis as are made for like care in other facilities. The unit of government concerned may maintain an action for recovery of such payments.

62A.095 SUBROGATION CLAUSES REGULATED.

Subd. 2.Subrogation clause; limits. No health plan described in subdivision 1 shall contain a subrogation, reimbursement, or similar clause that provides subrogation, reimbursement, or similar rights to the health carrier issuing the health plan, unless:
(1) the clause provides that it applies only after the covered person has received a full recovery from another source; and
(2) the clause provides that the health carrier's subrogation right is subject to subtraction for actual monies paid to account for the pro rata share of the covered person's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the health carrier is separately represented by an attorney.

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

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

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

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

◊62A.149 BENEFITS FOR ALCOHOLICS AND DRUG DEPENDENTS.(Group plans)

Subdivision 1.Application. The provisions of this section apply to all group policies of accident and health insurance and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, and to a plan or policy that is individually underwritten or provided for a specific individual and family members as a nongroup policy, when the policies or subscriber contracts are issued or delivered in Minnesota or provide benefits to Minnesota residents enrolled thereunder.

This section does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis or policies that provide accident only coverage.

Every insurance policy or subscriber contract included within the provisions of this subdivision, upon issuance or renewal, shall provide coverage that complies with the requirements of section **62Q.47, paragraphs (b) and (c)**, for the treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident entitled to coverage.

◊62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES.

Subd. 2.Minimum benefits. All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage that complies with the requirements of section **62Q.47, paragraphs (b) and (c).**

◊62A.153 OUTPATIENT MEDICAL AND SURGICAL SERVICES.

No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C that provides coverage for services in a hospital shall be issued, renewed, continued, delivered, issued for delivery or executed in this state, or approved for issuance or renewal in this state by the commissioner of commerce unless the policy, plan or contract specifically provides coverage for a health care treatment or surgery on an outpatient basis at a facility equipped to perform these services, whether or not the facility is part of a hospital. Coverage shall be on the same basis as coverage provided for the same health care treatment or service in a hospital.

◊62A.154 BENEFITS FOR DES RELATED CONDITIONS.

Subd. 2.Required coverage. No policy shall be issued or renewed in this state after August 1, 1981 if it provides an exclusion, reduction, or other limitation as to coverage, deductible, coinsurance or co-payment applicable solely to conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol, unless the covered person has been diagnosed as having diethylstilbestrol-related cancer prior to the date on which coverage for that person begins. In the absence of credible evidence of a higher morbidity rate due to exposure to diethylstilbestrol, no insurer shall surcharge or in any other manner increase the premium. If there is credible evidence of a higher morbidity rate due to exposure to diethylstilbestrol, no insurer shall surcharge or in any other manner increase the premium without the prior approval of the commissioner.

Subd. 3.Refusal to issue or renew. No insurer shall refuse to issue or renew a policy, or to provide coverage under a policy, in this state after August 1, 1981 solely because of conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol, unless the covered person has been diagnosed as having diethylstilbestrol-related cancer prior to the date on which an initial premium payment is received by the insurer.

◊62A.155 COVERAGE FOR SERVICES PROVIDED TO VENTILATOR-DEPENDENT PERSONS.

Subd. 2.Required coverage. If a policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1988, provides coverage for services provided by a private duty nurse or personal care assistant to a ventilator-dependent person in the person's home, it must provide coverage for up to 120 hours of services provided by a private duty nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under chapter 144. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

62A.18 PROHIBITION AGAINST DISABILITY OFFSETS.

No individual or group policy of accident and health insurance issued, amended, renewed, or delivered in this state on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit under the policy by the amount of, or in proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, the Railroad Retirement Act, any Veteran's Disability Compensation and Survivor Benefits Act, Workers' Compensation, or any similar federal or state law, as amended subsequent to the date of commencement of such benefit.

62A.22 REFUSAL TO PROVIDE COVERAGE BECAUSE OF OPTION UNDER WORKERS' COMPENSATION.

No insurer offering an individual or group policy of accident or health coverage in this state shall refuse to provide or renew accident or health coverage because the insured has an option to elect workers' compensation coverage pursuant to section 176.041, subdivision 1a.

◊62A.25 RECONSTRUCTIVE SURGERY.

Subd. 2.Required coverage.
(a) Every policy, plan, certificate or contract to which this section applies shall provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.

(b) The coverage limitations on reconstructive surgery in paragraph (a) do not apply to reconstructive breast surgery following mastectomies. In these cases, coverage for reconstructive surgery must be provided if the mastectomy is medically necessary as determined by the attending physician.

(c) Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient. Coverage may be subject to annual deductible, co-payment, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Coverage may not:

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

Written notice of the availability of the coverage must be delivered to the participant upon enrollment and annually thereafter.

◊62A.265 COVERAGE FOR LYME DISEASE.

Subdivision 1.Required coverage. Every health plan, including a plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), must cover treatment for diagnosed Lyme disease.

Subd. 2.Special restrictions prohibited. No health plan included in subdivision 1 may impose a special deductible, co-payment, waiting period, or other special restriction on treatment for Lyme disease that the health plan does not apply to nonpreventive treatment in general.

◊62A.28 COVERAGE FOR SCALP HAIR PROSTHESES.

Subd. 2.Required coverage.
Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1987, must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata.

The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items under the policy, plan, certificate, or contract and may be limited to one prosthesis per benefit year.

◊62A.30 COVERAGE FOR DIAGNOSTIC PROCEDURES FOR CANCER.

Subd. 2.Required coverage.

Every policy, plan, certificate, or contract referred to in subdivision 1 that provides coverage to a Minnesota resident must provide coverage for routine screening procedures for cancer and the office or facility visit, including mammograms, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer as defined in subdivision 3, pap smears, and colorectal screening tests for men and women, when ordered or provided by a physician in accordance with the standard practice of medicine.

Subd. 3.Ovarian cancer surveillance tests.

For purposes of subdivision 2:

(a) "At risk for ovarian cancer" means:

(1) having a family history:
(i) with one or more first- or second-degree relatives with ovarian cancer;
(ii) of clusters of women relatives with breast cancer; or
(iii) of nonpolyposis colorectal cancer; or
(2) testing positive for BRCA1 or BRCA2 mutations.

(b) "Surveillance tests for ovarian cancer" means annual screening using:
(1) CA-125 serum tumor marker testing;
(2) transvaginal ultrasound;
(3) pelvic examination; or
(4) other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

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

Subd. 2.Requirement.

Coverage described in subdivision 1 that covers prescription drugs must provide the same coverage for a prescription written by a health care provider authorized to prescribe the particular drug covered by the health coverage described in subdivision 1, regardless of the type of health care provider that wrote the prescription. This section is intended to prohibit denial of coverage based on the prescription having been written by an advanced practice nurse under section 148.235, a physician assistant under section 147A.18, or any other nonphysician health care provider authorized to prescribe the particular drug.

◊62A.3093 COVERAGE FOR DIABETES.

Subdivision 1.Required coverage.

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

Subd. 2.Medicare Part D exception.
A health plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), **is not subject to the requirements of subdivision 1, clause (1), with respect to equipment and supplies covered under the Medicare Part D Prescription Drug program,** whether or not the covered person is enrolled in a Medicare Part D plan.

This subdivision does not apply to a health plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), that was in effect on December 31, 2005, if the covered person remains enrolled in the plan and does not enroll in a Medicare Part D plan.

◊62A.3091 NONDISCRIMINATE COVERAGE OF TESTS.

Subd. 2.Requirement.
Coverage described in subdivision 1 that covers laboratory tests, diagnostic tests, and x-rays must provide the same coverage, without requiring additional signatures, for all such tests ordered by an advanced practice nurse operating pursuant to chapter 148. Nothing in this section shall be construed to interfere with any written agreement between a physician and an advanced practice nurse.

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

Subd. 2.Requirement.

Coverage described in subdivision 1 that provides for payment for surgical first assisting benefits or services shall be construed as providing for payment for a registered nurse who performs first assistant functions and services that are within the scope of practice of a registered nurse.

62A.3099 DEFINITIONS.

Subdivision 1.Scope.

The definitions provided in this section apply to sections 62A.3099 to 62A.44.

Subd. 13.Issuer.

"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.

Subd. 14.Medicare.

"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.

Subd. 15.Medicare Advantage plan.

"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.

Subd. 16.Medicare eligible expenses.

"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.

Subd. 17.Medicare-related coverage.

"Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.3099 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 "HCPP" contracts) or 1876 (known as "Cost" 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."

Subd. 18.Medicare supplement policy or certificate.
"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 1876 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 or as a supplement to Medicare Advantage plans established under Medicare Part C. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, any health care prepayment plan that provides benefits under an agreement under section 1833(a)(1)(A) of the Social Security Act, or any policy issued to an employer or employers or to the trustee of a fund established by an employer where only employees or retirees, and dependents of employees or retirees, are eligible for coverage, or any policy issued to a labor union or similar employee organization.

◊62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.

◊Subdivision 1.Policy requirements.

No individual or group policy, certificate, subscriber contract issued by a health service plan corporation regulated under chapter 62C, or other evidence of accident and health insurance the effect or purpose of which is to supplement Medicare coverage, including to supplement coverage under Medicare Advantage plans established under Medicare Part C, issued or delivered in this state or offered to a resident of this state shall be sold or issued to an individual covered by Medicare unless the requirements in subdivisions 1a to 1u are met.

◊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.

◊Subd. 1b.Preexisting condition coverage.
The policy must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage.

◊Subd. 1c.Limitation on cancellation or nonrenewal.
The policy must contain a provision that the plan will not be canceled or nonrenewed on the grounds of the deterioration of health of the insured.

Subd. 1d.Mandatory offer.
Before the policy is sold or issued, an offer of both categories of Medicare supplement insurance must be made to the individual, together with an explanation of both coverages.

Subd. 1e.Delivery of outline of coverage.

An outline of coverage as provided in section 62A.39 must be delivered at the time of application and prior to payment of any premium and, except for direct response policies, an acknowledgment of receipt of this outline must be obtained from the applicant.

◊**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.

◊**Subd. 1g.Notification of counseling services.**

The written statement required by an application for Medicare supplement insurance pursuant to section 62A.43, subdivision 1, shall be made on a form, approved by the commissioner, that states that counseling services may be available in the state to provide advice concerning the purchase of Medicare supplement policies and enrollment under the Medicaid program.

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.

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).

Subd. 1j.Filing and approval.
The policy must have been filed with and approved by the department as meeting all the requirements of sections 62A.3099 to 62A.44.

◊**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.

Subd. 1l.Treatment of sickness and accident losses.

A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

◊**Subd. 1m.Medicare cost sharing coverage changes.**

A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with the changes.

As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. Such notice shall:

(1) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(2) inform each policyholder or certificate holder as to when any premium adjustment is to be made, due to changes in Medicare.

The notice of benefit modifications and any premium adjustments must be in outline form and in clear and simple terms so as to facilitate comprehension.

The notices must not contain or be accompanied by any solicitation.

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 and section 62A.3099. A change in the rating structure or methodology shall be considered a discontinuance under this section and section 62A.3099 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.

Subd. 1o.Refund or credit calculation.
(a) Except as provided in paragraph **(b)**, the Minnesota experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section 62A.36.

(b) Forms assumed under an assumption reinsurance agreement shall not be combined with the Minnesota experience of other forms for purposes of the refund or credit calculation.

◊**Subd. 1p.Renewal or continuation provisions.**
Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy or certificate, and shall include any reservation by the issuer of the right to change premiums. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy or certificate, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy or certificate after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy or certificate shall require a signed acceptance by the insured. After the date of policy or certificate issue, a rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy or certificate term shall be agreed to in writing and signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, declaration page, or certificate. If a Medicare supplement policy or certificate contains limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "preexisting condition limitations."

Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a "Guide to Health Insurance for People with Medicare" in the form developed by the Centers for Medicare and Medicaid Services and in a type size no smaller than 12-point type. Delivery of the guide must be made whether or not such policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this section and section 62A.3099. Except in the case of direct response issuers, delivery of the guide must be made to the applicant at the time of application, and acknowledgment of receipt of the guide must be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request, but no later than the time at which the policy is delivered.

Subd. 1q.Marketing procedures.

(1) An issuer, directly or through its producers, shall:

(i) establish marketing procedures to assure that a comparison of policies by its agents or other producers will be fair and accurate;

(ii) establish marketing procedures to ensure that excessive insurance is not sold or issued;

(iii) establish marketing procedures that set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than the benefits under the replaced policy or certificate;

(iv) display prominently by type or other appropriate means, on the first page of the policy or certificate, the following:

"Notice to buyer: This policy or certificate may not cover all of your medical expenses";

(v) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of the insurance;

(vi) establish auditable procedures for verifying compliance with this subdivision;

(2) in addition to the practices prohibited in chapter 72A, the following acts and practices are prohibited:

(i) knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or issuers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer;

(ii) employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance;

(iii) making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company;

(3) the terms "Medicare supplement," "medigap," and words of similar import shall not be used unless the policy or certificate is issued in compliance with this subdivision.

◊**Subd. 1r.Community rate.**

Each health maintenance organization, health service plan corporation, insurer, or fraternal benefit society that sells Medicare-related coverage shall establish a separate community rate for that coverage. Beginning January 1, 1993, no Medicare-related coverage may be offered, issued, sold, or renewed to a Minnesota resident, except at the community rate required by this subdivision. The same community rate must apply to newly issued coverage and to renewal coverage.

◊**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.

◊**Subd. 2.General coverage.**

For a policy to meet the requirements of this section and section 62A.3099 it must contain (1) a designation specifying whether the policy is an extended basic Medicare supplement plan or a basic Medicare supplement plan, (2) a caption stating that the commissioner has established two categories of Medicare supplement insurance and minimum standards for each, with the extended basic Medicare supplement being the most comprehensive and the basic Medicare supplement being the least comprehensive, and (3) the policy must provide the coverage prescribed in sections 62A.315 and 62A.316.

◊**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.

◊**Subd. 5.Advertising.**

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through printed or electronic medium to the commissioner for review or approval to the extent it may be required.

◊**Subd. 6.Application to certain policies.**
The requirements of sections 62A.3099 to 62A.44 shall not apply to disability income protection insurance policies, long-term care policies issued pursuant to sections 62A.46 to 62A.56 or chapter 62S, or group policies of accident and health insurance which do not purport to supplement Medicare issued to any of the following groups:

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

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

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

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

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.

◊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 outpatient 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) coverage of cost sharing for all Medicare Part A eligible hospice care and respite care expenses; and

(9) coverage for cost sharing for Medicare Part A or B home health care services and medical supplies.

◊**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;

(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. Coverage under this clause is subject to section 62A.3093, subdivision 2;

(8) coverage of cost sharing for all Medicare Part A eligible hospice care and respite care expenses; and

(9) coverage for cost sharing for Medicare Part A or B home health care services and medical supplies subject to the Medicare Part B deductible amount.

(b) The following benefit riders must be offered with this plan:

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

(2) 100 percent of the Medicare Part B excess charges coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;

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

(4) 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 item (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.

62A.3161 MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT COVERAGE.

The Medicare supplement plan with 50 percent coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;
(2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (8);
(3) coverage for 50 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (8);
(4) coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (8);
(5) coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations, until the out-of-pocket limitation is met as described in clause (8);
(6) except for coverage provided in this clause, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B, after the policyholder pays the Medicare Part B deductible, until the out-of-pocket limitation is met as described in clause (8);

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible; and
(8) coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment by the secretary of the United States Department of Health and Human Services.

62A.3162 MEDICARE SUPPLEMENT PLAN WITH 75 PERCENT COVERAGE.

The basic Medicare supplement plan with 75 percent coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 75 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (8);

(3) coverage for 75 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (8);

(4) coverage for 75 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (8);

(5) coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations until the out-of-pocket limitation is met as described in clause (8);

(6) except for coverage provided in this clause, coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in clause (8);

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible; and

(8) coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2,000 in 2006, indexed each year by the appropriate inflation adjustment by the Secretary of the United States Department of Health and Human Services.

62A.3163 MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT PART A DEDUCTIBLE COVERAGE.

The Medicare supplement plan with 50 percent Medicare Part A deductible coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A;

(4) coverage for cost sharing for all Medicare Part A eligible hospice and respite care expenses;

(5) coverage under Medicare Part A or B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations;

(6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B, after the policyholder pays the Medicare Part B deductible;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

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

(9) coverage for 100 percent of the Medicare Part A or B home health care services and medical supplies after the policyholder pays the Medicare Part B deductible.

62A.3164 MEDICARE SUPPLEMENT PLAN WITH $20 AND $50 CO-PAYMENT MEDICARE PART B COVERAGE.

The Medicare supplement plan with $20 and $50 co-payment Medicare Part B coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A;

(4) coverage for the cost sharing for all Medicare Part A eligible hospice and respite care expenses;

(5) coverage for Medicare Part A or B of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations;

(6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B except for the lesser of $20 or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit and the lesser of $50 or the Medicare Part B coinsurance or co-payment for each covered emergency room visit; however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

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

(9) coverage for Medicare Part A or B home health care services and medical supplies after the policyholder pays the Medicare Part B deductible.

62A.3165 MEDICARE SUPPLEMENT PLAN WITH HIGH DEDUCTIBLE COVERAGE.

The Medicare supplement plan will pay 100 percent coverage upon payment of the annual high deductible. The annual deductible shall consist of out-of-pocket expenses, other than premiums, for services covered. This plan must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for 100 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A;

(4) coverage for 100 percent of cost sharing for all Medicare Part A eligible expenses and respite care;

(5) coverage for 100 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations;

(6) except for coverage provided in this clause, coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

(8) coverage of 100 percent of the hospital and medical expenses and supplies incurred during travel outside of the United States as a result of a medical emergency;

(9) coverage for 100 percent of Medicare Part A and B home health care services and medical supplies; and

(10) the basis for the deductible shall be $1,860 and shall be adjusted annually from 2010 by the secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

62A.317 STANDARDS FOR CLAIMS PAYMENT.

(a) An issuer shall comply with section 1882(c)(3) of the federal Social Security Act, as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA), Public Law 100-203, by:

(1) accepting a notice from a Medicare carrier on duly assigned claims submitted by Medicare participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the Medicare participating physician or supplier and the beneficiary of the payment determination;

(3) paying the Medicare participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy or certificate name, number, and a central mailing address to which notices from a Medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(b) Compliance with the requirements in paragraph (a) shall be certified on the Medicare supplement insurance experience reporting form.

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. 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. 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 offered by the issuer must provide the coverages specified in sections 62A.315 to 62A.3165. 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 each of the coverages specified in sections 62A.315 to 62A.3165 and must be provided with the opportunity of purchasing such coverage if offered by the issuer. 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.

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.3099 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.3099, subdivision 10. 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.

62A.37 GOVERNMENT CERTIFICATIONS, APPROVALS, AND ENDORSEMENTS.

Subdivision 1.Display of seal or emblem prohibited.

No graphic seal or emblem shall be displayed on any policy or promotional literature to indicate or give the impression that there is any connection, certification, approval or endorsement from Medicare or any governmental body of this state or any agency thereof or of the United States of America or any agency thereof.

Subd. 2.Display of false statement or representation prohibited.

Any false statement or representation printed on the policy or on promotional literature that indicates the policy has a connection with, is certified by, or has the approval or endorsement of any agency of this state or of the United States of America shall be unlawful.

62A.38 NOTICE OF FREE EXAMINATION.

Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded in full if, after examination of the policy or certificate, the insured person is not satisfied for any reason. Medicare supplement policies or certificates, issued pursuant to a direct response solicitation to persons eligible for Medicare by reason of age, shall have a notice prominently printed on the first page or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded within ten days after receipt of the returned policy or certificate to the insurer if, after examination, the insured person is not satisfied for any reason.

62A.39 DISCLOSURE.

No individual Medicare supplement plan shall be delivered or issued in this state and no certificate shall be delivered under a group Medicare supplement plan delivered or issued in this state unless the plan is shown on the cover page and an outline containing at least the following information in no less than 12-point type is delivered to the applicant at the time the application is made:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the exceptions, reductions, and limitations contained in the policy including the following language, as applicable, in bold print: "THIS POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THIS POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.";

(c) A statement of the renewal provisions including any reservations by the insurer of a right to change premiums. The premium and manner of payment shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated;

(d) Read your policy or certificate very carefully. A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions. Additionally, it does not give all the details of Medicare coverage. Contact your local Social Security office or consult the Medicare handbook for more details;
(e) A statement of the policy's loss ratio as follows: "This policy provides an anticipated loss ratio of (..%). This means that, on the average, policyholders may expect that ($....) of every $100.00 in premium will be returned as benefits to policyholders over the life of the contract.";

(f) When the outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:
"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.";

(g) Right to return policy or certificate. "If you find that you are not satisfied with your policy or certificate for any reason, you may return it to (insert issuer's address). If you send the policy or certificate back to us within 30 days after you receive it, we will treat the policy or certificate as if it had never been issued and return all of your payments within ten days.";

(h) Policy or certificate replacement. "If you are replacing another health insurance policy or certificate, do NOT cancel it until you have actually received your new policy or certificate and are sure you want to keep it.";

(i) Notice. "This policy or certificate may not fully cover all of your medical costs."
A. (for agents:) "Neither (insert company's name) nor its agents are connected with Medicare."
B. (for direct response:) "(insert company's name) is not connected with Medicare."

(j) Notice regarding policies or certificates which are not Medicare supplement policies.
Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, or a policy or certificate issued pursuant to a contract under the federal Social Security Act, section 1833 or 1876 (United States Code, title 42, section 1395, et seq.), disability income policy; or other policy, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:
"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company."
(k) Complete answers are very important. "When you fill out the application for the new policy or certificate, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy or certificate and refuse to pay any claims if you leave out or falsify important medical information." If the policy or certificate is guaranteed issue, this paragraph need not appear.
"Review the application carefully before you sign it. Be certain that all information has been properly recorded."
Include for each plan, prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments, and insured payments for each plan, using the same language, in the same order, using uniform layout and format. The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the insurer.

62A.40 REPLACEMENT REGULATED.

No insurer or agent shall replace a Medicare supplement plan with another Medicare supplement plan of the same category unless there is a substantial difference in cost favorable to the policyholder, or the insured has previously demonstrated a dissatisfaction with the service presently being received from the current insurer. An insurer or agent may replace a Medicare supplement plan with a less comprehensive plan only if the prospective insured signs an acknowledgment that it is understood that the prospective insured will receive less benefits under the new policy than under the policy presently in force.

62A.41 PENALTIES.

Subdivision 1.Generally.

Any insurer, general agent, agent, or other person who knowingly or willfully, either directly or indirectly, makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to compliance of any policy with the standards and requirements set forth in this section; falsely assumes or pretends to be acting, or misrepresents in any way, including a violation of section 62A.37, that the person is acting, under the authority or in association with Medicare, or any federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value; or knowingly sells a health insurance policy to an individual entitled to benefits under part A or part B of Medicare with the knowledge that such policy substantially duplicates health benefits to which such individual is otherwise entitled under a requirement of state or federal law other than under Medicare shall be guilty of a felony and subject to a civil penalty of not more than $5,000 per violation, and the commissioner may revoke or suspend the license of any company, association, society, other insurer, or agent thereof.

62A.43 LIMITATIONS ON SALES.

Subdivision 1.Duplicate coverage prohibited.

No agent shall sell a Medicare supplement plan, as defined in section 62A.3099, to a person who currently has one plan in effect; however, an agent may sell a replacement plan in accordance with section 62A.40, provided that the second plan is not made effective any sooner than necessary to provide continuous benefits for preexisting conditions. Every application for Medicare supplement insurance shall require a written statement signed by the applicant listing all health and accident insurance maintained by the applicant as of the date the application is taken and stating whether the applicant is entitled to any medical assistance. The written statement must be accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of the statement.

Subd. 2.Refunds.

Notwithstanding the provisions of section 62A.38, an insurer which issues a Medicare supplement plan to any person who has one plan then in effect, except as permitted in subdivision 1, shall, at the request of the insured, either refund the premiums or pay any claims on the policy, whichever is greater. Any refund of premium pursuant to this section or section 62A.38 shall be sent by the insurer directly to the insured within 15 days of the request by the insured.

Subd. 4.Other policies not prohibited.

The prohibition in this section or the requirements of section 62A.31, subdivision 1, against the sale of duplicate Medicare supplement coverage do not preclude the sale of a health insurance policy or certificate if it will pay benefits without regard to other health coverage and if prospective purchasers are provided, on or together with the application for the policy or certificate, the appropriate disclosure statement for health insurance policies sold to Medicare beneficiaries that duplicate Medicare as prescribed by the National Association of Insurance Commissioners. Notwithstanding this provision, if the commissioner determines that the coverage being sold is in fact Medicare supplement insurance, the commissioner shall notify the insurer in writing of the determination. If the insurer does not thereafter comply with sections 62A.3099 to 62A.44, the commissioner may, pursuant to chapter 14, revoke or suspend the insurer's authority to sell accident and health insurance in this state or impose a civil penalty not to exceed $10,000, or both.

62A.436 COMMISSIONS.

The commission, sales allowance, service fee, or compensation to an agent for the sale of a Medicare supplement plan must be the same for each of the first four years of the policy.

In no event may the rate of commission, sales allowance, service fee, or compensation for the sale of a basic Medicare supplement plan exceed that which applies to the sale of an extended basic Medicare supplement plan.

For purposes of this section, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, awards, and finder's fees.

This section also applies to sales of replacement policies.

62E.07 QUALIFIED MEDICARE SUPPLEMENT PLAN.

Any plan which provides benefits may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 100 percent of the deductibles required under Medicare and 80 percent of the charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by Medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services.

62J.25 MANDATORY MEDICARE ASSIGNMENT.

(d) Effective January 1, 1996, a health care provider shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of the Medicare-approved amount for any Medicare-covered service provided.

62Q.107 PROHIBITED PROVISION; JUDICIAL REVIEW.

Beginning January 1, 1999, no health plan, including the coverages described in section 62A.011, subdivision 3, clauses (7) and (10), may specify a standard of review upon which a court may review denial of a claim or of any other decision made by a health plan company with respect to an enrollee. This section prohibits limiting court review to a determination of whether the health plan company's decision is arbitrary and capricious, an abuse of discretion, or any other standard less favorable to the enrollee than a preponderance of the evidence.

62Q.471 EXCLUSION FOR SUICIDE ATTEMPTS PROHIBITED..

(a) No health plan may exclude or reduce coverage for health care for an enrollee who is otherwise covered under the health plan on the basis that the need for the health care arose out of a suicide or suicide attempt by the enrollee.

(b) For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section **62A.011, clauses (4), (6), and (7) through (10)**.

62Q.50 PROSTATE CANCER SCREENING.

A health plan must cover prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older.

The screening must consist at a minimum of a prostate-specific antigen blood test and a digital rectal examination.

This coverage is subject to any deductible, coinsurance, co-payment, or other limitation on coverage applicable to other coverages under the plan.

For purposes of this section, "health plan" includes coverage that is excluded under section **62A.011, subdivision 3, clauses (7) and (10).**

◊**62Q.525 COVERAGE FOR OFF-LABEL DRUG USE.**

Subdivision 1.Scope of coverage.

This section applies to all health plans, including the coverages described in section **62A.011, subdivision 3, clauses (7) and (10)**, that are issued or renewed to a Minnesota resident.

Subd. 3.Required coverage.

(a) Every type of coverage included in subdivision 1 that provides coverage for drugs may not exclude coverage of a drug for the treatment of cancer on the ground that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard reference compendia or in one article in the medical literature, as defined in subdivision 2.

(b) Coverage of a drug required by this subdivision includes coverage of medically necessary services directly related to and required for appropriate administration of the drug.

(c) Coverage required by this subdivision does not include coverage of a drug not listed on the formulary of the coverage included in subdivision 1.

(d) Coverage of a drug required under this subdivision must not be subject to any co-payment, coinsurance, deductible, or other enrollee cost-sharing greater than the coverage included in subdivision 1 applies to other drugs.

(e) The commissioner of commerce or health, as appropriate, may direct a person that issues coverage included in subdivision 1 to make payments required by this section.

Subd. 4.Construction.

This section must not be construed to:

(1) alter existing law limiting the coverage of drugs that have not been approved by the federal Food and Drug Administration;

(2) require coverage for any drug when the federal Food and Drug Administration has determined its use to be contraindicated;

(3) require coverage for experimental drugs not otherwise approved for any indication by the federal Food and Drug Administration; or

(4) reduce or limit coverage for off-label use of drugs otherwise required by law or contract.

◊62Q.527 NONFORMULARY ANTIPSYCHOTIC DRUGS; REQUIRED COVERAGE.

Subdivision 1.Definitions.

(a) For purposes of this section, the following terms have the meanings given them.

(b) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

(c) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph (a).

(d) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section **62A.011, subdivision 3, clauses (7) and (10).**

Subd. 2.Required coverage for antipsychotic drugs.

(a) A health plan that provides prescription drug coverage must provide coverage for an antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether the drug is in the health plan's drug formulary, if the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the health care provider has considered all equivalent drugs in the health plan's drug formulary and has determined that the drug prescribed will best treat the patient's condition.

(b) The health plan is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

(c) For drugs covered under this section, no health plan company that has received a certification from the health care provider as described in paragraph (a), may:

(1) impose a special deductible, co-payment, coinsurance, or other special payment requirement that the health plan does not apply to drugs that are in the health plan's drug formulary; or

(2) require written certification from the prescribing provider each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition.

Subd. 3.Continuing care.

(a) Enrollees receiving a prescribed drug to treat a diagnosed mental illness or emotional disturbance may continue to receive the prescribed drug for up to one year without the imposition of a special deductible, co-payment, coinsurance, or other special payment requirements, when a health plan's drug formulary changes or an enrollee changes health plans and the medication has been shown to effectively treat the patient's condition. In order to be eligible for this continuing care benefit:

(1) the patient must have been treated with the drug for 90 days prior to a change in a health plan's drug formulary or a change in the enrollee's health plan;

(2) the health care provider prescribing the drug indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(3) the health care provider prescribing the drug certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(b) The continuing care benefit shall be extended annually when the health care provider prescribing the drug**:**

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(c) The health plan company is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

Subd. 4.Exception to formulary.

A health plan company must promptly grant an exception to the health plan's drug formulary for an enrollee when the health care provider prescribing the drug indicates to the health plan company that:

(1) the formulary drug causes an adverse reaction in the patient;

(2) the formulary drug is contraindicated for the patient; or

(3) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

◊62Q.53 MENTAL HEALTH COVERAGE; MEDICALLY NECESSARY CARE.

Subdivision 1.Requirement.

No health plan that covers mental health services may be offered, sold, issued, or renewed in this state that requires mental health services to satisfy a definition of "medically necessary care," "medical necessity," or similar term that is more restrictive with respect to mental health than the definition provided in subdivision 2.

Subd. 2.Minimum definition.

"Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

(1) help restore or maintain the enrollee's health; or

(2) prevent deterioration of the enrollee's condition.

Subd. 3.Health plan; definition.

For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages listed in section 62A.011, subdivision 3, clauses (7) and (10).

◊62Q.535 COVERAGE FOR COURT-ORDERED MENTAL HEALTH SERVICES.

Subd. 2.Coverage required.

(a) All health plan companies that provide coverage for mental health services must cover or provide mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The health plan company must be given a copy of the court order and the behavioral care evaluation. The health plan company shall be financially liable for the evaluation if performed by a participating provider of the health plan company and shall be financially liable for the care included in the court-ordered individual treatment plan if the care is covered by the health plan and ordered to be provided by a participating provider or another provider as required by rule or law. This court-ordered coverage must not be subject to a separate medical necessity determination by a health plan company under its utilization procedures.

(b) A party or interested person, including a health plan company or its designee, may make a motion for modification of the court-ordered plan of care pursuant to the applicable rules of procedure for modification of the court's order. The motion may include a request for a new behavioral care evaluation according to this section.

62Q.56 CONTINUITY OF CARE.

Subdivision 1.Change in health care provider; general notification.

(a) If enrollees are required to access services through selected primary care providers for coverage, the health plan company shall prepare a written plan that provides for continuity of care in the event of contract termination between the health plan company and any of the contracted primary care providers, specialists, or general hospital providers. The written plan must explain:

(1) how the health plan company will inform affected enrollees about termination at least 30 days before the termination is effective, if the health plan company or health care network cooperative has received at least 120 days' prior notice;

(2) how the health plan company will inform the affected enrollees about what other participating providers are available to assume care and how it will facilitate an orderly transfer of its enrollees from the terminating provider to the new provider to maintain continuity of care;

(3) the procedures by which enrollees will be transferred to other participating providers, when special medical needs, special risks, or other special circumstances, such as cultural or language barriers, require them to have a longer transition period or be transferred to nonparticipating providers;

(4) who will identify enrollees with special medical needs or at special risk and what criteria will be used for this determination; and

(5) how continuity of care will be provided for enrollees identified as having special needs or at special risk, and whether the health plan company has assigned this responsibility to its contracted primary care providers.

(b) For purposes of this section, contract termination includes nonrenewal.

Helpful Resources and Links

CMS.gov, Center for Medicare and Medicaid Services:
http://www.cms.gov/
Medicare.gov, The Offical U.S. Government Site for Medicare:
http://www.medicare.gov/
Regulations & Guidance on Medicare and Medicaid Services
http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html
2015 Medicare and You handbook:
http://www.medicare.gov/Pubs/pdf/10050.pdf
Medicare Marketing Guidelines
http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html
2015 CMS Model Marketing Materials
http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html

Chapter 13 - Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans:
http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf