

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

SF-00006-04

DEPARTMENT : of Commerce

PHONE : 296-5689

DATE : 6/25/85

TO : Judith Wehrwein

STATE OF MINNESOTA

Office Memorandum

RECEIVED
JUN 26 1985
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

FROM : Richard G. Gomsrud
Department Counsel

SUBJECT : MCHA Rules

Enclosed are copies of the following materials regarding the above captioned rules (only those items with a circled number are enclosed):

1. Notice of Intent to Solicit Outside Opinion (2000.0400 subpart 1 B)
2. Written material received as a result of Notice to Solicit Outside Opinion (2000.0400 subpart 1 B)
3. Mailing List Certificate (2000.0400 subpart 1 E)
4. Statement of Need & Reasonableness (2000.0400 subpart 1 G)
5. Order for Notice of Intent to Adopt Rule Without Public Hearing (2000.0400 subpart 1 C)
6. Notice of Intent to Adopt Rule Without Public Hearing (2000.0400 subpart 2)
7. Affidavit of Mailing Notice of Intent to Adopt Rule Without Public Hearing (2000.0400 subpart 3)
8. Copy of Notice of Intent to Adopt Rule Without Public Hearing and rules as published in the State Register (2000.0400 subpart 4)
9. Written Comments on Rule (2000.0400 subpart 1 I)
10. Findings of Fact (if applicable) (2000.0400 subpart 1 F)
11. Affidavit of Mailing Notice of Submission to Attorney General (2000.0400 subpart 1 K); or

12. Affidavit that no request for Notice of Submission to Attorney General were received

13. Original and three copies of Rule as adopted (2000.0400 subpart 5)

14. Two copies of the Order Adopting Rule (2000.0400 subpart 6)

15. Certificate of Compliance With Rulemaking Procedure (2000.0400 subpart 1 J).

To:
Date: June 25
Re: Commerce – Comprehensive Health Insurance Assoc.

Rules as Adopted

p. 15, line 15. 2740. 9904 ✓
p. 16, lines 1-15

p. 17, lines 16-22 2740. 9914 — DELETE OK.

p. 21, line 10 2740. 9924, subp. 2. E ✓

p. 21, lines 19-24 2740. 9929 ✓

p. 22, lines 28-31 2740. 9944 ✓

p. 23, lines 9-14 2740. 9949 ("MUST BE" TO REPLACE "SHOULD BE"

All of the above appear to be "discussions" or statements of fact rather than directives to do or not do something.

p. 22, line 16 2740. 9934, subpt. 3 — GET CLARIFICATION ?
p. 22, lines 21, 22 2740. 9939 — REVERT deleted.

These sections provide for actions by the commissioner but are not specific as to criteria for such actions

p. 21, line 31 2740. 9934, subp. 2 ✓

p. 30, line 3 2740. 9959, subp. 15 ✓ CHECK w/ Gonsalves
p. 30, line 42 " , subp. 18. A ✓
p. 31, line 7 " , subp. 18. B ✓

All of the above use "should." it is not clear if the agency means "must" OR "may"

all changed to must

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE
ST. PAUL 55101

OFFICE OF THE COMMISSIONER

500 METRO SQUARE BUILDING
ST. PAUL, MN 55101

July 15, 1985

Judith Wehrwein
Legal Assistant
Administrative Division
Attorney General's Office
204 Administrative Builidng
50 Sherburne Ave.
St. Paul, MN 55101

Dear Judith:

Pursuant to your previous request enclosed please find two copies of the Supplemental Findings of Fact, Conclusions and Order Adopting Rule incorporating the changes that were requested. Also enclosed are 6 copies of the Rule as adopted with the changes incorporated. According to my recollection of our conversation I believe this takes care of the shortcomings in the original filing and you can proceed with the review of the rules. If anything additional is needed, please advise me accordingly.

Very truly yours,

MICHAEL A. HATCH
Commissioner of Commerce

By:

RICHARD G. GOMSRUD
Department Counsel

RGG/js

RECEIVED
JUL 18 1985
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

SF-00006-04

DEPARTMENT : of Commerce

PHONE : 296-5689

DATE : 6/21/85

TO : Judith Wahrwein
Attorney General's Office
204 Administration Building

FROM : Richard G. Gomsrud
Department Counsel

STATE OF MINNESOTA

Office Memorandum

RECEIVED
JUN 21 1985
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

SUBJECT : Comprehensive Health Insurance Association Rules

Enclosed are copies of the following materials regarding the above captioned rules (only those items with a circled number are enclosed):

(1) Notice of Intent to Solicit Outside Opinion (2000.0400 subpart 1 B)

~~2.~~ Written material received as a result of Notice to Solicit Outside Opinion (2000.0400 subpart 1 B) NONE RECEIVED

(3) Mailing List Certificate (2000.0400 subpart 1 E)

(4) Statement of Need & Reasonableness (2000.0400 subpart 1 G)

(5) Order for Notice of Intent to Adopt Rule Without Public Hearing (2000.0400 subpart 1 C)

(6) Notice of Intent to Adopt Rule Without Public Hearing (2000.0400 subpart 2)

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14. Two copies of the Order Adopting Rule (2000.0400 subpart 6)

15. Certificate of Compliance With Rulemaking Procedure (2000.0400 subpart 1 J).

Our File No. 1173 05. 0009-0114 6/25 Need SR. Requested Comsrud to send

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 6-21-85
DATE FOR REVIEW 6-30-85
DATE DUE Resubmission 7-5-85 July 85

Adopted w/a hearing
Adopted w/o hearing ✓
Temporary rule

Approved 8/5/85 Disapproved Returned to Agency

Resubmitted Due
Approved Disapproved Returned to Agency

Date filed w/Secretary of State 11-18-85 Revisor approved 7/8/85 disapproved

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✓ ✓ Rule as Adopted

✓ Rule as Proposed 7.16.85.

✓ ✓ Order Adopting 6.14.85 Date combined with FofF.

✓ Notice of Intent to Solicit Outside Opinion

✓ Order for rulemaking
N/A date of Hearing

N/A Certificate of Board's Authorizing Resolution

✓ Notice of rulemaking
✓ Sufficiency contains small biz statement but no encouragement

✓ Affidavit of Mailing Notice or rulemaking
3.28.85 At least 30 days prior to ~~hearing~~/adoption

✓ Mailing list Certificate

Publication in State Register
At least 30/20 days prior to hearing/adoption

N/A Hearing Examiner's Report

Chief Hearing Examiner's Report(s)
Approving H.E.'s Report
Approving agency action

✓ Agency's Findings of Fact combined w/ Order Adopting

N/A LCRAR Report or agency Affidavit

Certificate of Board's Resolution Adopting Rules

Order Approving Incorporation by Reference

✓ Statement of Need and Reasonableness contains small biz statement

N/A Petition for Adoption of a Rule

✓ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

✓ Certificate of Compliance w/Rulemaking Procedures

✓ Affidavit ~~of Mailing~~ Notice of Submission to Attorney General

N/A Notice of Submission to the Attorney General

Department of Commerce

Adopted Rules Relating to the Comprehensive Health Insurance Association

Rules as Adopted

2740.0100 DEFINITIONS.

Subpart 1. to 12. [Unchanged.]

Subp. 13. **Covered expenses.** "Covered expenses" means the usual and customary charges for the services and articles listed in Minnesota Statutes, section 62E.06, or, with respect to qualified plans, the actuarial equivalence thereof, when prescribed for a covered person by a physician and when the expenses are incurred during a period in which the policy or contract is in effect.

Subp. 14. to 28. [Unchanged.]

Subp. 29. **Licensed and tested insurance agent or insurance agent.** "Licensed and tested insurance agent" or "insurance agent" means an insurance agent as defined in Minnesota Statutes, section 60A.02, subdivision 7, and licensed as such by the commissioner.

Subp. 30. and 31. [Unchanged.]

Subp. 32. **Net gains.** "Net gains" means the excess of premiums or contract charges over claims expenses, after the writing carrier's expenses and agent referral fees, not to exceed 15 percent of premiums or contract charges, have been paid as provided in part 2740.4400, subpart 4.

Subp. 33. to 44. [Unchanged.]

Subp. 44a. **Qualified medicare supplement plan.** "Qualified medicare supplement plan" means a plan of health coverage meeting the requirements of Minnesota Statutes, sections 62A.31, 62A.32, 62E.02, subdivision 5, and 62E.07.

Subp. 45. to 52. [Unchanged.]

Subp. 53. **Rejection.** "Rejection," for the purpose of state plan eligibility, means refusal by any association member, or any authorized representative, including any insurance agent,

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acting on behalf of any association member, to issue a qualified plan or a qualified medicare supplement plan to a person who completes an application for coverage under such qualified plan, or a qualified medicare supplement plan, as determined by the board.

Subp. 54. to 56. [Unchanged.]

Subp. 56a. **Self-insurer.** "Self-insurer" means an entity defined by Minnesota Statutes, section 62E.02, subdivision 21, which is a "governmental plan" as defined by United States Code, title 29, section 1002(32) or a "church plan" as defined by United States Code, title 29, section 1002(33)(A) or which is otherwise exempt from or outside of the scope of the provisions of the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001 to 1381, as amended.

Subp. 57. [Unchanged.]

Subp. 58. **Total cost of self-insurance.** "Total cost of self-insurance" includes any direct and indirect administrative expenses incurred that are related to the operation of a plan of self-insurance, plus the sum of any payment made to or on behalf of Minnesota residents for costs or charges for health benefits by a self-insurer under a plan of health coverage, which is not counted as premium by an insurer, except to the extent of such payments made for coverage of the types described in Minnesota Statutes, section 62E.02, subdivision 11, clauses (1) to (8).

Subp. 59. [Unchanged.]

2740.1100 DUTIES OF EMPLOYERS.

Subpart 1. **Duty to make available a qualified plan.** An employer shall be deemed to have made available a qualified plan to its employees as required in Minnesota Statutes, section 62E.03, subdivision 1 when participation under a number 2 or number 3 qualified plan or a health maintenance plan is offered to the employee by a self-insurer or through an insurer or health maintenance organization, without regard to whether the cost of such participation is paid directly or indirectly by the employer or by the employee or by their joint payment.

Subp. 2. [Unchanged.]

APPROVED IN THE [illegible] STATUTES

Subp. 3. **Frequency of required offer.** Except as provided in subpart 2, an employer shall be deemed to have complied with the requirements of Minnesota Statutes, section 62E.03, subdivision 1 if the employer makes available to the employer's employees a plan of health coverage which is certified as a number 2 or number 3 qualified plan or a health maintenance plan at least once during each accounting period utilized by the employer for Minnesota income tax purposes.

2740.1200 DUTIES OF INSURERS AND FRATERNALS.

Subpart 1. [Unchanged.]

Subp. 2. **Timing of required offer of a qualified plan or qualified medicare supplement plan.** Timing of required offer of a qualified plan or qualified medicare supplement plan is as follows:

A. The offer of each type of qualified plan (that is, a number 1, number 2, and number 3 qualified plan) that is required when an insurer or fraternal is offering an individual policy of accident and health insurance shall occur no later than the date of delivery of such policy to the applicant.

B. to E. [Unchanged.]

Subp. 3. [Unchanged.]

Subp. 4. **Duty to offer major medical coverage.** Each insurer and fraternal shall affirmatively offer, subject to its underwriting standards, coverage of major medical expenses to every applicant for a new unqualified policy at the time of application and annually thereafter to every holder of an unqualified policy of accident and health insurance renewed by the insurer or fraternal as required by Minnesota Statutes, section 62E.04, subdivision 4. "Affirmatively offer" shall mean written advice to the applicant for, or the holder of, an unqualified policy of accident and health insurance, of the availability of coverage for major medical expenses. Such written advice of the availability of the coverage for major medical expenses may be satisfied by a contractual provision in the unqualified policy that gives the insured the contractual right to apply to the insurer or fraternal for a new policy or a

rider on an existing unqualified policy that provides coverage for 80 percent of the covered expenses for services listed in Minnesota Statutes, section 62E.06, subdivision 1 or the actuarial equivalence thereof subject to a $5,000 deductible for out-of-pocket expenses, subject to the insurer's or fraternal's underwriting requirements.

Subp. 5. and 6. [Unchanged.]

Subp. 7. **Exceptions to duties for certain policies and contracts.** Exceptions to duties for certain policies and contracts are as follows:

A. [Unchanged.]

B. The issuance or renewal by an insurer or fraternal on or after June 3, 1977, of a policy or contract that is designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis, shall not be subject to Minnesota Statutes, section 62E.04, except for policies and contracts sold by an insurer to provide payments on a hospital indemnity basis if such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue.

Subp. 8. [Unchanged.]

2740.1600 TERMINATION OF COVERAGE; CONVERSION PRIVILEGES.

Subpart 1. and 2. [Unchanged.]

Subp. 3. **Due notice of cancellation or termination.** An insurer, health maintenance organization, or self-insurer shall be deemed to have provided "due notice of cancellation or termination" as required in Minnesota Statutes, section 62E.16 if the insurer, health maintenance organization, or self-insurer notifies in writing those employees at their respective addresses as provided to the insurer, health maintenance organization, or self-insurer by the employer pursuant to the terms of Minnesota Statutes, section 62E.16.

2740.2100 DEFINITIONS.

Subpart 1. **Accident and health insurance business.** "Accident and health insurance business" means the

issuance or renewal of any accident and health insurance policy as defined in Minnesota Statutes, section 62E.02, subdivision 11.

A. [Unchanged.]

B. Such business shall not include the issuance or renewal of policies or contracts providing coverage that is:

(1) to (8) [Unchanged.]

(9) limited to accident-only coverage issued by an insurance agent and that provides reasonable benefits in relation to the cost of covered services.

Subp. 2. and 3. [Unchanged.]

Subp. 4. **Self-insurance business.** "Self-insurance business" means the provision, directly or indirectly, of a plan of health coverage by a self-insurer. "Self-insurance business" does not include the direct provision of health care services to employees at no charge to them by an employer engaged in the business of providing health care services to the public, nor does it include provision of benefits that, if provided by an insurer doing accident and health insurance business, would be excluded under subpart 1, item B. "Directly or indirectly" for the purposes of parts 2740.2100 to 2740.5500 means that the self-insurer funds the plan of health coverage in any amount or collects any employee contributions which are used to pay for the plan of health coverage.

2740.2400 ASSESSMENTS.

Contributing members will be assessed for their proportionate share of the operating and administrative expenses of the association, incurred or estimated to be incurred, together with losses, if any, incurred by the association as a result of operation of the state plan. The total amount of operating and administrative expenses and losses:

A. [Unchanged.]

B. may, at the recommendation of the board, subject to the approval of the commissioner, consist of a reasonable estimate of the operating and administrative expenses of the association for the succeeding fiscal year, which amount shall be adjusted at the end of the succeeding fiscal year to the

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amount of actual operating and administrative expenses, and contributing members shall be entitled to credit for any excess or shall be assessed for any deficit in these expenses in future assessments.

2740.2500 LEVY OF ASSESSMENTS.

Subpart 1. **Annual.** The association shall make an annual determination of each contributing member's liability, if any, and may levy assessments following each fiscal year end. The fiscal year ends on December 31 unless the association establishes a different fiscal year end. Assessments are due and payable 30 days after receipt of a written assessment notice.

Subp. 2. **Interim.** The association may also, upon approval of the commissioner, levy interim assessments when deemed necessary to assure the financial capability of the association to meet the incurred or estimated operating and administrative expenses of the association and losses resulting from the state plan. Interim assessments shall be due and payable within 30 days of receipt by a contributing member of a written interim assessment notice.

Subp. 3. **Member share.** The association shall levy each contributing member's share of the total assessment based on the ratio of: the contributing member's total premium for accident and health insurance business as defined in part 2740.2100, subparts 1 and 2, received from or on behalf of residents of Minnesota, as determined by the commissioner; to the total premium for accident and health insurance business for all contributing members.

Subp. 4. **Costs and charges.** The costs and charges referred to in the ratio in subpart 3 shall, to the extent possible, be determined by reference to a form issued by the association or the commissioner which all contributing members shall submit to the commissioner annually for the preceding calendar year.

A. [Unchanged.]

B. The commissioner shall have the authority to audit the accounts and records of any contributing member for the

purpose of obtaining information necessary to levy an assessment.

Subp. 5. **Discretionary waiver.** The board may, in its discretion, decline to levy assessments against contributing members that owe $10 or less in a given year.

2740.2600 FAILURE TO PAY ASSESSMENTS.

Any contributing members that fail to pay annual or interim assessments when such assessments become payable will be reported by the association to the commissioner for appropriate action within the discretion of the commissioner.

2740.2900 DETERMINATION OF MEMBER'S VOTING RIGHTS.

Subpart 1. [Unchanged.]

Subp. 2. **Weighted vote.** A member's vote shall be a weighted vote based on the member's total cost of self-insurance, accident and health insurance premiums, subscriber contract charges, or health maintenance contract charges derived from or on behalf of residents of Minnesota in the previous calendar year, as determined by the commissioner. To the extent possible, this figure shall be determined by reference to the annual reporting form submitted by contributing members to the commissioner in accordance with part 2740.2500, subpart 4, and similar forms showing all other members' total accident and health insurance premiums, subscriber contract charges (defined as charges for business specified in part 2740.2100, subparts 1 and 2) received from or on behalf of residents of Minnesota, or total cost of self-insurance, as defined in part 2740.0100, subpart 58, as determined by the commissioner.

If the necessary information is not available to the commissioner on the form described in this subpart at the time that voting rights must be determined, the commissioner may estimate the member's weighted vote based on other information available to the commissioner.

Subp. 3. **Voting procedures.** Members are entitled to vote in person, by proxy, or by mail as determined by the board.

When a member elects to vote in person at a members'

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meeting, the representative casting the vote shall present credentials as required pursuant to the bylaws or operating rules of the association.

When a member elects to vote by proxy, the proxy statement as approved by the board shall be returned on or before the date indicated in the meeting notice sent to the members.

Voting by mail may be permitted as authorized by the bylaws or operating rules of the association, and the meeting notice to members shall so indicate.

2740.3100 MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLANS.

Subpart 1. [Unchanged.]

Subp. 2. **Benefits of number 1 and number 2 qualified plan.** Benefits shall meet or exceed the requirements of Minnesota Statutes, section 62E.06 or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables in parts 2740.9905 to 2740.9986, except where substitution of an actuarially equivalent benefit is not permissible under the act.

A. [Unchanged.]

B. Coverage shall include an annual (calendar year) limitation of not more than $3,000 per covered person on total out-of-pocket expenses, which out-of-pocket expenses shall include the deductible under the state plan policy or contract, and which out-of-pocket expense limitation is not subject to substitution of an actuarially equivalent benefit.

C. Coverage shall be subject to a maximum lifetime benefit of not less than $250,000 per covered person, less any amount paid to or on behalf of the covered person under any other qualified plan of the state plan. This benefit is not subject to substitution of an actuarially equivalent benefit.

Subp. 3. **Benefits of qualified medicare supplement plan.** Benefits of a qualified medicare supplement plan shall meet or exceed the following minimum standards.

A. The plan shall provide benefits to covered persons by supplementing medicare through provision of:

(1) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare to at least 50 percent of the deductible and copayment required under medicare for the first 60 days of any medicare benefit period;

(2) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period;

(3) coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days to the extent not covered by medicare;

(4) upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of at least 50 100 percent of the medicare calendar year part B deductible.

B. The plan shall provide 80 percent of the covered charges for expenses as provided in Minnesota Statutes, section 62E.06, which charges are not paid or payable under medicare or would not have been paid or payable had the covered person who is or was entitled or eligible to enroll in medicare been so enrolled or which charges are not paid or payable under item A.

C. Coverage shall include an annual limitation of $1,000 total out-of-pocket expenses per covered person for covered charges, provided that an annual deductible of not more than $200 is permissible for those covered charges not paid or payable under medicare or otherwise included in item A or B.

D. Coverage shall be subject to a maximum lifetime benefit of not less than $100,000 per covered person, less any amount paid to or on behalf of the covered person under any other qualified medicare supplement plan of the state plan.

E. The minimum coverage of a qualified medicare

supplement plan required by this subpart is not subject to substitution of actuarially equivalent benefits.

Subp. 4. and 5. [Unchanged.]

2740.3600 ENROLLMENT.

Subp. 1. [Unchanged.]

Subp. 2. **Eligible person.** "Eligible person," as used in subpart 1, means a resident of Minnesota who submits or on whose behalf is submitted a complete certificate of eligibility and enrollment form to the association or its writing carrier and who is not already covered by another state plan policy or contract.

A. A complete certificate of eligibility and enrollment form may provide:

(1) name, address, age, and length of time as a resident of Minnesota;

(2) [Unchanged.]

(3) evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, by one association member, or by an authorized representative, including an insurance agent, acting on behalf of an association member, within six months of the date of application. "Substantially reduce coverage from that received by a person who is considered a standard risk" includes any restriction on coverage as a result of an illness, condition, or risk which the association deems substantial, any increase in rates for an applicant based on an illness, condition, or risk, which the association deems substantial, and any preexisting conditions limitation which the association deems substantial.

B. In lieu of evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, as required by item A, subitem (3), a complete certificate of eligibility and enrollment form may provide evidence which

meets the requirements of an operating rule adopted by the association of a proposed covered person having been treated within three years of the date of the certificate of eligibility and enrollment form for one or more conditions listed in the operating rule.

C. Before a person is determined to be an eligible person, the board may require that any items listed in items A and B or, if acting pursuant to provisions of the association's operating rules, other necessary information be submitted to the association or its writing carrier and may also investigate the authenticity of information submitted as a part of the certificate of eligiblity.

D. If a covered person, under a qualified plan of the state plan, upon reaching age 65, or becoming enrolled in medicare, wishes to purchase a state plan qualified medicare supplement plan, the requirement that the person obtain one rejection, restrictive rider, rate-up, or preexisting conditions limitation on a qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, from one member of the association, or from an authorized representative, including an insurance agent acting on behalf of an association member, within the preceding six months may be waived by the board if acting pursuant to provisions of the association's operating rules.

E. A person who is age 65 or older shall be eligible for coverage only under the state plan's qualified medicare supplement plan and when an insured person under a qualified plan reaches age 65, the board may, if acting pursuant to provisions of the association's operating rules, terminate or refuse to renew coverage under the qualified plan. A person under age 65 who is otherwise eligible for coverage under the state plan and is enrolled in medicare shall be permitted to purchase a qualified plan 1 or 2 or the qualified medicare supplement plan of the state plan.

F. An applicant or any person proposed to be covered

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under a qualified plan of the state plan who has previously been covered under one or more qualified plans of the state plan and who has exhausted the $250,000 maximum lifetime benefit shall not be an eligible person for coverage under a qualified plan of the state plan; an applicant or any person proposed to be covered under a qualified medicare supplement plan of the state plan who has previously been covered under one or more qualified medicare supplement plans of the state plan and who has exhausted the $100,000 maximum lifetime benefit shall not be an eligible person for coverage under a qualified medicare supplement plan of the state plan.

G. When a covered person under the state plan no longer meets one or more of the requirements for eligibility for coverage under the state plan, the board may, if acting pursuant to the association's operating rules, terminate or refuse to renew coverage under the state plan.

2740.3700 ASSOCIATION'S RESPONSE.

Subpart 1. **Time limitation.** Within 30 days of receipt of a complete certificate of eligibility and enrollment form pursuant to part 2740.3600, subpart 2, items A, B, and C, the association or the writing carrier shall accept the certificate of eligibility or shall reject the certificate of eligibility for failure to meet the eligibility requirements.

Subp. 2. **Acceptance.** If the association or its writing carrier accepts the certificate of eligibility, it shall forward a notice of acceptance, billing information, and a policy or contract or certificate that shall evidence coverage under the state plan.

A. [Unchanged.]

B. When the state plan premium is received by the association or its writing carrier for the first billing period and accepted in accordance with this part, the coverage shall be effective retroactive to the date of receipt by the association or its writing carrier of the completed certificate of eligibility pursuant to part 2740.3600, subpart 2, items A, B, and C unless otherwise requested by the insured person and

approved by the board.

Subp. 3. **Nonacceptance.** If the association does not accept the certificate of eligibility, the applicant shall be informed of the reason for the rejection and shall have the opportunity to submit additional information to substantiate eligibility for coverage under the state plan and to request reconsideration of the decision. The board may establish a review mechanism for reviewing requests for reconsideration of rejected certificates of eligibility. The association shall give notice of a final determination of ineligibility to the applicant stating the reasons therefor and advising the applicant of the right to appeal to the commissioner within a reasonable period of time.

2740.3900 DISSEMINATION OF INFORMATION CONCERNING STATE PLAN.

Subpart 1. **Plan.** The association shall develop a plan for use by the association, upon approval by the commissioner, to publicize the existence of the state plan and the eligibility requirements and procedures for enrollment, and to maintain public awareness of and participation in the state plan.

Subp. 2. **Forms and instructions.** The association shall prepare and make available certificate of eligibility forms and enrollment instruction forms to members, insurance agents and brokers, and to the general public in Minnesota.

Subp. 3. **Referral fee.** The association shall require the writing carrier to pay a referral fee of $50 for any certificate of eligibility accepted by the association or its writing carrier if the referring agent is licensed by the commissioner as an insurance agent and if the referring agent's signature appears as the agent on the accepted certificate of eligibility. The referral fee shall be paid from the premium received for the state plan. Referring agents shall not be authorized to interpret, amend, or alter the terms of the state plan policy or contract, nor shall referring agents be authorized to bind the association in any way. Referring agents shall not be agents of the association for any purpose, and the association shall not bear responsibility for acts of referring

agents.

2740.4400 OPERATIONS OF WRITING CARRIER.

Subpart 1. **Administrative and claims payment functions.** The writing carrier shall perform all administrative and claims payment functions relating to the state plan.

A. [Unchanged.]

B. The writing carrier shall perform all necessary functions to assure timely payment of benefits to covered persons under the state plan.

(1) to (3) [Unchanged.]

(4) The writing carrier shall exercise reasonable efforts to advise covered persons, within 60 business days of receipt of a properly completed and executed proof of loss, whether the submitted claim was accepted or rejected by the writing carrier, unless sooner settled.

(5) The writing carrier may establish an appeals procedure approved by the board to review claims that are denied in whole or in part. When a claim or any portion thereof is denied, the writing carrier shall inform the covered person of the existence of the procedure, including the right to appeal to the commissioner within a reasonable period of time.

Subp. 2. [Unchanged.]

Subp. 3. **Claims expenses.** The writing carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the state plan. If the writing carrier's payments for claims expenses exceed the portion of the state plan premiums allocated by the board for payment of claims expenses, the association shall provide to the writing carrier additional funds for payment of claims expenses. Not less than 85 percent of the state plan premium, as determined by the board, shall be used to pay claims expenses, and not more than 15 percent of the state plan premium shall be used to pay agent referral fees (authorized by Minnesota Statutes, section 62E.15, subdivision 3) and to pay the writing carrier's direct and indirect expenses, as defined and authorized in Minnesota Statutes, section 62E.13, subdivision 7 and described in subpart

5.

Subp. 4. **Direct and indirect expense reimbursement.** The writing carrier shall be paid from time to time as provided in the association's contract with the writing carrier for its direct and indirect expenses incurred in the performance of its services from the state plan premiums received in an amount not to exceed the lesser of:

A. 15 percent of the state plan premium, less agent referral fees payable under part 2740.3900, subpart 3;

B. and C. [Unchanged.]

Subp. 5. **Direct and indirect expenses.** Direct and indirect expenses shall include that portion of the writing carrier's actual administrative, printing, claims administration, management, building overhead expenses, and other actual operating and administrative expenses approved by the board as allocable to the administration of the state plan.

Subp. 6. and 7. [Unchanged.]

2740.5200 REINSURANCE PLAN.

Subpart 1. [Unchanged.]

Subp. 2. **Application and acceptance.** Insurer or fraternal members wishing to participate in the pool shall apply to the association for participation in the pool, specifying the categories of coverage that the member desires to reinsure.

Each member entering into a reinsurance pooling agreement for a particular category or categories of coverage shall offer to place in the pool all policies and contracts that it issues in the category or categories listed in part 2740.5100 that it wishes to reinsure.

Only policies and contracts acceptable to the association or its reinsurance administrator may be accepted for reinsurance. The association is under no obligation to accept any but standard risks in the reinsurance plan.

Subp. 3. to 5. [Unchanged.]

2740.9904 PURPOSE.

Minnesota Statutes, section 62E.02, defines "qualified

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plans" as health benefit plans that provide the benefits required in Minnesota Statutes, section 62E.06 or "the actuarial equivalent of those benefits." Minnesota Statutes, section 62E.06 describes three qualified plans. These statutes require all plans of health coverage subject to Minnesota Statutes, section 62E.06 to be labeled as qualified or non-qualified. The commissioner may be requested to determine whether a plan is qualified and may take up to 90 days to make that determination. Minnesota Statutes, section 62E.02 defines a qualified medicare supplement plan as one which has been certified by the commissioner as providing the minimum benefits required by Minnesota Statutes, section 62E.07. Since the definition does not allow the option of an actuarial equivalent plan, the current rules do not include actuarial equivalent tables for medicare supplement policies.

2740.9909 COMPOSITE POINT VALUES FOR QUALIFIED PLAN NUMBER THREE.

The composite point values for a qualified plan number three for 1984 are as shown herein.

Composite Point Values for Minnesota Qualified Plan No. 3

Points	Benefit
363	Hospital room and board, unlimited days, semi-private.
480	Hospital extras (i.e., hospital services, hospital miscellaneous, hospital special services, or ancillary services) including anesthesia.
243	Surgery, including administration of anesthesia, assistant surgeon and oral surgery but no tooth repair or extractions.
215	Home and office physician care, unlimited.
51	Physician care in hospital, unlimited.
63	Obstetrics, unlimited.
110	Hospital maternity, unlimited.
105	X rays and laboratory tests, outpatient and out of hospital.
100	Prescription drugs and medicine, outpatient and out of hospital.
15	Radioactive therapy, outpatient and out of hospital.
16	Nursing or convalescent facility.
8	Home health agency care.
10	Physical therapy.
4	Oxygen.
5	Prostheses.
5	Durable medical equipment rental or purchase.
2	Second opinion surgery.
2	Private duty nursing.
3	Ambulance.
-12	Adjustment for major medical maximum.
1788	Total reasonable and customary medical services
-245	$150 deductible.

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-309	20 percent coinsurance.
1234	Total after deductions for deductible and coinsurance
-49	Coordination of benefits.
-31	Nonduplication with no-fault.
30	3,000 annual "out-of-pocket" expense limit.
8	Well baby care.
0	Emergency accident.
0	Supplement accident.
0	Student dependents.
1192	Grand Total

2740.9914 DETERMINATION OF AVERAGE SEMI-PRIVATE HOSPITAL ROOM AND BOARD LEVEL OF SURGICAL CHARGES.

Subpart 1. ~~Why-develop-values-annually.--Many-companies issue-policies-with-scheduled-benefits.--Due-to-inflation-the value-of-scheduled-benefits-declines-each-year-in-relation-to reasonable-and-customary-charges.--It-would-be-best-if-the-test of-actuarial-equivalence-would-automatically-adjust-for inflation-and-thus-would-more-accurately-value-these-types-of benefits.~~

~~Subp.-2.~~ **When values determined.** In December of each year, the commissioner will publish the following values:

A. the average semi-private hospital room and board (ASP value);

B. the value of surgical charges (SURG value);

C. the ratios of the average semi-private hospital room and board for the year to that in 1984 (ASP factor);

D. the ratio of the value of surgical charges for the year to that in 1984 (SURG factor); and

E. the composite ratio of medical care for the year to that in 1984 (COMP factor).

The commissioner may appoint a service agency to calculate these values on a consistent basis each year.

Subp. ~~3.~~ 2. **How values determined.** Values will be determined as follows:

A. The ASP value will be the weighted bed average of semi-private room and board charges for acute hospitals in Minnesota. The information will be derived from each hospital's latest room and board charge filed with the commissioner or the service agency. A semi-private room will be defined as a room

with two beds.

B. The SURG value will be the sum of the product of the average charge, filed with the commissioner or the service agency, for each of the surgical operations shown below times the factor shown for that operation. The surgical operations and their factors are shown in part 2740.9919.

C. The ASP factor will be the ASP value to be published for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

D. The SURG factor is the ratio of the SURG value for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

E. The COMP factor is the composite factor for medical care. This equals 54 percent times the ASP factor for the year plus 46 percent times the SURG factor for the year.

2740.9919 TABLE OF SURGICAL FACTORS TO DEVELOP SURG VALUE.

CPT4 Code	Surgical Factor	Description
SKIN		
10060	.7710	Abscess, incision, and drainage, simple
11400	2.0161	Benign lesion removal of (up to 0.5 cm.)
11750	.4368	Nail, permanent removal of
12011	1.9732	Simple wound, simple repair (up to 2.5 cm.)
17100	4.6520	Benign skin lesion, destruction of
MUSCULOSKELETAL		
20610	1.9226	Major joint or bursa, injection or aspiration of
27130	.1565	Total hip joint replacement, simple
29425	1.0286	Application walking cast
CARDIOVASCULAR		
33512	.1111	Coronary bypass, three arteries
93547	.2166	Left heart catheterization with coronary angiogram
DIGESTIVE SYSTEM		
43235	.4514	Gastroscopy, diagnostic
43844	.0569	Stomach bypass for morbid obesity
44950	.2618	Appendectomy
45300	2.7170	Proctosigmoidoscopy, diagnostic
47600	.3765	Gallbladder, removal of
49505	.3086	Inquinal hernia repair, unilateral
URINARY SYSTEM		
52601	.1579	Prostate resection (TUR), complete
53670	3.5273	Urinary bladder catheterization
MALE GENITAL		
54150	.8509	Circumcision by clamp, newborn
FEMALE GENITAL		
58120	.8470	Uterus, dilation and curettage (D & C),

		nonobstetrical
58150	.4792	Uterus, removal of
58980	.9455	Laparoscopy, diagnostic
NERVOUS SYSTEM		
63030	.0694	Laminotomy herniated disc, lumbar
64721	.1988	Carpal tunnel symdrome repair
EYE		
66980	.2003	Cataract removal, intraocular lens insertion
EAR		
69437	.3934	Tympanostomy with ventilating tube insertion

2740.9924 HOW TO USE THE LIST.

Subpart 1. **Basic and comprehensive major medical plans.** The list is used in the following manner:

A. Determine the ASP value, SURG value, ASP factor, SURG factor, and COMP factor for the calendar year. This is published annually by the commissioner.

B. List the plan benefits, ignoring deductibles, coinsurance, well baby care, emergency accident, supplemental accident, and student dependents. Include the plan maximum in the plan benefits.

C. For each benefit, find the appropriate table of equivalent points for basic and major medical plans.

D. Extract the appropriate point value for the benefit from the table, interpolating as necessary or indicated, and place it opposite the listed benefit. Ignore benefits for which no table exists.

E. Total the points for these benefits.

F. List deductible and coinsurance if the plan is a comprehensive major medical plan.

G. Determine the appropriate point values for deductible, interpolating as necessary, and place the value in the list of points. Calculate the coinsurance points and place the values in the list of points.

H. Determine the total points after the deduction for deductible and coinsurance.

I. Determine the deduction for coordination and nonduplication of benefits.

J. Determine the number of points for the limit on "out-of-pocket" expenses, well baby care, emergency accident,

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supplemental accident, and student dependents.

K. Calculate the grand total.

L. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

Subp. 2. **Superimposed major medical plans.** The following govern superimposed major medical plans:

A. Follow steps outlined in subpart 1, items A to D for basic health plan benefits.

B. Total the points for the basic plan.

C. Utilize part 2740.9964, subparts 23, 24, and 25 to determine the point value of a Minnesota qualified plan superimposed over the basic plan with the deductible and benefit period of the plan at hand, interpolating as necessary. Put the points in the point column.

D. Compare the benefits in the superimposed major medical plan with the benefit structure of a Minnesota qualified plan:

(1) $250,000 lifetime maximum.

(2) 80/20 coinsurance.

(3) $3,000 annual per person out-of-pocket maximum.

(4) Eligible expenses are usual and customary expenses for:

(a) hospital services;

(b) physician care;

(c) prescription drugs;

(d) nursing home care of up to 120 days in one year, commencing within 14 days of hospitalization of at least three days;

(e) home health care;

(f) radium and radioactive therapy;

(g) oxygen;

(h) anesthetics;

(i) prostheses;

(j) rental or purchase of durable medical equipment;

(k) diagnostic x rays and laboratory tests;

(l) oral surgery on impacted teeth, on tooth roots, or on gums and tissues of the mouth when not performed in connection with tooth extraction;

(m) physical therapy;

(n) maternity same as any illness;

(o) Minnesota statutorily-mandated benefits; and

(p) coordination of benefits.

E. Consult the tables for point adjustments (usually negative for Minnesota qualified plan benefits not in the superimposed major medical plan being tested). Put the adjustments in the point column.

F. Calculate the total by adding the points for the basic plan (item B), the superimposed major medical plan (item C), and the adjustments (item E).

G. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

2740.9929 BENEFIT VARIATIONS NOT COVERED BY TABLES.

Only those plan variations that are most common are recognized. For instance, comprehensive plan coinsurance was assumed normally not to exceed 20 percent. Therefore, no points are shown for 25 percent. However, points for such missing benefit variations can be extrapolated or estimated.

2740.9934 USE OF TABLES.

Subpart 1. **Certification of plans.** Any insurer, self-insurer, or policyholder may use the test for actuarial equivalence as a guide. To obtain certification of any plan of health benefits as qualified, it must be submitted to the commissioner.

Subp. 2. **Filing with commissioner.** The following ~~should~~ must be sent to the commissioner:

A. The plan document if an uninsured plan or the policy form if an insured plan.

B. A statement of the grand total from part 2740.9924.

C. A certification that the plan is qualified as either a plan 1, 2, or 3, or is nonqualified, by using the test of actuarial equivalence in part 2740.9949. The certification must be by a principal or officer, or by a member of the Academy of Actuaries.

D. If the plan is not a qualified plan by using the test of actuarial equivalence, and the insurer or self-insurer desires to have it certified as a qualified plan, a statement of the specific reasons for the desired qualification.

Subp. 3. **Certification by commissioner.** If the documents required by subpart 2 are filed and the plan is a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be deemed certified as filed. If the documents required by subpart 2 are filed and the plan is not a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be qualified ~~if, and when, the commissioner certifies it as a qualified plan~~ upon certification by the commissioner.

2740.9939 UPDATE OF TABLES.

Periodically, the tables may be revised as health care costs change. ~~The commissioner may revalue the actuarial equivalence of any plan or policy at any time deemed appropriate.~~ Also, as health care costs change, a plan may automatically lose or change its qualification. Annual revaluation of plans is required. When a plan is revalued and its qualification status changes, the filing procedures in part 2740.9934 will be followed.

2740.9944 MISUSE OF TABLES.

The tables of equivalent points are not intended for any other use, especially not for premium calculations. They represent a composite of data and were adjusted to be useable for testing actuarial equivalence. No other use is contemplated.

2740.9949 TEST FOR ACTUARIAL EQUIVALENCE FOR PLANS OTHER THAN MEDICARE SUPPLEMENT PLANS.

Subpart 1. **Table for 1984.**

If the Grand Total of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualified Plan No.
1192 + points	3
911 + points	2
767 + points	1
Less than 767 points	Nonqualified

Subp. 2. **Effect of inflation.** Each year the number of points required for each qualified plan will increase due to the effects of inflation on the benefits. Particular care ~~should~~ must be taken to revalue any policy form which contains scheduled benefits or other policy forms which have different deductible or coinsurance provisions.

2740.9954 WORKSHEET FOR OTHER THAN MEDICARE SUPPLEMENT PLANS.

Comprehensive Health Insurance

Test for Actuarial Equivalence

Other than Medicare Supplement Plans

Subparts of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board			
2.	Hospital extras			
3.	Surgery			
4.	Physician care-home, office			
5.	Physician care-hospital			
6.	Maternity			
7.	Diagnostic X-ray and lab			
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility			
11.	Home health care			
12.	Physical therapy			
12.	Oxygen			
12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty nursing			
12.	Ambulance			
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			
	Subtotal reasonable and customary			

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medical services
16. Deductible
16. Coinsurance
Subtotal net of deductible and coinsurance
17. Adjust (Comb. medical/dental deductible)
18. COB/No-Fault
19. Limit on "out-of-pocket" expenses
20. Well baby care
21. Emergency and supplemental accident
22. Student dependents
23.-25. Superimposed major medical
Grand Total
Combined Basic and Superimposed

XXX XXX

Equivalent to Minnesota qualified plan number___ nonqualified___

Date_____ By_____

2740.9959 LOCATION OF TABLES OF EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS.

Subparts of part 2740.9964	Other than Medicare Supplement Plans Name
1.	Hospital room and board
2.	Hospital extras
3.	Surgery
4.	Home and office physician care
5.	In-hospital physician care
6.	Maternity
7.	Diagnostic X-ray and laboratory
8.	Drugs and medicine
9.	Radioactive therapy
10.	Nursing or convalescent - home care
11.	Home health care agency service
12.	Physical therapy
12.	Oxygen
12.	Prostheses
12.	Durable medical equipment
12.	Second opinion surgery
12.	Private duty nursing
12.	Ambulance
13.	Hospital room and board in full
14.	All hospital charges in full
15.	Major medical maximums
16.	Coinsurance and deductibles
17.	Combined dental and health insurance deductible
18.	Coordination and nonduplication of benefits
19.	Limit on "out-of-pocket" expenses
20.	Well baby care
21.	Emergency and supplement accident
22.	Student dependents
23.	Superimposed major medical
24.	Superimposed major medical
25.	Superimposed major medical

2740.9964 EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS; NOT TO BE USED FOR MEDICARE SUPPLEMENT PLANS.

Subpart 1. **Hospital room and board.**

Maximum Days	Room & Board
31	327
70	347
120	351
365	359
Unlimited	363

A. Room and board is defined to include a semi-private room, or charges for a private room if prescribed as medically necessary by a physician. If the policy does not pay the additional charges for a private room, then deduct three points from hospital room and board.

B. If the policy pays the private room charge even though not medically necessary, then add ten points if average charge per day is four percent greater than the average semi-private room and board charge.

C. If the policy pays the hospital room and board charge up to a maximum daily benefit which is less than the average semi-private room and board charge in the area, then multiply the points for the semi-private room and board at the indicated maximum days by the ratio of the scheduled amount to the ASP value in the area for the year.

Subp. 2. **Hospital extras.** Hospital extras such as hospital services, special hospital services, ancillary services, and hospital therapeutics.

Maximum Amount*	Anesthesia** Included	Not Included
$ 500	130	130
1,000	217	216
2,000	317	312
5,000	413	401
10,000	454	433
15,000	469	444
Unlimited	480	451

*Before entering this table, divide the maximum amount in the policy by the ASP factor for the year.

**Anesthesia does not include the administration of anesthesia.

This is for miscellaneous hospital services and includes the cost for inpatient hospital care, the cost for outpatient hospital treatment and the excess cost of intensive care unit or

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coronary care unit over the average semi-private room and board.

Subp. 3. **Surgery.**

Limit	Administration of Anesthesia Included	Not Included
Prevailing Fee with Assistant Surgeon	243	206
Prevailing Fee without Assistant Surgeon	244	187

If the policy pays the reasonable and customary charges up to a maximum in a schedule, then multiply the points for the prevailing fee by the ratio of the value of the schedule used in the policy to the SURG value for the year.

Subp. 4. **Home and office physician care.**

Annual Maximum*	First Visit Sickness	First Visit Accident Third Visit Sickness
$ 200	111	63
500	141	72
1,000	165	93
Unlimited	215	118

*Before entering this table, divide the annual maximum in the policy by SURG factor for the year.

Subp. 5. **In-hospital physician care.**

Maximum Number of Visits	Prevailing Fee
31	46
70	49
120	49
365	50
Unlimited	51

A. This benefit pays the reasonable and customary charge to the physician (other than the surgeon, assistant surgeon, or anesthetist) while confined in the hospital for medical or surgical reasons.

B. If the policy pays the greater of this benefit or the surgical benefit, then reduce these points by 30 percent.

C. A number of policies pay a limited amount per visit (limited to one visit per day) which is less than or equal to the cost for a routine follow-up visit in the hospital. If it is equal to the cost for a routine follow-up visit (assumed to be $24.20*/day in 1984), then deduct 14 points from the above points. If it is less than that, then use a proportional part

of the points determined as if the maximum was equal to the cost for a routine follow-up visit.

*Multiply the indicated value by the SURG factor for the year.

Subp. 6. **Maternity.**

A. complications only:

limited to some specified list	20
any complications	25

B. full maternity (including complications):

Maximum Limit*	Deductible	Flat Maternity	Obstetrics	Hospital Maternity
$ 300	None	-	23	28
600	None	49	44	55
1,000	None	81	59	80
2,000	None	149	-	-
Unlimited	None	173	63	110

*Before entering this table, divide maximum limit in the policy by the ASP factor for the year.

Subp. 7. **X rays and laboratory tests (out of hospital).**

Maximum*	Scheduled (Any Scheduled)	Unscheduled
$100	56	70
200	67	89
500	74	101
Unlimited	77	105

*Before entering this table, divide the maximum in the policy by the ASP factor for the year.

Subp. 8. **Prescription drugs and medicine (out of hospital).**

Deductible* Per Prescription	
$4.00	69
2.00	86
None	100

*Before entering this table, divide the deductible per prescription by the SURG factor for the year.

Subp. 9. **Radioactive therapy (out of hospital).**

Scheduled (Any Schedule)	10
Unscheduled	15

Subp. 10. **Nursing or convalescent home care (within 14 days of hospital confinement of at least three days).**

Maximum Days

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120 or More	16
Less than 120	0

Subp. 11. **Home health care agency services.**

Maximum Visits/Year	
180 or More	8
Less than 180	0

Subp. 12. **Miscellaneous.**

A. physical therapy (out of hospital), 10;

B. oxygen (out of hospital), 4;

C. prostheses (out of hospital), 5;

D. durable medical equipment rental or purchase (out of hospital), 5;

E. second opinion surgery, 2;

F. private duty nursing (in hospital only), 2; and

G. ambulance, 3.

Subp. 13. **Hospital room and board in full to indicated limit (basic and comprehensive major medical plans).** Add these points to the points in subpart 1 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

	Plan Deductible* On All	Limit*			
Plan	Benefits	$1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0 - 300	58	60	66	79
Comprehensive	301 - 600	61	63	69	82
Comprehensive	601 - 900	66	68	74	87
Comprehensive	901 - 1200	74	76	82	95

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the policyholder pays 20 percent after the deductible. If the policyholder pays a different percentage, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that hospital room and board will be paid at 100 percent and that the deductible will not be applied to it. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining

deductible will not be applied but the coinsurance will be applied, to the hospital room and board benefits.

Subp. 14. **All hospital charges in full to indicated limit (basic and comprehensive major medical plans).** Add these points to the total points in subparts 1 and 2 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

Plan	Plan Deductible* On All Benefits	LIMIT* $1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0- 300	70	110	121	177
Comprehensive	301- 600	171	151	162	218
Comprehensive	601- 900	198	238	249	305
Comprehensive	901-1200	343	383	394	450

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is 1800. If the percentage being paid by the insured is not 20 percent, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that the hospital room and board and hospital services will be paid at 100 percent and that the deductible will not be applied to them. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining deductible will not be applied but the coinsurance will be applied, to either hospital room and board or hospital services benefits.

Subp. 15. **Major medical maximum (comprehensive and superimposed plans).**

Maximum*	Add (+) or Subtract (-)
$ 100,000	-27
250,000	-12
500,000	- 7
1,000,000	- 2

* Before entering the table, divide the maximum in the policy by

the COMP factor for the year.

The smallest maximum in a qualified plan is $250,000. The $100,000 maximum as provided ~~should~~ must be used in future years to help determine the reduction for a $250,000 plan.

Subp. 16. **Coinsurance and deductibles (comprehensive major medical plans).**

A. This table assumes that the point values for all medical services and supplies are approximately 1800 points before deduction for the maximum on total benefits. If the total points are significantly greater or smaller, then the point values must be adjusted.

Deductible*	Deducted Points
$ 0	0
50	85
100	170
150	245
200	310
500	622
1,000	820

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

B. To determine the deduction for the coinsurance, subtract the points deducted for the deductible from the total point value for the benefits and then multiply the result by the coinsurance percentage.

Subp. 17. **Combined dental and health insurance deductible (comprehensive major medical plans).**

Deductible*	Added Points
$ 50	75
100	60
150	43
200	38
500	35
1,000	15

* Before entering this table, divide the deductible in the policy by the COMP factor for the year.

Subp. 18. **Coordination and nonduplication of benefits (all plans).**

A. The following percentage of points after deduction for deductible and coinsurance ~~should~~ must be subtracted if the policy coordinates benefits with other plans and its pricing assumes that a number of insured will have other policies in

force.

(1) with other health plans, 4.0 percent;

(2) with no fault, 2.5 percent;

(3) with both subitems (1) and (2), 6.5 percent; and

(4) with neither, 0.

B. The percentage ~~should~~ must be applied to the total points after deduction for deductible and coinsurance.

Subp. 19. **Limit on "out-of-pocket" expenses (maximum copayment and deductible per benefit year) -- comprehensive and superimposed major medical plans.**

Maximum Claim When Out-of-Pocket is reached*	Points
$ 500	236
1,000	196
2,000	158
3,000	130
4,000	110
11,000	45
13,000	36
14,400	30

*Before entering this table, divide the maximum claim when out-of-pocket limit by the COMP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is about 1800. If the percentage of claims being paid by the insured is other than 20 percent, multiply the number of points above by the ratio of the coinsurance being paid by the insured to 20 percent.

B. The above table assumes that the amounts paid by the policyholder for deductible and coinsurance are included in determining the out-of-pocket limitation.

Subp. 20. **Well baby care.**

Deductible*	Points
$ 0	17
150	8
500	2
1,000	0

*Before entering this table, multiply the deductible in the

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policy by the COMP factor for the year.

The above benefit assumes that the deductible and coinsurance are applied to the costs of the newborn.

Subp. 21. **Emergency and supplemental accident (basic plans only).**

Maximum*	Emergency	Supplemental
$ 50	10	--
100	15	20
300	--	30
500	--	35
1,000	--	40
Unlimited	20	--

*Before entering this table, divide the maximum in the policy by the SURG factor for the year.

Subp. 22. **Student dependents.**

Student Extension Beyond Age 19	
None	0
To age 21	2
To age 23	4
To age 25	5

Subp. 23. **Superimposed major medical plans--over basic health plans with less than 500 points.**

A. Calculate point value of a comprehensive major medical plan by using deductible* $200 greater than actual.

B. Add basic health plan points.

* Before entering the table, divide the deductible in the policy by the COMP factor for the year before adding $200. Do not make any further adjustments to the deductible.

Subp. 24. **Superimposed major medical plans--80/20 coinsurance--over basic health plans with 500-799 points.**

	Calendar Year Plan		Two year benefit period plan	
Deductible*	Individual	2 x family	Individual	2 x family
a. Corridor				
$ 100	740	780	745	765
200	665	705	680	700
300	615	655	630	650
500	543	582	558	578
1,000	385	425	400	420
b. Integrated				
$1,000	615	635	650	670
2,000	515	525	535	545

Note: Points assume major medical contains Minnesota

qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

Subp. 25. **Superimposed major medical plans--80/20 coinsurance--over basic health plans with 800 or more points.**

	Add to Basic Plan Points			
	Calendar Year Plan		Two year benefit period plan	
Deductible*	Individual	2 x family	Individual	2 x family
a. Corridor				
$ 100	515	545	525	535
200	445	475	455	465
300	405	435	415	425
500	339	369	349	359
1,000	215	245	225	235
b. Integrated				
$1,000	505	525	530	550
2,000	405	415	420	430

Note: Points assume major medical contains Minnesota qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

2740.9979 BASIC BACKGROUND FOR EXAMPLES.

Subpart 1. **Inflation assumptions for 1985.** The examples which follow assume that the actuarial equivalence of a series of plans is being calculated for calendar year 1985. Inflation was assumed to be 15.5 percent and 8.0 percent for hospital related and all other services, respectively.

Subp. 2. **Values published by commissioner for 1985.**

ASP value for 1984	190*
ASP value for current year (1985*)	220*
SURG value for 1984	4,000.00
SURG value for current year (1985*)	4,320.00*
ASP factor for 1985*	1.155*
SURG factor for 1985*	1.080*
COMP factor for 1985*	1.121*

*Estimated. Please substitute the actual values.

Subp. 3. **Point values for qualified plans in 1985.** The following are the revised point values used to determine plans which are actuarially equivalent to qualified plans 1, 2, and 3

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for 1985.

Qualified Plan Number	If plan has the indicated number of points then plan is actuarially equivalent to the qualified plan in: 1984	1985
3	1192 + points	1216 + points
2	911 + points	957 + points
1	767 + points	847 + points
Nonqualified	Less than 767	Less than 847

2740.9991 EXAMPLE I.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Surgery	Includes Assistant Surgeon and Administration of Anesthesia
Deductible:	$100
Coinsurance:	80/20
Maximum:	$250,000
Maternity:	Any complications
Student dependents:	To age 23
Limits on specified benefits	Outpatient mental limited to Minnesota
Required benefits	--
Excluded care	Home health care
Out-of-pocket limit	$3,000 per year
Coordination of benefits	Yes, but no COB for no-fault.

B. Answer (calculated January 1, 1985): test result is 1186 points. This plan is a Minnesota qualified plan number 2.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subparts of part 2740.9964	Benefit	Major Medical Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board			363
2.	Hospital extras			480
3.	Surgery			243
4.	Physician care-home, office			215
5.	Physician care-hospital			51
6.	Maternity			25
7.	Diagnostic X-ray and lab			105
8.	Drugs and medicine			100
9.	Radioactive therapy			15
10.	Nursing/convalescent facility			16
11.	Home health care			0

12.	Physical therapy	10
12.	Oxygen	4
12.	Prostheses	5
12.	Durable medical equipment	5
12.	Second opinion surgery	2
12.	Private duty nursing	2
12.	Ambulance	3
13.	Hospital room and board in full	
14.	All hospital expenses in full	
15.	Major medical maximums	-12
	Subtotal reas. and cust. med. services	1632
16.	Deductible	-138
16.	Coinsurance	-299
	Subtotal net of ded. and coin.	1195
17.	Adjust (comb. medical/dental ded)	
18.	COB/No-fault	-48
19.	Limit on "out-of-pocket expenses"	35
20.	Well baby care	
21.	Emergency and supplemental accident	
22.	Student dependents	4
23.-25.	Superimposed major medical	
	Grand Total	1186
	Combined basic and superimposed XXX	XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) The maximum in the policy ($250,000) divided by the COMP factor (1.121) is $223,015. This is 82.01 percent of the difference between the $100,000 and $250,000 maximums in part 2740.9964, subpart 15. The points would be minus 27 plus .8201 times 15 or -14.70 points.

(2) The deductible in the policy ($100) divided by the COMP factor (1.121) is 89.21. This is 78.41 percent of the difference between the $50 and $100 deductibles in part 2740.9964, subpart 16. Points deducted for the deductible would be 85 plus .7841 times 85 or 151.65. Since the total points in the policy before the deductible is significantly less than 1800, multiply 151.65 by (1632/1800). The result is 137.50.

(3) The out-of-pocket maximum is $3,000. The maximum claim when the out-of-pocket is reached is $14,600. This divided by the COMP factor (1.121) is 13,024. This is

10.29 percent of the difference between the $13,000 and $14,400 maximum claim when out-of-pocket is reached. The adjustment for the out-of-pocket limit is 36 minus .1029 times 6 or 35.38.

2740.9992 EXAMPLE II.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital:	$170 per day, 365 days; 80 percent of misc. extras, the cost of anesthesia is included. The policy does not pay for private room even if medically necessary.
Surgery:	$3,000 maximum surgical schedule. Add 15 percent for the administration of anesthesia.
In hospital physicians calls:	$25 per day - 365 day maximum
Maternity:	Any complications
X-ray and lab tests (out of hospital):	$500 maximum - unscheduled

B. Answer (calculated January 1, 1985): test result is 1004 points. This plan is a Minnesota qualified plan number two.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subpart of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board	275		
2.	Hospital extras (80 percent)	384		
3.	Surgery	189		
4.	Physician care - home, office			
5.	Physician care - hospital	33		
6.	Maternity	25		
7.	Diagnostic X-ray and lab	98		
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility			
11.	Home health care			
12.	Physical therapy			
12.	Oxygen			

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12.	Prostheses	
12.	Durable medical equipment	
12.	Second opinion surgery	
12.	Private duty nursing	
12.	Ambulance	
13.	Hospital room and board in full	
14.	All hospital expenses in full	
15.	Major medical maximums	
	Subtotal reas. and cust. med. services	
16.	Deductible	
16.	Coinsurance	
	Subtotal net of ded. and coin.	
17.	Adjust (comb. medical/dental ded)	
18.	COB/No-fault	
19.	Limit on "out-of-pocket expenses"	
20.	Well baby care	
21.	Emergency and supplemental accident	
22.	Student dependents	
23.-25.	Superimposed major medical	
	Grand Total	1004
	Combined basic and superimposed	XXX XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) Policy does not pay extra for private room even if medically necessary. Deduct three points from the 359. Since the ASP value in 1985 is 220, the number of points will be 356 times the ratio of 170 to 220 or 275.09 points.

(2) The surgical table was evaluated as 3,680.02 points. The points not including administration of anesthesia is 206 times the ratio of 3680.02 to 4620.00 or 164.09 points. For administration of anesthesia, the points are 164 times .15 or 24.6 points.

(3) Since the maximum per diem cost of in-hospital physicians calls is less than the cost for routine follow-up (24.20 times 1.08 or 26.14), subtract 14 points from the number of points for prevailing fee with 365-day maximum. The result is 35 points. Multiply the 35 points by the ratio of $25 to 26.14 or 33.47 points.

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(4) Since the ASP factor is 1.15, the $200 and $500 maximum shown in part 2740.9964, subpart 7 is now 230 and 575 respectively. Thus the $500 maximum is 78.26 percent of the way between the two maximums. Therefore the point value equals 89 plus .7826 times (101-89) or 98.39 points.

2740.9993 EXAMPLE III.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital:	$80 per day, 120 days, $2,000 extras.
Surgery:	$1,500 maximum surgical schedule, add ten percent for administration of anesthesia.
Coordination of benefits	Yes, does not include no-fault
Superimposed major medical:	
Deductible:	$200 corridor per calendar year
Coinsurance:	80/20
Maximum:	$250,000
Maternity:	Any complications
Student dependents:	No
Out-of-pocket limit:	$3,000
Excluded care:	Home health care and skilled nursing care
Limits on specified benefits:	
1. Room and board	$200 less basic benefits. Unlimited days
Coordination of benefits	Yes, does not include no-fault

B. Answer (calculated January 1, 1985): test result is 1147 points. This plan is a Minnesota qualified plan number two.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

Subpart of part 2740.9964	Benefit	Basic	Major medical Superimposed	Comprehensive
1.	Hospital room and board	128	-26	
2.	Hospital extras	290		
3.	Surgery	114		
4.	Physician care - home, office			
5.	Physician care - hospital			
6.	Maternity			
7.	Diagnostic X-ray and lab			

8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility		-13	
11.	Home health care		-6	
12.	Physical therapy			
12.	Oxygen			
12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty nursing			
12.	Ambulance			
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			
	Subtotal reas. and cust. med. serv.	532		
16.	Deductible			
16.	Coinsurance			
	Subtotal net of ded. and coin.			
17.	Adjust (comb. medical/dental ded)			
18.	COB/no-fault	21		
19.	Limit on "out-of-pocket expenses"			
20.	Well baby care			
21.	Emergency and supplemental accident			
22.	Student dependents			
23.-25.	Superimposed major medical		681	
	Grand Total	511	636	
	Combined basic and superimposed	1147	XXX	XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) Since the room and board limit is less than the ASP factor, the number of points will equal 351 times the ratio of 80 to 220.

(2) The $2,000 maximum divided by 1.155 is 1731.60. This is 73.16 percent of the difference between the $1,000 and $2,000 maximums in the table. The points would be 217 plus .7316 times (317 - 217) or 290.16 points.

(3) The surgical schedule is the same as in example II in part 2740.9992 value. The value of the table is 1840.1 for the $1,500 maximum. The points excluding administration of anesthesia is 243 times 1840.1 divided by

4320.00 or 103.51 points. The administration of anesthesia would add 10.35 points.

(4) The $200 corridor deductible would be adjusted before entering part 2740.9964, subpart 24. The adjusted deductible would be 200 divided by 1.121 or 178.41. Since this is 78.41 percent of the way between the $100 and $200 deductibles, the points would be 740 minus .7841 times (740-665) or 681.19 points.

(5) Home health care and skilled nursing home care are excluded. Therefore we should deduct 80 percent of their points shown in part 2740.9964, subparts 10 and 11.

(6) Hospital room and board is limited to $200 per day less what the basic benefit pays. The adjustment should equal .8 (363 times 20 divided by 220) or 26.4 points.

REPEALER. Minnesota Rules, parts 2740.2300; 2740.9905; 2740.9910; 2740.9915; 2740.9920; 2740.9925; 2740.9930; 2740.9935; 2740.9940; 2740.9945; 2740.9950; 2740.9955; 2740.9960; 2740.9965; 2740.9970; 2740.9981; 2740.9982; 2740.9983; 2740.9984; 2740.9985; and 2740.9986 are repealed.

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
NOV 1 8 1985
Joan Anderson Growe
Secretary of State 9:00 AM

APPROVED AS TO FORM AND LEGALITY
8/5 1985
HUBERT H. HUMPHREY, III
ATTORNEY GENERAL
BY
ASSISTANT ATTORNEY GENERAL

AG copy

Department of Commerce

Adopted Rules Relating to the Comprehensive Health Insurance Association

Rules as Adopted

2740.0100 DEFINITIONS.

Subpart 1. to 12. [Unchanged.]

Subp. 13. **Covered expenses.** "Covered expenses" means the usual and customary charges for the services and articles listed in Minnesota Statutes, section 62E.06, or, with respect to qualified plans, the actuarial equivalence thereof, when prescribed for a covered person by a physician and when the expenses are incurred during a period in which the policy or contract is in effect.

Subp. 14. to 28. [Unchanged.]

Subp. 29. **Licensed and tested insurance agent or insurance agent.** "Licensed and tested insurance agent" or "insurance agent" means an insurance agent as defined in Minnesota Statutes, section 60A.02, subdivision 7, and licensed as such by the commissioner.

Subp. 30. and 31. [Unchanged.]

Subp. 32. **Net gains.** "Net gains" means the excess of premiums or contract charges over claims expenses, after the writing carrier's expenses and agent referral fees, not to exceed 15 percent of premiums or contract charges, have been paid as provided in part 2740.4400, subpart 4.

Subp. 33. to 44. [Unchanged.]

Subp. 44a. **Qualified medicare supplement plan.** "Qualified medicare supplement plan" means a plan of health coverage meeting the requirements of Minnesota Statutes, sections 62A.31, 62A.32, 62E.02, subdivision 5, and 62E.07.

Subp. 45. to 52. [Unchanged.]

Subp. 53. **Rejection.** "Rejection," for the purpose of state plan eligibility, means refusal by any association member, or any authorized representative, including any insurance agent,

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acting on behalf of any association member, to issue a qualified plan or a qualified medicare supplement plan to a person who completes an application for coverage under such qualified plan, or a qualified medicare supplement plan, as determined by the board.

Subp. 54. to 56. [Unchanged.]

Subp. 56a. **Self-insurer.** "Self-insurer" means an entity defined by Minnesota Statutes, section 62E.02, subdivision 21, which is a "governmental plan" as defined by United States Code, title 29, section 1002(32) or a "church plan" as defined by United States Code, title 29, section 1002(33)(A) or which is otherwise exempt from or outside of the scope of the provisions of the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001 to 1381, as amended.

Subp. 57. [Unchanged.]

Subp. 58. **Total cost of self-insurance.** "Total cost of self-insurance" includes any direct and indirect administrative expenses incurred that are related to the operation of a plan of self-insurance, plus the sum of any payment made to or on behalf of Minnesota residents for costs or charges for health benefits by a self-insurer under a plan of health coverage, which is not counted as premium by an insurer, except to the extent of such payments made for coverage of the types described in Minnesota Statutes, section 62E.02, subdivision 11, clauses (1) to (8).

Subp. 59. [Unchanged.]

2740.1100 DUTIES OF EMPLOYERS.

Subpart 1. **Duty to make available a qualified plan.** An employer shall be deemed to have made available a qualified plan to its employees as required in Minnesota Statutes, section 62E.03, subdivision 1 when participation under a number 2 or number 3 qualified plan or a health maintenance plan is offered to the employee by a self-insurer or through an insurer or health maintenance organization, without regard to whether the cost of such participation is paid directly or indirectly by the employer or by the employee or by their joint payment.

Subp. 2. [Unchanged.]

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Subp. 3. **Frequency of required offer.** Except as provided in subpart 2, an employer shall be deemed to have complied with the requirements of Minnesota Statutes, section 62E.03, subdivision 1 if the employer makes available to the employer's employees a plan of health coverage which is certified as a number 2 or number 3 qualified plan or a health maintenance plan at least once during each accounting period utilized by the employer for Minnesota income tax purposes.

2740.1200 DUTIES OF INSURERS AND FRATERNALS.

Subpart 1. [Unchanged.]

Subp. 2. **Timing of required offer of a qualified plan or qualified medicare supplement plan.** Timing of required offer of a qualified plan or qualified medicare supplement plan is as follows:

A. The offer of each type of qualified plan (that is, a number 1, number 2, and number 3 qualified plan) that is required when an insurer or fraternal is offering an individual policy of accident and health insurance shall occur no later than the date of delivery of such policy to the applicant.

B. to E. [Unchanged.]

Subp. 3. [Unchanged.]

Subp. 4. **Duty to offer major medical coverage.** Each insurer and fraternal shall affirmatively offer, subject to its underwriting standards, coverage of major medical expenses to every applicant for a new unqualified policy at the time of application and annually thereafter to every holder of an unqualified policy of accident and health insurance renewed by the insurer or fraternal as required by Minnesota Statutes, section 62E.04, subdivision 4. "Affirmatively offer" shall mean written advice to the applicant for, or the holder of, an unqualified policy of accident and health insurance, of the availability of coverage for major medical expenses. Such written advice of the availability of the coverage for major medical expenses may be satisfied by a contractual provision in the unqualified policy that gives the insured the contractual right to apply to the insurer or fraternal for a new policy or a

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rider on an existing unqualified policy that provides coverage for 80 percent of the covered expenses for services listed in Minnesota Statutes, section 62E.06, subdivision 1 or the actuarial equivalence thereof subject to a $5,000 deductible for out-of-pocket expenses, subject to the insurer's or fraternal's underwriting requirements.

Subp. 5. and 6. [Unchanged.]

Subp. 7. **Exceptions to duties for certain policies and contracts.** Exceptions to duties for certain policies and contracts are as follows:

A. [Unchanged.]

B. The issuance or renewal by an insurer or fraternal on or after June 3, 1977, of a policy or contract that is designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis, shall not be subject to Minnesota Statutes, section 62E.04, except for policies and contracts sold by an insurer to provide payments on a hospital indemnity basis if such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue.

Subp. 8. [Unchanged.]

2740.1600 TERMINATION OF COVERAGE; CONVERSION PRIVILEGES.

Subpart 1. and 2. [Unchanged.]

Subp. 3. **Due notice of cancellation or termination.** An insurer, health maintenance organization, or self-insurer shall be deemed to have provided "due notice of cancellation or termination" as required in Minnesota Statutes, section 62E.16 if the insurer, health maintenance organization, or self-insurer notifies in writing those employees at their respective addresses as provided to the insurer, health maintenance organization, or self-insurer by the employer pursuant to the terms of Minnesota Statutes, section 62E.16.

2740.2100 DEFINITIONS.

Subpart 1. **Accident and health insurance business.** "Accident and health insurance business" means the

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issuance or renewal of any accident and health insurance policy as defined in Minnesota Statutes, section 62E.02, subdivision 11.

A. [Unchanged.]

B. Such business shall not include the issuance or renewal of policies or contracts providing coverage that is:

(1) to (8) [Unchanged.]

(9) limited to accident-only coverage issued by an insurance agent and that provides reasonable benefits in relation to the cost of covered services.

Subp. 2. and 3. [Unchanged.]

Subp. 4. **Self-insurance business.** "Self-insurance business" means the provision, directly or indirectly, of a plan of health coverage by a self-insurer. "Self-insurance business" does not include the direct provision of health care services to employees at no charge to them by an employer engaged in the business of providing health care services to the public, nor does it include provision of benefits that, if provided by an insurer doing accident and health insurance business, would be excluded under subpart 1, item B. "Directly or indirectly" for the purposes of parts 2740.2100 to 2740.5500 means that the self-insurer funds the plan of health coverage in any amount or collects any employee contributions which are used to pay for the plan of health coverage.

2740.2400 ASSESSMENTS.

Contributing members will be assessed for their proportionate share of the operating and administrative expenses of the association, incurred or estimated to be incurred, together with losses, if any, incurred by the association as a result of operation of the state plan. The total amount of operating and administrative expenses and losses:

A. [Unchanged.]

B. may, at the recommendation of the board, subject to the approval of the commissioner, consist of a reasonable estimate of the operating and administrative expenses of the association for the succeeding fiscal year, which amount shall be adjusted at the end of the succeeding fiscal year to the

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amount of actual operating and administrative expenses, and contributing members shall be entitled to credit for any excess or shall be assessed for any deficit in these expenses in future assessments.

2740.2500 LEVY OF ASSESSMENTS.

Subpart 1. **Annual.** The association shall make an annual determination of each contributing member's liability, if any, and may levy assessments following each fiscal year end. The fiscal year ends on December 31 unless the association establishes a different fiscal year end. Assessments are due and payable 30 days after receipt of a written assessment notice.

Subp. 2. **Interim.** The association may also, upon approval of the commissioner, levy interim assessments when deemed necessary to assure the financial capability of the association to meet the incurred or estimated operating and administrative expenses of the association and losses resulting from the state plan. Interim assessments shall be due and payable within 30 days of receipt by a contributing member of a written interim assessment notice.

Subp. 3. **Member share.** The association shall levy each contributing member's share of the total assessment based on the ratio of: the contributing member's total premium for accident and health insurance business as defined in part 2740.2100, subparts 1 and 2, received from or on behalf of residents of Minnesota, as determined by the commissioner; to the total premium for accident and health insurance business for all contributing members.

Subp. 4. **Costs and charges.** The costs and charges referred to in the ratio in subpart 3 shall, to the extent possible, be determined by reference to a form issued by the association or the commissioner which all contributing members shall submit to the commissioner annually for the preceding calendar year.

A. [Unchanged.]

B. The commissioner shall have the authority to audit the accounts and records of any contributing member for the

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purpose of obtaining information necessary to levy an assessment.

Subp. 5. **Discretionary waiver.** The board may, in its discretion, decline to levy assessments against contributing members that owe $10 or less in a given year.

2740.2600 FAILURE TO PAY ASSESSMENTS.

Any contributing members that fail to pay annual or interim assessments when such assessments become payable will be reported by the association to the commissioner for appropriate action within the discretion of the commissioner.

2740.2900 DETERMINATION OF MEMBER'S VOTING RIGHTS.

Subpart 1. [Unchanged.]

Subp. 2. **Weighted vote.** A member's vote shall be a weighted vote based on the member's total cost of self-insurance, accident and health insurance premiums, subscriber contract charges, or health maintenance contract charges derived from or on behalf of residents of Minnesota in the previous calendar year, as determined by the commissioner. To the extent possible, this figure shall be determined by reference to the annual reporting form submitted by contributing members to the commissioner in accordance with part 2740.2500, subpart 4, and similar forms showing all other members' total accident and health insurance premiums, subscriber contract charges (defined as charges for business specified in part 2740.2100, subparts 1 and 2) received from or on behalf of residents of Minnesota, or total cost of self-insurance, as defined in part 2740.0100, subpart 58, as determined by the commissioner.

If the necessary information is not available to the commissioner on the form described in this subpart at the time that voting rights must be determined, the commissioner may estimate the member's weighted vote based on other information available to the commissioner.

Subp. 3. **Voting procedures.** Members are entitled to vote in person, by proxy, or by mail as determined by the board.

When a member elects to vote in person at a members'

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meeting, the representative casting the vote shall present credentials as required pursuant to the bylaws or operating rules of the association.

When a member elects to vote by proxy, the proxy statement as approved by the board shall be returned on or before the date indicated in the meeting notice sent to the members.

Voting by mail may be permitted as authorized by the bylaws or operating rules of the association, and the meeting notice to members shall so indicate.

2740.3100 MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLANS.

Subpart 1. [Unchanged.]

Subp. 2. **Benefits of number 1 and number 2 qualified plan.** Benefits shall meet or exceed the requirements of Minnesota Statutes, section 62E.06 or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables in parts 2740.9905 to 2740.9986, except where substitution of an actuarially equivalent benefit is not permissible under the act.

A. [Unchanged.]

B. Coverage shall include an annual (calendar year) limitation of not more than $3,000 per covered person on total out-of-pocket expenses, which out-of-pocket expenses shall include the deductible under the state plan policy or contract, and which out-of-pocket expense limitation is not subject to substitution of an actuarially equivalent benefit.

C. Coverage shall be subject to a maximum lifetime benefit of not less than $250,000 per covered person, less any amount paid to or on behalf of the covered person under any other qualified plan of the state plan. This benefit is not subject to substitution of an actuarially equivalent benefit.

Subp. 3. **Benefits of qualified medicare supplement plan.** Benefits of a qualified medicare supplement plan shall meet or exceed the following minimum standards.

A. The plan shall provide benefits to covered persons by supplementing medicare through provision of:

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(1) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare to at least 50 percent of the deductible and copayment required under medicare for the first 60 days of any medicare benefit period;

(2) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period;

(3) coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days to the extent not covered by medicare;

(4) upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of at least 50 FF 100 percent of the medicare calendar year part B deductible.

B. The plan shall provide 80 percent of the covered charges for expenses as provided in Minnesota Statutes, section 62E.06, which charges are not paid or payable under medicare or would not have been paid or payable had the covered person who is or was entitled or eligible to enroll in medicare been so enrolled or which charges are not paid or payable under item A.

C. Coverage shall include an annual limitation of $1,000 total out-of-pocket expenses per covered person for covered charges, provided that an annual deductible of not more than $200 is permissible for those covered charges not paid or payable under medicare or otherwise included in item A or B.

D. Coverage shall be subject to a maximum lifetime benefit of not less than $100,000 per covered person, less any amount paid to or on behalf of the covered person under any other qualified medicare supplement plan of the state plan.

E. The minimum coverage of a qualified medicare

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supplement plan required by this subpart is not subject to substitution of actuarially equivalent benefits.

Subp. 4. and 5. [Unchanged.]

2740.3600 ENROLLMENT.

Subp. 1. [Unchanged.]

Subp. 2. **Eligible person.** "Eligible person," as used in subpart 1, means a resident of Minnesota who submits or on whose behalf is submitted a complete certificate of eligibility and enrollment form to the association or its writing carrier and who is not already covered by another state plan policy or contract.

A. A complete certificate of eligibility and enrollment form may provide:

(1) name, address, age, and length of time as a resident of Minnesota;

(2) [Unchanged.]

(3) evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, by one association member, or by an authorized representative, including an insurance agent, acting on behalf of an association member, within six months of the date of application. "Substantially reduce coverage from that received by a person who is considered a standard risk" includes any restriction on coverage as a result of an illness, condition, or risk which the association deems substantial, any increase in rates for an applicant based on an illness, condition, or risk, which the association deems substantial, and any preexisting conditions limitation which the association deems substantial.

B. In lieu of evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, as required by item A, subitem (3), a complete certificate of eligibility and enrollment form may provide evidence which

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meets the requirements of an operating rule adopted by the association of a proposed covered person having been treated within three years of the date of the certificate of eligibility and enrollment form for one or more conditions listed in the operating rule.

C. Before a person is determined to be an eligible person, the board may require that any items listed in items A and B or, if acting pursuant to provisions of the association's operating rules, other necessary information be submitted to the association or its writing carrier and may also investigate the authenticity of information submitted as a part of the certificate of eligiblity.

D. If a covered person, under a qualified plan of the state plan, upon reaching age 65, or becoming enrolled in medicare, wishes to purchase a state plan qualified medicare supplement plan, the requirement that the person obtain one rejection, restrictive rider, rate-up, or preexisting conditions limitation on a qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, from one member of the association, or from an authorized representative, including an insurance agent acting on behalf of an association member, within the preceding six months may be waived by the board if acting pursuant to provisions of the association's operating rules.

E. A person who is age 65 or older shall be eligible for coverage only under the state plan's qualified medicare supplement plan and when an insured person under a qualified plan reaches age 65, the board may, if acting pursuant to provisions of the association's operating rules, terminate or refuse to renew coverage under the qualified plan. A person under age 65 who is otherwise eligible for coverage under the state plan and is enrolled in medicare shall be permitted to purchase a qualified plan 1 or 2 or the qualified medicare supplement plan of the state plan.

F. An applicant or any person proposed to be covered

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under a qualified plan of the state plan who has previously been covered under one or more qualified plans of the state plan and who has exhausted the $250,000 maximum lifetime benefit shall not be an eligible person for coverage under a qualified plan of the state plan; an applicant or any person proposed to be covered under a qualified medicare supplement plan of the state plan who has previously been covered under one or more qualified medicare supplement plans of the state plan and who has exhausted the $100,000 maximum lifetime benefit shall not be an eligible person for coverage under a qualified medicare supplement plan of the state plan.

G. When a covered person under the state plan no longer meets one or more of the requirements for eligibility for coverage under the state plan, the board may, if acting pursuant to the association's operating rules, terminate or refuse to renew coverage under the state plan.

2740.3700 ASSOCIATION'S RESPONSE.

Subpart 1. **Time limitation.** Within 30 days of receipt of a complete certificate of eligibility and enrollment form pursuant to part 2740.3600, subpart 2, items A, B, and C, the association or the writing carrier shall accept the certificate of eligibility or shall reject the certificate of eligibility for failure to meet the eligibility requirements.

Subp. 2. **Acceptance.** If the association or its writing carrier accepts the certificate of eligibility, it shall forward a notice of acceptance, billing information, and a policy or contract or certificate that shall evidence coverage under the state plan.

A. [Unchanged.]

B. When the state plan premium is received by the association or its writing carrier for the first billing period and accepted in accordance with this part, the coverage shall be effective retroactive to the date of receipt by the association or its writing carrier of the completed certificate of eligibility pursuant to part 2740.3600, subpart 2, items A, B, and C unless otherwise requested by the insured person and

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approved by the board.

Subp. 3. **Nonacceptance.** If the association does not accept the certificate of eligibility, the applicant shall be informed of the reason for the rejection and shall have the opportunity to submit additional information to substantiate eligibility for coverage under the state plan and to request reconsideration of the decision. The board may establish a review mechanism for reviewing requests for reconsideration of rejected certificates of eligibility. The association shall give notice of a final determination of ineligibility to the applicant stating the reasons therefor and advising the applicant of the right to appeal to the commissioner within a reasonable period of time.

2740.3900 DISSEMINATION OF INFORMATION CONCERNING STATE PLAN.

Subpart 1. **Plan.** The association shall develop a plan for use by the association, upon approval by the commissioner, to publicize the existence of the state plan and the eligibility requirements and procedures for enrollment, and to maintain public awareness of and participation in the state plan.

Subp. 2. **Forms and instructions.** The association shall prepare and make available certificate of eligibility forms and enrollment instruction forms to members, insurance agents and brokers, and to the general public in Minnesota.

Subp. 3. **Referral fee.** The association shall require the writing carrier to pay a referral fee of $50 for any certificate of eligibility accepted by the association or its writing carrier if the referring agent is licensed by the commissioner as an insurance agent and if the referring agent's signature appears as the agent on the accepted certificate of eligibility. The referral fee shall be paid from the premium received for the state plan. Referring agents shall not be authorized to interpret, amend, or alter the terms of the state plan policy or contract, nor shall referring agents be authorized to bind the association in any way. Referring agents shall not be agents of the association for any purpose, and the association shall not bear responsibility for acts of referring

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agents.

2740.4400 OPERATIONS OF WRITING CARRIER.

Subpart 1. **Administrative and claims payment functions.** The writing carrier shall perform all administrative and claims payment functions relating to the state plan.

A. [Unchanged.]

B. The writing carrier shall perform all necessary functions to assure timely payment of benefits to covered persons under the state plan.

(1) to (3) [Unchanged.]

(4) The writing carrier shall exercise reasonable efforts to advise covered persons, within 60 business days of receipt of a properly completed and executed proof of loss, whether the submitted claim was accepted or rejected by the writing carrier, unless sooner settled.

(5) The writing carrier may establish an appeals procedure approved by the board to review claims that are denied in whole or in part. When a claim or any portion thereof is denied, the writing carrier shall inform the covered person of the existence of the procedure, including the right to appeal to the commissioner within a reasonable period of time.

Subp. 2. [Unchanged.]

Subp. 3. **Claims expenses.** The writing carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the state plan. If the writing carrier's payments for claims expenses exceed the portion of the state plan premiums allocated by the board for payment of claims expenses, the association shall provide to the writing carrier additional funds for payment of claims expenses. Not less than 85 percent of the state plan premium, as determined by the board, shall be used to pay claims expenses, and not more than 15 percent of the state plan premium shall be used to pay agent referral fees (authorized by Minnesota Statutes, section 62E.15, subdivision 3) and to pay the writing carrier's direct and indirect expenses, as defined and authorized in Minnesota Statutes, section 62E.13, subdivision 7 and described in subpart

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5.

Subp. 4. **Direct and indirect expense reimbursement.** The writing carrier shall be paid from time to time as provided in the association's contract with the writing carrier for its direct and indirect expenses incurred in the performance of its services from the state plan premiums received in an amount not to exceed the lesser of:

A. 15 percent of the state plan premium, less agent referral fees payable under part 2740.3900, subpart 3;

B. and C. [Unchanged.]

Subp. 5. **Direct and indirect expenses.** Direct and indirect expenses shall include that portion of the writing carrier's actual administrative, printing, claims administration, management, building overhead expenses, and other actual operating and administrative expenses approved by the board as allocable to the administration of the state plan.

Subp. 6. and 7. [Unchanged.]

2740.5200 REINSURANCE PLAN.

Subpart 1. [Unchanged.]

Subp. 2. **Application and acceptance.** Insurer or fraternal members wishing to participate in the pool shall apply to the association for participation in the pool, specifying the categories of coverage that the member desires to reinsure.

Each member entering into a reinsurance pooling agreement for a particular category or categories of coverage shall offer to place in the pool all policies and contracts that it issues in the category or categories listed in part 2740.5100 that it wishes to reinsure.

Only policies and contracts acceptable to the association or its reinsurance administrator may be accepted for reinsurance. The association is under no obligation to accept any but standard risks in the reinsurance plan.

Subp. 3. to 5. [Unchanged.]

All new material from this point

2740.9904 PURPOSE.

Minnesota Statutes, section 62E.02, defines "qualified

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plans" as health benefit plans that provide the benefits required in Minnesota Statutes, section 62E.06 or "the actuarial equivalent of those benefits." Minnesota Statutes, section 62E.06 describes three qualified plans. These statutes require all plans of health coverage subject to Minnesota Statutes, section 62E.06 to be labeled as qualified or non-qualified. The commissioner may be requested to determine whether a plan is qualified and may take up to 90 days to make that determination. Minnesota Statutes, section 62E.02 defines a qualified medicare supplement plan as one which has been certified by the commissioner as providing the minimum benefits required by Minnesota Statutes, section 62E.07. Since the definition does not allow the option of an actuarial equivalent plan, the current rules do not include actuarial equivalent tables for medicare supplement policies.

non-rule

2740.9909 COMPOSITE POINT VALUES FOR QUALIFIED PLAN NUMBER THREE.

The composite point values for a qualified plan number three for 1984 are as shown herein.

Composite Point Values for Minnesota Qualified Plan No. 3

Points	Benefit
363	Hospital room and board, unlimited days, semi-private.
480	Hospital extras (i.e., hospital services, hospital miscellaneous, hospital special services, or ancillary services) including anesthesia.
243	Surgery, including administration of anesthesia, assistant surgeon and oral surgery but no tooth repair or extractions.
215	Home and office physician care, unlimited.
51	Physician care in hospital, unlimited.
63	Obstetrics, unlimited.
110	Hospital maternity, unlimited.
105	X rays and laboratory tests, outpatient and out of hospital.
100	Prescription drugs and medicine, outpatient and out of hospital.
15	Radioactive therapy, outpatient and out of hospital.
16	Nursing or convalescent facility.
8	Home health agency care.
10	Physical therapy.
4	Oxygen.
5	Prostheses.
5	Durable medical equipment rental or purchase.
2	Second opinion surgery.
2	Private duty nursing.
3	Ambulance.
-12	Adjustment for major medical maximum.
1788	Total reasonable and customary medical services
-245	$150 deductible.

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-309	20 percent coinsurance.
1234	Total after deductions for deductible and coinsurance
-49	Coordination of benefits.
-31	Nonduplication with no-fault.
30	3,000 annual "out-of-pocket" expense limit.
8	Well baby care.
0	Emergency accident.
0	Supplement accident.
0	Student dependents.
1192	Grand Total

2740.9914 DETERMINATION OF AVERAGE SEMI-PRIVATE HOSPITAL ROOM AND BOARD LEVEL OF SURGICAL CHARGES.

Subpart 1. **Why develop values annually.** Many companies issue policies with scheduled benefits. Due to inflation the value of scheduled benefits declines each year in relation to reasonable and customary charges. It would be best if the test of actuarial equivalence would automatically adjust for inflation and thus would more accurately value these types of benefits.

Not rule.

Subp. 2. **When values determined.** In December of each year, the commissioner will publish the following values:

A. the average semi-private hospital room and board (ASP value);

B. the value of surgical charges (SURG value);

C. the ratios of the average semi-private hospital room and board for the year to that in 1984 (ASP factor);

D. the ratio of the value of surgical charges for the year to that in 1984 (SURG factor); and

E. the composite ratio of medical care for the year to that in 1984 (COMP factor).

The commissioner may appoint a service agency to calculate these values on a consistent basis each year.

Subp. 3. **How values determined.** Values will be determined as follows:

A. The ASP value will be the weighted bed average of semi-private room and board charges for acute hospitals in Minnesota. The information will be derived from each hospital's latest room and board charge filed with the commissioner or the service agency. A semi-private room will be defined as a room

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with two beds.

B. The SURG value will be the sum of the product of the average charge, filed with the commissioner or the service agency, for each of the surgical operations shown below times the factor shown for that operation. The surgical operations and their factors are shown in part 2740.9919.

C. The ASP factor will be the ASP value to be published for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

D. The SURG factor is the ratio of the SURG value for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

E. The COMP factor is the composite factor for medical care. This equals 54 percent times the ASP factor for the year plus 46 percent times the SURG factor for the year.

2740.9919 TABLE OF SURGICAL FACTORS TO DEVELOP SURG VALUE.

CPT4 Code	Surgical Factor	Description
SKIN		
10060	.7710	Abscess, incision, and drainage, simple
11400	2.0161	Benign lesion removal of (up to 0.5 cm.)
11750	.4368	Nail, permanent removal of
12011	1.9732	Simple wound, simple repair (up to 2.5 cm.)
17100	4.6520	Benign skin lesion, destruction of
MUSCULOSKELETAL		
20610	1.9226	Major joint or bursa, injection or aspiration of
27130	.1565	Total hip joint replacement, simple
29425	1.0286	Application walking cast
CARDIOVASCULAR		
33512	.1111	Coronary bypass, three arteries
93547	.2166	Left heart catheterization with coronary angiogram
DIGESTIVE SYSTEM		
43235	.4514	Gastroscopy, diagnostic
43844	.0569	Stomach bypass for morbid obesity
44950	.2618	Appendectomy
45300	2.7170	Proctosigmoidoscopy, diagnostic
47600	.3765	Gallbladder, removal of
49505	.3086	Inquinal hernia repair, unilateral
URINARY SYSTEM		
52601	.1579	Prostate resection (TUR), complete
53670	3.5273	Urinary bladder catheterization
MALE GENITAL		
54150	.8509	Circumcision by clamp, newborn
FEMALE GENITAL		
58120	.8470	Uterus, dilation and curettage (D & C),

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		nonobstetrical
58150	.4792	Uterus, removal of
58980	.9455	Laparoscopy, diagnostic
NERVOUS SYSTEM		
63030	.0694	Laminotomy herniated disc, lumbar
64721	.1988	Carpal tunnel symdrome repair
EYE		
66980	.2003	Cataract removal, intraocular lens insertion
EAR		
69437	.3934	Tympanostomy with ventilating tube insertion

2740.9924 HOW TO USE THE LIST.

Subpart 1. **Basic and comprehensive major medical plans.** The list is used in the following manner:

A. Determine the ASP value, SURG value, ASP factor, SURG factor, and COMP factor for the calendar year. This is published annually by the commissioner.

B. List the plan benefits, ignoring deductibles, coinsurance, well baby care, emergency accident, supplemental accident, and student dependents. Include the plan maximum in the plan benefits.

C. For each benefit, find the appropriate table of equivalent points for basic and major medical plans.

D. Extract the appropriate point value for the benefit from the table, interpolating as necessary or indicated, and place it opposite the listed benefit. Ignore benefits for which no table exists.

E. Total the points for these benefits.

F. List deductible and coinsurance if the plan is a comprehensive major medical plan.

G. Determine the appropriate point values for deductible, interpolating as necessary, and place the value in the list of points. Calculate the coinsurance points and place the values in the list of points.

H. Determine the total points after the deduction for deductible and coinsurance.

I. Determine the deduction for coordination and nonduplication of benefits.

J. Determine the number of points for the limit on "out-of-pocket" expenses, well baby care, emergency accident,

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supplemental accident, and student dependents.

K. Calculate the grand total.

L. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

Subp. 2. **Superimposed major medical plans.** The following govern superimposed major medical plans:

A. Follow steps outlined in subpart 1, items A to D for basic health plan benefits.

B. Total the points for the basic plan.

C. Utilize part 2740.9964, subparts 23, 24, and 25 to determine the point value of a Minnesota qualified plan superimposed over the basic plan with the deductible and benefit period of the plan at hand, interpolating as necessary. Put the points in the point column.

D. Compare the benefits in the superimposed major medical plan with the benefit structure of a Minnesota qualified plan:

(1) $250,000 lifetime maximum.

(2) 80/20 coinsurance.

(3) $3,000 annual per person out-of-pocket maximum.

(4) Eligible expenses are usual and customary expenses for:

(a) hospital services;

(b) physician care;

(c) prescription drugs;

(d) nursing home care of up to 120 days in one year, commencing within 14 days of hospitalization of at least three days;

(e) home health care;

(f) radium and radioactive therapy;

(g) oxygen;

(h) anesthetics;

(i) prostheses;

(j) rental or purchase of durable medical equipment;

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(k) diagnostic x rays and laboratory tests;

(l) oral surgery on impacted teeth, on tooth roots, or on gums and tissues of the mouth when not performed in connection with tooth extraction;

(m) physical therapy;

(n) maternity same as any illness;

(o) Minnesota statutorily-mandated benefits; and

(p) coordination of benefits.

E. Consult the tables for point adjustments (usually negative for Minnesota qualified plan benefits not in the superimposed major medical plan being tested). Put the adjustments in the point column.

F. Calculate the total by adding the points for the basic plan (item B), the superimposed major medical plan (item C), and the adjustments (item E).

G. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

2740.9929 BENEFIT VARIATIONS NOT COVERED BY TABLES.

Only those plan variations that are most common are recognized. For instance, comprehensive plan coinsurance was assumed normally not to exceed 20 percent. Therefore, no points are shown for 25 percent. However, points for such missing benefit variations can be extrapolated or estimated.

2740.9934 USE OF TABLES.

Subpart 1. **Certification of plans.** Any insurer, self-insurer, or policyholder may use the test for actuarial equivalence as a guide. To obtain certification of any plan of health benefits as qualified, it must be submitted to the commissioner.

Subp. 2. **Filing with commissioner.** The following should be sent to the commissioner:

A. The plan document if an uninsured plan or the policy form if an insured plan.

B. A statement of the grand total from part 2740.9924.

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C. A certification that the plan is qualified as either a plan 1, 2, or 3, or is nonqualified, by using the test of actuarial equivalence in part 2740.9949. The certification must be by a principal or officer, or by a member of the Academy of Actuaries.

D. If the plan is not a qualified plan by using the test of actuarial equivalence, and the insurer or self-insurer desires to have it certified as a qualified plan, a statement of the specific reasons for the desired qualification.

Subp. 3. **Certification by commissioner.** If the documents required by subpart 2 are filed and the plan is a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be deemed certified as filed. If the documents required by subpart 2 are filed and the plan is not a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be qualified if, and when, the commissioner certifies it as a qualified plan.

? vague.

2740.9939 UPDATE OF TABLES.

Periodically, the tables may be revised as health care costs change. The commissioner may revalue the actuarial equivalence of any plan or policy at any time deemed appropriate. Also, as health care costs change, a plan may automatically lose or change its qualification. Annual revaluation of plans is required. When a plan is revalued and its qualification status changes, the filing procedures in part 2740.9934 will be followed.

? vague.

2740.9944 MISUSE OF TABLES.

The tables of equivalent points are not intended for any other use, especially not for premium calculations. They represent a composite of data and were adjusted to be useable for testing actuarial equivalence. No other use is contemplated.

non-rule

2740.9949 TEST FOR ACTUARIAL EQUIVALENCE FOR PLANS OTHER THAN MEDICARE SUPPLEMENT PLANS.

Subpart 1. **Table for 1984.**

Then that Plan is

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If the Grand Total of any Plan is:	the Actuarial Equivalent of Minnesota Qualified Plan No.
1192 + points	3
911 + points	2
767 + points	1
Less than 767 points	Nonqualified

Subp. 2. **Effect of inflation.** Each year the number of points required for each qualified plan will increase due to the effects of inflation on the benefits. Particular care should be taken to revalue any policy form which contains scheduled benefits or other policy forms which have different deductible or coinsurance provisions.

non-rule

2740.9954 WORKSHEET FOR OTHER THAN MEDICARE SUPPLEMENT PLANS.

Comprehensive Health Insurance

Test for Actuarial Equivalence

Other than Medicare Supplement Plans

Subparts of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board			
2.	Hospital extras			
3.	Surgery			
4.	Physician care-home, office			
5.	Physician care-hospital			
6.	Maternity			
7.	Diagnostic X-ray and lab			
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility			
11.	Home health care			
12.	Physical therapy			
12.	Oxygen			
12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty nursing			
12.	Ambulance			
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			
	Subtotal reasonable and customary medical services			

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16.	Deductible	
16.	Coinsurance	
	Subtotal net of deductible and coinsurance	
17.	Adjust (Comb. medical/dental deductible)	
18.	COB/No-Fault	
19.	Limit on "out-of-pocket" expenses	
20.	Well baby care	
21.	Emergency and supplemental accident	
22.	Student dependents	
23.-25.	Superimposed major medical	
	Grand Total Combined Basic and Superimposed	XXX XXX

Equivalent to Minnesota qualified plan number___ nonqualified___

Date_____ By_____

2740.9959 LOCATION OF TABLES OF EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS.

Subparts of part 2740.9964	Other than Medicare Supplement Plans Name
1.	Hospital room and board
2.	Hospital extras
3.	Surgery
4.	Home and office physician care
5.	In-hospital physician care
6.	Maternity
7.	Diagnostic X-ray and laboratory
8.	Drugs and medicine
9.	Radioactive therapy
10.	Nursing or convalescent - home care
11.	Home health care agency service
12.	Physical therapy
12.	Oxygen
12.	Prostheses
12.	Durable medical equipment
12.	Second opinion surgery
12.	Private duty nursing
12.	Ambulance
13.	Hospital room and board in full
14.	All hospital charges in full
15.	Major medical maximums
16.	Coinsurance and deductibles
17.	Combined dental and health insurance deductible
18.	Coordination and nonduplication of benefits
19.	Limit on "out-of-pocket" expenses
20.	Well baby care
21.	Emergency and supplement accident
22.	Student dependents
23.	Superimposed major medical
24.	Superimposed major medical
25.	Superimposed major medical

2740.9964 EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS; NOT TO BE USED FOR MEDICARE SUPPLEMENT PLANS.

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Subpart 1. **Hospital room and board.**

Maximum Days	Room & Board
31	327
70	347
120	351
365	359
Unlimited	363

A. Room and board is defined to include a semi-private room, or charges for a private room if prescribed as medically necessary by a physician. If the policy does not pay the additional charges for a private room, then deduct three points from hospital room and board.

B. If the policy pays the private room charge even though not medically necessary, then add ten points if average charge per day is four percent greater than the average semi-private room and board charge.

C. If the policy pays the hospital room and board charge up to a maximum daily benefit which is less than the average semi-private room and board charge in the area, then multiply the points for the semi-private room and board at the indicated maximum days by the ratio of the scheduled amount to the ASP value in the area for the year.

Subp. 2. **Hospital extras.** Hospital extras such as hospital services, special hospital services, ancillary services, and hospital therapeutics.

Maximum Amount*	Anesthesia** Included	Not Included
$ 500	130	130
1,000	217	216
2,000	317	312
5,000	413	401
10,000	454	433
15,000	469	444
Unlimited	480	451

*Before entering this table, divide the maximum amount in the policy by the ASP factor for the year.

**Anesthesia does not include the administration of anesthesia.

This is for miscellaneous hospital services and includes the cost for inpatient hospital care, the cost for outpatient hospital treatment and the excess cost of intensive care unit or

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coronary care unit over the average semi-private room and board.

Subp. 3. **Surgery.**

Limit	Administration of Anesthesia Included	Not Included
Prevailing Fee with Assistant Surgeon	243	206
Prevailing Fee without Assistant Surgeon	244	187

If the policy pays the reasonable and customary charges up to a maximum in a schedule, then multiply the points for the prevailing fee by the ratio of the value of the schedule used in the policy to the SURG value for the year.

Subp. 4. **Home and office physician care.**

Annual Maximum*	First Visit Sickness	First Visit Accident Third Visit Sickness
$ 200	111	63
500	141	72
1,000	165	93
Unlimited	215	118

*Before entering this table, divide the annual maximum in the policy by SURG factor for the year.

Subp. 5. **In-hospital physician care.**

Maximum Number of Visits	Prevailing Fee
31	46
70	49
120	49
365	50
Unlimited	51

A. This benefit pays the reasonable and customary charge to the physician (other than the surgeon, assistant surgeon, or anesthetist) while confined in the hospital for medical or surgical reasons.

B. If the policy pays the greater of this benefit or the surgical benefit, then reduce these points by 30 percent.

C. A number of policies pay a limited amount per visit (limited to one visit per day) which is less than or equal to the cost for a routine follow-up visit in the hospital. If it is equal to the cost for a routine follow-up visit (assumed to be $24.20*/day in 1984), then deduct 14 points from the above points. If it is less than that, then use a proportional part

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of the points determined as if the maximum was equal to the cost for a routine follow-up visit.

*Multiply the indicated value by the SURG factor for the year.

Subp. 6. **Maternity.**

A. complications only:

limited to some specified list	20
any complications	25

B. full maternity (including complications):

Maximum Limit*	Deductible	Flat Maternity	Obstetrics	Hospital Maternity
$ 300	None	-	23	28
600	None	49	44	55
1,000	None	81	59	80
2,000	None	149	-	-
Unlimited	None	173	63	110

*Before entering this table, divide maximum limit in the policy by the ASP factor for the year.

Subp. 7. **X rays and laboratory tests (out of hospital).**

Maximum*	Scheduled (Any Scheduled)	Unscheduled
$100	56	70
200	67	89
500	74	101
Unlimited	77	105

*Before entering this table, divide the maximum in the policy by the ASP factor for the year.

Subp. 8. **Prescription drugs and medicine (out of hospital).**

Deductible* Per Prescription	
$4.00	69
2.00	86
None	100

*Before entering this table, divide the deductible per prescription by the SURG factor for the year.

Subp. 9. **Radioactive therapy (out of hospital).**

Scheduled (Any Schedule)	10
Unscheduled	15

Subp. 10. **Nursing or convalescent home care (within 14 days of hospital confinement of at least three days).**

Maximum Days

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120 or More	16
Less than 120	0

Subp. 11. **Home health care agency services.**

Maximum Visits/Year	
180 or More	8
Less than 180	0

Subp. 12. **Miscellaneous.**

A. physical therapy (out of hospital), 10;

B. oxygen (out of hospital), 4;

C. prostheses (out of hospital), 5;

D. durable medical equipment rental or purchase (out of hospital), 5;

E. second opinion surgery, 2;

F. private duty nursing (in hospital only), 2; and

G. ambulance, 3.

Subp. 13. **Hospital room and board in full to indicated limit (basic and comprehensive major medical plans).** Add these points to the points in subpart 1 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

	Plan Deductible* On All	Limit*			
Plan	Benefits	$1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0 - 300	58	60	66	79
Comprehensive	301 - 600	61	63	69	82
Comprehensive	601 - 900	66	68	74	87
Comprehensive	901 - 1200	74	76	82	95

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the policyholder pays 20 percent after the deductible. If the policyholder pays a different percentage, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that hospital room and board will be paid at 100 percent and that the deductible will not be applied to it. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining

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deductible will not be applied but the coinsurance will be applied, to the hospital room and board benefits.

Subp. 14. **All hospital charges in full to indicated limit (basic and comprehensive major medical plans).** Add these points to the total points in subparts 1 and 2 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

Plan	Plan Deductible* On All Benefits	LIMIT* $1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0- 300	70	110	121	177
Comprehensive	301- 600	171	151	162	218
Comprehensive	601- 900	198	238	249	305
Comprehensive	901-1200	343	383	394	450

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is 1800. If the percentage being paid by the insured is not 20 percent, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that the hospital room and board and hospital services will be paid at 100 percent and that the deductible will not be applied to them. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining deductible will not be applied but the coinsurance will be applied, to either hospital room and board or hospital services benefits.

Subp. 15. **Major medical maximum (comprehensive and superimposed plans).**

Maximum*	Add (+) or Subtract (-)
$ 100,000	-27
250,000	-12
500,000	- 7
1,000,000	- 2

* Before entering the table, divide the maximum in the policy by

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the COMP factor for the year.

The smallest maximum in a qualified plan is $250,000. The $100,000 maximum as provided should be used in future years to help determine the reduction for a $250,000 plan.

Subp. 16. **Coinsurance and deductibles (comprehensive major medical plans).**

A. This table assumes that the point values for all medical services and supplies are approximately 1800 points before deduction for the maximum on total benefits. If the total points are significantly greater or smaller, then the point values must be adjusted.

Deductible*	Deducted Points
$ 0	0
50	85
100	170
150	245
200	310
500	622
1,000	820

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

B. To determine the deduction for the coinsurance, subtract the points deducted for the deductible from the total point value for the benefits and then multiply the result by the coinsurance percentage.

Subp. 17. **Combined dental and health insurance deductible (comprehensive major medical plans).**

Deductible*	Added Points
$ 50	75
100	60
150	43
200	38
500	35
1,000	15

* Before entering this table, divide the deductible in the policy by the COMP factor for the year.

Subp. 18. **Coordination and nonduplication of benefits (all plans).**

A. The following percentage of points after deduction for deductible and coinsurance should be subtracted if the policy coordinates benefits with other plans and its pricing assumes that a number of insured will have other policies in

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force.

(1) with other health plans, 4.0 percent;

(2) with no fault, 2.5 percent;

(3) with both subitems (1) and (2), 6.5 percent; and

(4) with neither, 0.

B. The percentage should be applied to the total points after deduction for deductible and coinsurance.

Subp. 19. **Limit on "out-of-pocket" expenses (maximum copayment and deductible per benefit year) -- comprehensive and superimposed major medical plans.**

Maximum Claim When Out-of-Pocket is reached*	Points
$ 500	236
1,000	196
2,000	158
3,000	130
4,000	110
11,000	45
13,000	36
14,400	30

*Before entering this table, divide the maximum claim when out-of-pocket limit by the COMP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is about 1800. If the percentage of claims being paid by the insured is other than 20 percent, multiply the number of points above by the ratio of the coinsurance being paid by the insured to 20 percent.

B. The above table assumes that the amounts paid by the policyholder for deductible and coinsurance are included in determining the out-of-pocket limitation.

Subp. 20. **Well baby care.**

Deductible*	Points
$ 0	17
150	8
500	2
1,000	0

*Before entering this table, multiply the deductible in the

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policy by the COMP factor for the year.

The above benefit assumes that the deductible and coinsurance are applied to the costs of the newborn.

Subp. 21. **Emergency and supplemental accident (basic plans only).**

Maximum*	Emergency	Supplemental
$ 50	10	--
100	15	20
300	--	30
500	--	35
1,000	--	40
Unlimited	20	--

*Before entering this table, divide the maximum in the policy by the SURG factor for the year.

Subp. 22. **Student dependents.**

Student Extension Beyond Age 19	
None	0
To age 21	2
To age 23	4
To age 25	5

Subp. 23. **Superimposed major medical plans--over basic health plans with less than 500 points.**

A. Calculate point value of a comprehensive major medical plan by using deductible* $200 greater than actual.

B. Add basic health plan points.

* Before entering the table, divide the deductible in the policy by the COMP factor for the year before adding $200. Do not make any further adjustments to the deductible.

Subp. 24. **Superimposed major medical plans--80/20 coinsurance--over basic health plans with 500-799 points.**

	Calendar Year Plan		Two year benefit period plan	
Deductible*	Individual	2 x family	Individual	2 x family
a. Corridor				
$ 100	740	780	745	765
200	665	705	680	700
300	615	655	630	650
500	543	582	558	578
1,000	385	425	400	420
b. Integrated				
$1,000	615	635	650	670
2,000	515	525	535	545

Note: Points assume major medical contains Minnesota

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qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

Subp. 25. **Superimposed major medical plans--80/20 coinsurance--over basic health plans with 800 or more points.**

	Add to Basic Plan Points			
	Calendar Year Plan		Two year benefit period plan	
Deductible*	Individual	2 x family	Individual	2 x family
a. Corridor				
$ 100	515	545	525	535
200	445	475	455	465
300	405	435	415	425
500	339	369	349	359
1,000	215	245	225	235
b. Integrated				
$1,000	505	525	530	550
2,000	405	415	420	430

Note: Points assume major medical contains Minnesota qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

2740.9979 BASIC BACKGROUND FOR EXAMPLES.

Subpart 1. **Inflation assumptions for 1985.** The examples which follow assume that the actuarial equivalence of a series of plans is being calculated for calendar year 1985. Inflation was assumed to be 15.5 percent and 8.0 percent for hospital related and all other services, respectively.

Subp. 2. **Values published by commissioner for 1985.**

ASP value for 1984	190*
ASP value for current year (1985*)	220*
SURG value for 1984	4,000.00
SURG value for current year (1985*)	4,320.00*
ASP factor for 1985*	1.155*
SURG factor for 1985*	1.080*
COMP factor for 1985*	1.121*

*Estimated. Please substitute the actual values.

Subp. 3. **Point values for qualified plans in 1985.** The following are the revised point values used to determine plans which are actuarially equivalent to qualified plans 1, 2, and 3

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for 1985.

Qualified Plan Number	If plan has the indicated number of points then plan is actuarially equivalent to the qualified plan in: 1984	1985
3	1192 + points	1216 + points
2	911 + points	957 + points
1	767 + points	847 + points
Nonqualified	Less than 767	Less than 847

2740.9991 EXAMPLE I.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Surgery	Includes Assistant Surgeon and Administration of Anesthesia
Deductible:	$100
Coinsurance:	80/20
Maximum:	$250,000
Maternity:	Any complications
Student dependents:	To age 23
Limits on specified benefits	Outpatient mental limited to Minnesota
Required benefits	--
Excluded care	Home health care
Out-of-pocket limit	$3,000 per year
Coordination of benefits	Yes, but no COB for no-fault.

B. Answer (calculated January 1, 1985): test result is 1186 points. This plan is a Minnesota qualified plan number 2.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subparts of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board			363
2.	Hospital extras			480
3.	Surgery			243
4.	Physician care-home, office			215
5.	Physician care-hospital			51
6.	Maternity			25
7.	Diagnostic X-ray and lab			105
8.	Drugs and medicine			100
9.	Radioactive therapy			15
10.	Nursing/convalescent facility			16
11.	Home health care			0

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12.	Physical therapy		10
12.	Oxygen		4
12.	Prostheses		5
12.	Durable medical equipment		5
12.	Second opinion surgery		2
12.	Private duty nursing		2
12.	Ambulance		3
13.	Hospital room and board in full		
14.	All hospital expenses in full		
15.	Major medical maximums		-12
	Subtotal reas. and cust. med. services		1632
16.	Deductible		-138
16.	Coinsurance		-299
	Subtotal net of ded. and coin.		1195
17.	Adjust (comb. medical/dental ded)		
18.	COB/No-fault		-48
19.	Limit on "out-of-pocket expenses"		35
20.	Well baby care		
21.	Emergency and supplemental accident		
22.	Student dependents		4
23.-25.	Superimposed major medical		
	Grand Total		1186
	Combined basic and superimposed	XXX	XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) The maximum in the policy ($250,000) divided by the COMP factor (1.121) is $223,015. This is 82.01 percent of the difference between the $100,000 and $250,000 maximums in part 2740.9964, subpart 15. The points would be minus 27 plus .8201 times 15 or -14.70 points.

(2) The deductible in the policy ($100) divided by the COMP factor (1.121) is 89.21. This is 78.41 percent of the difference between the $50 and $100 deductibles in part 2740.9964, subpart 16. Points deducted for the deductible would be 85 plus .7841 times 85 or 151.65. Since the total points in the policy before the deductible is significantly less than 1800, multiply 151.65 by (1632/1800). The result is 137.50.

(3) The out-of-pocket maximum is $3,000. The maximum claim when the out-of-pocket is reached is $14,600. This divided by the COMP factor (1.121) is 13,024. This is

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10.29 percent of the difference between the $13,000 and $14,400 maximum claim when out-of-pocket is reached. The adjustment for the out-of-pocket limit is 36 minus .1029 times 6 or 35.38.

2740.9992 EXAMPLE II.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital:	$170 per day, 365 days; 80 percent of misc. extras, the cost of anesthesia is included. The policy does not pay for private room even if medically necessary.
Surgery:	$3,000 maximum surgical schedule. Add 15 percent for the administration of anesthesia.
In hospital physicians calls:	$25 per day - 365 day maximum
Maternity:	Any complications
X-ray and lab tests (out of hospital):	$500 maximum - unscheduled

B. Answer (calculated January 1, 1985): test result is 1004 points. This plan is a Minnesota qualified plan number two.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subpart of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board	275		
2.	Hospital extras (80 percent)	384		
3.	Surgery	189		
4.	Physician care - home, office			
5.	Physician care - hospital	33		
6.	Maternity	25		
7.	Diagnostic X-ray and lab	98		
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility			
11.	Home health care			
12.	Physical therapy			
12.	Oxygen			

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12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty nursing			
12.	Ambulance			
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			
	Subtotal reas. and cust. med. services			
16.	Deductible			
16.	Coinsurance			
	Subtotal net of ded. and coin.			
17.	Adjust (comb. medical/dental ded)			
18.	COB/No-fault			
19.	Limit on "out-of-pocket expenses"			
20.	Well baby care			
21.	Emergency and supplemental accident			
22.	Student dependents			
23.-25.	Superimposed major medical			
	Grand Total	1004		
	Combined basic and superimposed		XXX	XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) Policy does not pay extra for private room even if medically necessary. Deduct three points from the 359. Since the ASP value in 1985 is 220, the number of points will be 356 times the ratio of 170 to 220 or 275.09 points.

(2) The surgical table was evaluated as 3,680.02 points. The points not including administration of anesthesia is 206 times the ratio of 3680.02 to 4620.00 or 164.09 points. For administration of anesthesia, the points are 164 times .15 or 24.6 points.

(3) Since the maximum per diem cost of in-hospital physicians calls is less than the cost for routine follow-up (24.20 times 1.08 or 26.14), subtract 14 points from the number of points for prevailing fee with 365-day maximum. The result is 35 points. Multiply the 35 points by the ratio of $25 to 26.14 or 33.47 points.

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4320.00 or 103.51 points. The administration of anesthesia would add 10.35 points.

(4) The $200 corridor deductible would be adjusted before entering part 2740.9964, subpart 24. The adjusted deductible would be 200 divided by 1.121 or 178.41. Since this is 78.41 percent of the way between the $100 and $200 deductibles, the points would be 740 minus .7841 times (740-665) or 681.19 points.

(5) Home health care and skilled nursing home care are excluded. Therefore we should deduct 80 percent of their points shown in part 2740.9964, subparts 10 and 11.

(6) Hospital room and board is limited to $200 per day less what the basic benefit pays. The adjustment should equal .8 (363 times 20 divided by 220) or 26.4 points.

REPEALER. Minnesota Rules, parts 2740.2300; 2740.9905; 2740.9910; 2740.9915; 2740.9920; 2740.9925; 2740.9930; 2740.9935; 2740.9940; 2740.9945; 2740.9950; 2740.9955; 2740.9960; 2740.9965; 2740.9970; 2740.9981; 2740.9982; 2740.9983; 2740.9984; 2740.9985; and 2740.9986 are repealed.

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Certificate of Approval of Adopted Rules

AR0549

Agency: Department of Commerce

Division:

Agency Contact: Richard G. Gomsrud

Minnesota Rules: Parts 2740.0100; 2740.1100; 2740.1200; 2740.1600; 2740.2100; 2740.2400; 2740.2500; 2740.2600; 2740.2900; 2740.3100; 2740.3600; 2740.3700; 2740.3900; 2740.4400; 2740.5200; 2740.9904; 2740.9909; 2740.9914; 2740.9919; 2740.9924; 2740.9929; 2740.9934; 2740.9939; 2740.9944; 2740.9949; 2740.9954; 2740.9959; 2740.9964; 2740.9979; 2740.9991 to 2740.9993

Title: Adopted Rules Relating to the Comprehensive Health Insurance Association

Type of Rules: Permanent

Steven C. Cross
Revisor of Statutes

Paul M. Marinac
Assistant Deputy Revisor
Phone: 296-0948
Date: June 24, 1985

Department of Commerce

Adopted Rules Relating to the Comprehensive Health Insurance Association

Rules as Adopted

2740.0100 DEFINITIONS.

Subpart 1. to 12. [Unchanged.]

Subp. 13. **Covered expenses.** "Covered expenses" means the usual and customary charges for the services and articles listed in Minnesota Statutes, section 62E.06, or, with respect to qualified plans, the actuarial equivalence thereof, when prescribed for a covered person by a physician and when the expenses are incurred during a period in which the policy or contract is in effect.

Subp. 14. to 28. [Unchanged.]

Subp. 29. **Licensed and tested insurance agent or insurance agent.** "Licensed and tested insurance agent" or "insurance agent" means an insurance agent as defined in Minnesota Statutes, section 60A.02, subdivision 7, and licensed as such by the commissioner.

Subp. 30. and 31. [Unchanged.]

Subp. 32. **Net gains.** "Net gains" means the excess of premiums or contract charges over claims expenses, after the writing carrier's expenses and agent referral fees, not to exceed 15 percent of premiums or contract charges, have been paid as provided in part 2740.4400, subpart 4.

Subp. 33. to 44. [Unchanged.]

Subp. 44a. **Qualified medicare supplement plan.** "Qualified medicare supplement plan" means a plan of health coverage meeting the requirements of Minnesota Statutes, sections 62A.31, 62A.32, 62E.02, subdivision 5, and 62E.07.

Subp. 45. to 52. [Unchanged.]

Subp. 53. **Rejection.** "Rejection," for the purpose of state plan eligibility, means refusal by any association member, or any authorized representative, including any insurance agent,

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acting on behalf of any association member, to issue a qualified plan or a qualified medicare supplement plan to a person who completes an application for coverage under such qualified plan, or a qualified medicare supplement plan, as determined by the board.

Subp. 54. to 56. [Unchanged.]

Subp. 56a. **Self-insurer.** "Self-insurer" means an entity defined by Minnesota Statutes, section 62E.02, subdivision 21, which is a "governmental plan" as defined by United States Code, title 29, section 1002(32) or a "church plan" as defined by United States Code, title 29, section 1002(33)(A) or which is otherwise exempt from or outside of the scope of the provisions of the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001 to 1381, as amended.

Subp. 57. [Unchanged.]

Subp. 58. **Total cost of self-insurance.** "Total cost of self-insurance" includes any direct and indirect administrative expenses incurred that are related to the operation of a plan of self-insurance, plus the sum of any payment made to or on behalf of Minnesota residents for costs or charges for health benefits by a self-insurer under a plan of health coverage, which is not counted as premium by an insurer, except to the extent of such payments made for coverage of the types described in Minnesota Statutes, section 62E.02, subdivision 11, clauses (1) to (8).

Subp. 59. [Unchanged.]

2740.1100 DUTIES OF EMPLOYERS.

Subpart 1. **Duty to make available a qualified plan.** An employer shall be deemed to have made available a qualified plan to its employees as required in Minnesota Statutes, section 62E.03, subdivision 1 when participation under a number 2 or number 3 qualified plan or a health maintenance plan is offered to the employee by a self-insurer or through an insurer or health maintenance organization, without regard to whether the cost of such participation is paid directly or indirectly by the employer or by the employee or by their joint payment.

Subp. 2. [Unchanged.]

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Subp. 3. **Frequency of required offer.** Except as provided in subpart 2, an employer shall be deemed to have complied with the requirements of Minnesota Statutes, section 62E.03, subdivision 1 if the employer makes available to the employer's employees a plan of health coverage which is certified as a number 2 or number 3 qualified plan or a health maintenance plan at least once during each accounting period utilized by the employer for Minnesota income tax purposes.

2740.1200 DUTIES OF INSURERS AND FRATERNALS.

Subpart 1. [Unchanged.]

Subp. 2. **Timing of required offer of a qualified plan or qualified medicare supplement plan.** Timing of required offer of a qualified plan or qualified medicare supplement plan is as follows:

A. The offer of each type of qualified plan (that is, a number 1, number 2, and number 3 qualified plan) that is required when an insurer or fraternal is offering an individual policy of accident and health insurance shall occur no later than the date of delivery of such policy to the applicant.

B. to E. [Unchanged.]

Subp. 3. [Unchanged.]

Subp. 4. **Duty to offer major medical coverage.** Each insurer and fraternal shall affirmatively offer, subject to its underwriting standards, coverage of major medical expenses to every applicant for a new unqualified policy at the time of application and annually thereafter to every holder of an unqualified policy of accident and health insurance renewed by the insurer or fraternal as required by Minnesota Statutes, section 62E.04, subdivision 4. "Affirmatively offer" shall mean written advice to the applicant for, or the holder of, an unqualified policy of accident and health insurance, of the availability of coverage for major medical expenses. Such written advice of the availability of the coverage for major medical expenses may be satisfied by a contractual provision in the unqualified policy that gives the insured the contractual right to apply to the insurer or fraternal for a new policy or a

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rider on an existing unqualified policy that provides coverage for 80 percent of the covered expenses for services listed in Minnesota Statutes, section 62E.06, subdivision 1 or the actuarial equivalence thereof subject to a $5,000 deductible for out-of-pocket expenses, subject to the insurer's or fraternal's underwriting requirements.

Subp. 5. and 6. [Unchanged.]

Subp. 7. **Exceptions to duties for certain policies and contracts.** Exceptions to duties for certain policies and contracts are as follows:

A. [Unchanged.]

B. The issuance or renewal by an insurer or fraternal on or after June 3, 1977, of a policy or contract that is designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis, shall not be subject to Minnesota Statutes, section 62E.04, except for policies and contracts sold by an insurer to provide payments on a hospital indemnity basis if such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue.

Subp. 8. [Unchanged.]

2740.1600 TERMINATION OF COVERAGE; CONVERSION PRIVILEGES.

Subpart 1. and 2. [Unchanged.]

Subp. 3. **Due notice of cancellation or termination.** An insurer, health maintenance organization, or self-insurer shall be deemed to have provided "due notice of cancellation or termination" as required in Minnesota Statutes, section 62E.16 if the insurer, health maintenance organization, or self-insurer notifies in writing those employees at their respective addresses as provided to the insurer, health maintenance organization, or self-insurer by the employer pursuant to the terms of Minnesota Statutes, section 62E.16.

2740.2100 DEFINITIONS.

Subpart 1. **Accident and health insurance business.** "Accident and health insurance business" means the

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issuance or renewal of any accident and health insurance policy as defined in Minnesota Statutes, section 62E.02, subdivision 11.

A. [Unchanged.]

B. Such business shall not include the issuance or renewal of policies or contracts providing coverage that is:

(1) to (8) [Unchanged.]

(9) limited to accident-only coverage issued by an insurance agent and that provides reasonable benefits in relation to the cost of covered services.

Subp. 2. and 3. [Unchanged.]

Subp. 4. **Self-insurance business.** "Self-insurance business" means the provision, directly or indirectly, of a plan of health coverage by a self-insurer. "Self-insurance business" does not include the direct provision of health care services to employees at no charge to them by an employer engaged in the business of providing health care services to the public, nor does it include provision of benefits that, if provided by an insurer doing accident and health insurance business, would be excluded under subpart 1, item B. "Directly or indirectly" for the purposes of parts 2740.2100 to 2740.5500 means that the self-insurer funds the plan of health coverage in any amount or collects any employee contributions which are used to pay for the plan of health coverage.

2740.2400 ASSESSMENTS.

Contributing members will be assessed for their proportionate share of the operating and administrative expenses of the association, incurred or estimated to be incurred, together with losses, if any, incurred by the association as a result of operation of the state plan. The total amount of operating and administrative expenses and losses:

A. [Unchanged.]

B. may, at the recommendation of the board, subject to the approval of the commissioner, consist of a reasonable estimate of the operating and administrative expenses of the association for the succeeding fiscal year, which amount shall be adjusted at the end of the succeeding fiscal year to the

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amount of actual operating and administrative expenses, and contributing members shall be entitled to credit for any excess or shall be assessed for any deficit in these expenses in future assessments.

2740.2500 LEVY OF ASSESSMENTS.

Subpart 1. **Annual.** The association shall make an annual determination of each contributing member's liability, if any, and may levy assessments following each fiscal year end. The fiscal year ends on December 31 unless the association establishes a different fiscal year end. Assessments are due and payable 30 days after receipt of a written assessment notice.

Subp. 2. **Interim.** The association may also, upon approval of the commissioner, levy interim assessments when deemed necessary to assure the financial capability of the association to meet the incurred or estimated operating and administrative expenses of the association and losses resulting from the state plan. Interim assessments shall be due and payable within 30 days of receipt by a contributing member of a written interim assessment notice.

Subp. 3. **Member share.** The association shall levy each contributing member's share of the total assessment based on the ratio of: the contributing member's total premium for accident and health insurance business as defined in part 2740.2100, subparts 1 and 2, received from or on behalf of residents of Minnesota, as determined by the commissioner; to the total premium for accident and health insurance business for all contributing members.

Subp. 4. **Costs and charges.** The costs and charges referred to in the ratio in subpart 3 shall, to the extent possible, be determined by reference to a form issued by the association or the commissioner which all contributing members shall submit to the commissioner annually for the preceding calendar year.

A. [Unchanged.]

B. The commissioner shall have the authority to audit the accounts and records of any contributing member for the

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purpose of obtaining information necessary to levy an assessment.

Subp. 5. **Discretionary waiver.** The board may, in its discretion, decline to levy assessments against contributing members that owe $10 or less in a given year.

2740.2600 FAILURE TO PAY ASSESSMENTS.

Any contributing members that fail to pay annual or interim assessments when such assessments become payable will be reported by the association to the commissioner for appropriate action within the discretion of the commissioner.

2740.2900 DETERMINATION OF MEMBER'S VOTING RIGHTS.

Subpart 1. [Unchanged.]

Subp. 2. **Weighted vote.** A member's vote shall be a weighted vote based on the member's total cost of self-insurance, accident and health insurance premiums, subscriber contract charges, or health maintenance contract charges derived from or on behalf of residents of Minnesota in the previous calendar year, as determined by the commissioner. To the extent possible, this figure shall be determined by reference to the annual reporting form submitted by contributing members to the commissioner in accordance with part 2740.2500, subpart 4, and similar forms showing all other members' total accident and health insurance premiums, subscriber contract charges (defined as charges for business specified in part 2740.2100, subparts 1 and 2) received from or on behalf of residents of Minnesota, or total cost of self-insurance, as defined in part 2740.0100, subpart 58, as determined by the commissioner.

If the necessary information is not available to the commissioner on the form described in this subpart at the time that voting rights must be determined, the commissioner may estimate the member's weighted vote based on other information available to the commissioner.

Subp. 3. **Voting procedures.** Members are entitled to vote in person, by proxy, or by mail as determined by the board.

When a member elects to vote in person at a members'

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meeting, the representative casting the vote shall present credentials as required pursuant to the bylaws or operating rules of the association.

When a member elects to vote by proxy, the proxy statement as approved by the board shall be returned on or before the date indicated in the meeting notice sent to the members.

Voting by mail may be permitted as authorized by the bylaws or operating rules of the association, and the meeting notice to members shall so indicate.

2740.3100 MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLANS.

Subpart 1. [Unchanged.]

Subp. 2. **Benefits of number 1 and number 2 qualified plan.** Benefits shall meet or exceed the requirements of Minnesota Statutes, section 62E.06 or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables in parts 2740.9905 to 2740.9986, except where substitution of an actuarially equivalent benefit is not permissible under the act.

A. [Unchanged.]

B. Coverage shall include an annual (calendar year) limitation of not more than $3,000 per covered person on total out-of-pocket expenses, which out-of-pocket expenses shall include the deductible under the state plan policy or contract, and which out-of-pocket expense limitation is not subject to substitution of an actuarially equivalent benefit.

C. Coverage shall be subject to a maximum lifetime benefit of not less than $250,000 per covered person, less any amount paid to or on behalf of the covered person under any other qualified plan of the state plan. This benefit is not subject to substitution of an actuarially equivalent benefit.

Subp. 3. **Benefits of qualified medicare supplement plan.** Benefits of a qualified medicare supplement plan shall meet or exceed the following minimum standards.

A. The plan shall provide benefits to covered persons by supplementing medicare through provision of:

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(1) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare to at least 50 percent of the deductible and copayment required under medicare for the first 60 days of any medicare benefit period;

(2) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period;

(3) coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days to the extent not covered by medicare;

(4) upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of at least ~~50~~ 100 percent of the medicare calendar year part B deductible.

B. The plan shall provide 80 percent of the covered charges for expenses as provided in Minnesota Statutes, section 62E.06, which charges are not paid or payable under medicare or would not have been paid or payable had the covered person who is or was entitled or eligible to enroll in medicare been so enrolled or which charges are not paid or payable under item A.

C. Coverage shall include an annual limitation of $1,000 total out-of-pocket expenses per covered person for covered charges, provided that an annual deductible of not more than $200 is permissible for those covered charges not paid or payable under medicare or otherwise included in item A or B.

D. Coverage shall be subject to a maximum lifetime benefit of not less than $100,000 per covered person, less any amount paid to or on behalf of the covered person under any other qualified medicare supplement plan of the state plan.

E. The minimum coverage of a qualified medicare

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supplement plan required by this subpart is not subject to substitution of actuarially equivalent benefits.

Subp. 4. and 5. [Unchanged.]

2740.3600 ENROLLMENT.

Subp. 1. [Unchanged.]

Subp. 2. **Eligible person.** "Eligible person," as used in subpart 1, means a resident of Minnesota who submits or on whose behalf is submitted a complete certificate of eligibility and enrollment form to the association or its writing carrier and who is not already covered by another state plan policy or contract.

A. A complete certificate of eligibility and enrollment form may provide:

(1) name, address, age, and length of time as a resident of Minnesota;

(2) [Unchanged.]

(3) evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, by one association member, or by an authorized representative, including an insurance agent, acting on behalf of an association member, within six months of the date of application. "Substantially reduce coverage from that received by a person who is considered a standard risk" includes any restriction on coverage as a result of an illness, condition, or risk which the association deems substantial, any increase in rates for an applicant based on an illness, condition, or risk, which the association deems substantial, and any preexisting conditions limitation which the association deems substantial.

B. In lieu of evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, as required by item A, subitem (3), a complete certificate of eligibility and enrollment form may provide evidence which

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meets the requirements of an operating rule adopted by the association of a proposed covered person having been treated within three years of the date of the certificate of eligibility and enrollment form for one or more conditions listed in the operating rule.

C. Before a person is determined to be an eligible person, the board may require that any items listed in items A and B or, if acting pursuant to provisions of the association's operating rules, other necessary information be submitted to the association or its writing carrier and may also investigate the authenticity of information submitted as a part of the certificate of eligiblity.

D. If a covered person, under a qualified plan of the state plan, upon reaching age 65, or becoming enrolled in medicare, wishes to purchase a state plan qualified medicare supplement plan, the requirement that the person obtain one rejection, restrictive rider, rate-up, or preexisting conditions limitation on a qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, from one member of the association, or from an authorized representative, including an insurance agent acting on behalf of an association member, within the preceding six months may be waived by the board if acting pursuant to provisions of the association's operating rules.

E. A person who is age 65 or older shall be eligible for coverage only under the state plan's qualified medicare supplement plan and when an insured person under a qualified plan reaches age 65, the board may, if acting pursuant to provisions of the association's operating rules, terminate or refuse to renew coverage under the qualified plan. A person under age 65 who is otherwise eligible for coverage under the state plan and is enrolled in medicare shall be permitted to purchase a qualified plan 1 or 2 or the qualified medicare supplement plan of the state plan.

F. An applicant or any person proposed to be covered

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under a qualified plan of the state plan who has previously been covered under one or more qualified plans of the state plan and who has exhausted the $250,000 maximum lifetime benefit shall not be an eligible person for coverage under a qualified plan of the state plan; an applicant or any person proposed to be covered under a qualified medicare supplement plan of the state plan who has previously been covered under one or more qualified medicare supplement plans of the state plan and who has exhausted the $100,000 maximum lifetime benefit shall not be an eligible person for coverage under a qualified medicare supplement plan of the state plan.

G. When a covered person under the state plan no longer meets one or more of the requirements for eligibility for coverage under the state plan, the board may, if acting pursuant to the association's operating rules, terminate or refuse to renew coverage under the state plan.

2740.3700 ASSOCIATION'S RESPONSE.

Subpart 1. **Time limitation.** Within 30 days of receipt of a complete certificate of eligibility and enrollment form pursuant to part 2740.3600, subpart 2, items A, B, and C, the association or the writing carrier shall accept the certificate of eligibility or shall reject the certificate of eligibility for failure to meet the eligibility requirements.

Subp. 2. **Acceptance.** If the association or its writing carrier accepts the certificate of eligibility, it shall forward a notice of acceptance, billing information, and a policy or contract or certificate that shall evidence coverage under the state plan.

A. [Unchanged.]

B. When the state plan premium is received by the association or its writing carrier for the first billing period and accepted in accordance with this part, the coverage shall be effective retroactive to the date of receipt by the association or its writing carrier of the completed certificate of eligibility pursuant to part 2740.3600, subpart 2, items A, B, and C unless otherwise requested by the insured person and

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approved by the board.

Subp. 3. **Nonacceptance.** If the association does not accept the certificate of eligibility, the applicant shall be informed of the reason for the rejection and shall have the opportunity to submit additional information to substantiate eligibility for coverage under the state plan and to request reconsideration of the decision. The board may establish a review mechanism for reviewing requests for reconsideration of rejected certificates of eligibility. The association shall give notice of a final determination of ineligibility to the applicant stating the reasons therefor and advising the applicant of the right to appeal to the commissioner within a reasonable period of time.

2740.3900 DISSEMINATION OF INFORMATION CONCERNING STATE PLAN.

Subpart 1. **Plan.** The association shall develop a plan for use by the association, upon approval by the commissioner, to publicize the existence of the state plan and the eligibility requirements and procedures for enrollment, and to maintain public awareness of and participation in the state plan.

Subp. 2. **Forms and instructions.** The association shall prepare and make available certificate of eligibility forms and enrollment instruction forms to members, insurance agents and brokers, and to the general public in Minnesota.

Subp. 3. **Referral fee.** The association shall require the writing carrier to pay a referral fee of $50 for any certificate of eligibility accepted by the association or its writing carrier if the referring agent is licensed by the commissioner as an insurance agent and if the referring agent's signature appears as the agent on the accepted certificate of eligibility. The referral fee shall be paid from the premium received for the state plan. Referring agents shall not be authorized to interpret, amend, or alter the terms of the state plan policy or contract, nor shall referring agents be authorized to bind the association in any way. Referring agents shall not be agents of the association for any purpose, and the association shall not bear responsibility for acts of referring

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agents.

2740.4400 OPERATIONS OF WRITING CARRIER.

Subpart 1. **Administrative and claims payment functions.** The writing carrier shall perform all administrative and claims payment functions relating to the state plan.

A. [Unchanged.]

B. The writing carrier shall perform all necessary functions to assure timely payment of benefits to covered persons under the state plan.

(1) to (3) [Unchanged.]

(4) The writing carrier shall exercise reasonable efforts to advise covered persons, within 60 business days of receipt of a properly completed and executed proof of loss, whether the submitted claim was accepted or rejected by the writing carrier, unless sooner settled.

(5) The writing carrier may establish an appeals procedure approved by the board to review claims that are denied in whole or in part. When a claim or any portion thereof is denied, the writing carrier shall inform the covered person of the existence of the procedure, including the right to appeal to the commissioner within a reasonable period of time.

Subp. 2. [Unchanged.]

Subp. 3. **Claims expenses.** The writing carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the state plan. If the writing carrier's payments for claims expenses exceed the portion of the state plan premiums allocated by the board for payment of claims expenses, the association shall provide to the writing carrier additional funds for payment of claims expenses. Not less than 85 percent of the state plan premium, as determined by the board, shall be used to pay claims expenses, and not more than 15 percent of the state plan premium shall be used to pay agent referral fees (authorized by Minnesota Statutes, section 62E.15, subdivision 3) and to pay the writing carrier's direct and indirect expenses, as defined and authorized in Minnesota Statutes, section 62E.13, subdivision 7 and described in subpart

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5.

Subp. 4. **Direct and indirect expense reimbursement.** The writing carrier shall be paid from time to time as provided in the association's contract with the writing carrier for its direct and indirect expenses incurred in the performance of its services from the state plan premiums received in an amount not to exceed the lesser of:

A. 15 percent of the state plan premium, less agent referral fees payable under part 2740.3900, subpart 3;

B. and C. [Unchanged.]

Subp. 5. **Direct and indirect expenses.** Direct and indirect expenses shall include that portion of the writing carrier's actual administrative, printing, claims administration, management, building overhead expenses, and other actual operating and administrative expenses approved by the board as allocable to the administration of the state plan.

Subp. 6. and 7. [Unchanged.]

2740.5200 REINSURANCE PLAN.

Subpart 1. [Unchanged.]

Subp. 2. **Application and acceptance.** Insurer or fraternal members wishing to participate in the pool shall apply to the association for participation in the pool, specifying the categories of coverage that the member desires to reinsure.

Each member entering into a reinsurance pooling agreement for a particular category or categories of coverage shall offer to place in the pool all policies and contracts that it issues in the category or categories listed in part 2740.5100 that it wishes to reinsure.

Only policies and contracts acceptable to the association or its reinsurance administrator may be accepted for reinsurance. The association is under no obligation to accept any but standard risks in the reinsurance plan.

Subp. 3. to 5. [Unchanged.]

2740.9904 PURPOSE.

Minnesota Statutes, section 62E.02, defines "qualified

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plans" as health benefit plans that provide the benefits required in Minnesota Statutes, section 62E.06 or "the actuarial equivalent of those benefits." Minnesota Statutes, section 62E.06 describes three qualified plans. These statutes require all plans of health coverage subject to Minnesota Statutes, section 62E.06 to be labeled as qualified or non-qualified. The commissioner may be requested to determine whether a plan is qualified and may take up to 90 days to make that determination. Minnesota Statutes, section 62E.02 defines a qualified medicare supplement plan as one which has been certified by the commissioner as providing the minimum benefits required by Minnesota Statutes, section 62E.07. Since the definition does not allow the option of an actuarial equivalent plan, the current rules do not include actuarial equivalent tables for medicare supplement policies.

2740.9909 COMPOSITE POINT VALUES FOR QUALIFIED PLAN NUMBER THREE.

The composite point values for a qualified plan number three for 1984 are as shown herein.

Composite Point Values for Minnesota Qualified Plan No. 3

Points	Benefit
363	Hospital room and board, unlimited days, semi-private.
480	Hospital extras (i.e., hospital services, hospital miscellaneous, hospital special services, or ancillary services) including anesthesia.
243	Surgery, including administration of anesthesia, assistant surgeon and oral surgery but no tooth repair or extractions.
215	Home and office physician care, unlimited.
51	Physician care in hospital, unlimited.
63	Obstetrics, unlimited.
110	Hospital maternity, unlimited.
105	X rays and laboratory tests, outpatient and out of hospital.
100	Prescription drugs and medicine, outpatient and out of hospital.
15	Radioactive therapy, outpatient and out of hospital.
16	Nursing or convalescent facility.
8	Home health agency care.
10	Physical therapy.
4	Oxygen.
5	Prostheses.
5	Durable medical equipment rental or purchase.
2	Second opinion surgery.
2	Private duty nursing.
3	Ambulance.
-12	Adjustment for major medical maximum.
1788	Total reasonable and customary medical services
-245	$150 deductible.

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-309	20 percent coinsurance.
1234	Total after deductions for deductible and coinsurance
-49	Coordination of benefits.
-31	Nonduplication with no-fault.
30	3,000 annual "out-of-pocket" expense limit.
8	Well baby care.
0	Emergency accident.
0	Supplement accident.
0	Student dependents.
1192	Grand Total

2740.9914 DETERMINATION OF AVERAGE SEMI-PRIVATE HOSPITAL ROOM AND BOARD LEVEL OF SURGICAL CHARGES.

Subpart 1. **Why develop values annually.** Many companies issue policies with scheduled benefits. Due to inflation the value of scheduled benefits declines each year in relation to reasonable and customary charges. It would be best if the test of actuarial equivalence would automatically adjust for inflation and thus would more accurately value these types of benefits.

Subp. 2. **When values determined.** In December of each year, the commissioner will publish the following values:

A. the average semi-private hospital room and board (ASP value);

B. the value of surgical charges (SURG value);

C. the ratios of the average semi-private hospital room and board for the year to that in 1984 (ASP factor);

D. the ratio of the value of surgical charges for the year to that in 1984 (SURG factor); and

E. the composite ratio of medical care for the year to that in 1984 (COMP factor).

The commissioner may appoint a service agency to calculate these values on a consistent basis each year.

Subp. 3. **How values determined.** Values will be determined as follows:

A. The ASP value will be the weighted bed average of semi-private room and board charges for acute hospitals in Minnesota. The information will be derived from each hospital's latest room and board charge filed with the commissioner or the service agency. A semi-private room will be defined as a room

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with two beds.

B. The SURG value will be the sum of the product of the average charge, filed with the commissioner or the service agency, for each of the surgical operations shown below times the factor shown for that operation. The surgical operations and their factors are shown in part 2740.9919.

C. The ASP factor will be the ASP value to be published for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

D. The SURG factor is the ratio of the SURG value for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

E. The COMP factor is the composite factor for medical care. This equals 54 percent times the ASP factor for the year plus 46 percent times the SURG factor for the year.

2740.9919 TABLE OF SURGICAL FACTORS TO DEVELOP SURG VALUE.

CPT4 Code	Surgical Factor	Description
SKIN		
10060	.7710	Abscess, incision, and drainage, simple
11400	2.0161	Benign lesion removal of (up to 0.5 cm.)
11750	.4368	Nail, permanent removal of
12011	1.9732	Simple wound, simple repair (up to 2.5 cm.)
17100	4.6520	Benign skin lesion, destruction of
MUSCULOSKELETAL		
20610	1.9226	Major joint or bursa, injection or aspiration of
27130	.1565	Total hip joint replacement, simple
29425	1.0286	Application walking cast
CARDIOVASCULAR		
33512	.1111	Coronary bypass, three arteries
93547	.2166	Left heart catheterization with coronary angiogram
DIGESTIVE SYSTEM		
43235	.4514	Gastroscopy, diagnostic
43844	.0569	Stomach bypass for morbid obesity
44950	.2618	Appendectomy
45300	2.7170	Proctosigmoidoscopy, diagnostic
47600	.3765	Gallbladder, removal of
49505	.3086	Inquinal hernia repair, unilateral
URINARY SYSTEM		
52601	.1579	Prostate resection (TUR), complete
53670	3.5273	Urinary bladder catheterization
MALE GENITAL		
54150	.8509	Circumcision by clamp, newborn
FEMALE GENITAL		
58120	.8470	Uterus, dilation and curettage (D & C),

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		nonobstetrical
58150	.4792	Uterus, removal of
58980	.9455	Laparoscopy, diagnostic
NERVOUS SYSTEM		
63030	.0694	Laminotomy herniated disc, lumbar
64721	.1988	Carpal tunnel symdrome repair
EYE		
66980	.2003	Cataract removal, intraocular lens insertion
EAR		
69437	.3934	Tympanostomy with ventilating tube insertion

2740.9924 HOW TO USE THE LIST.

Subpart 1. **Basic and comprehensive major medical plans.** The list is used in the following manner:

A. Determine the ASP value, SURG value, ASP factor, SURG factor, and COMP factor for the calendar year. This is published annually by the commissioner.

B. List the plan benefits, ignoring deductibles, coinsurance, well baby care, emergency accident, supplemental accident, and student dependents. Include the plan maximum in the plan benefits.

C. For each benefit, find the appropriate table of equivalent points for basic and major medical plans.

D. Extract the appropriate point value for the benefit from the table, interpolating as necessary or indicated, and place it opposite the listed benefit. Ignore benefits for which no table exists.

E. Total the points for these benefits.

F. List deductible and coinsurance if the plan is a comprehensive major medical plan.

G. Determine the appropriate point values for deductible, interpolating as necessary, and place the value in the list of points. Calculate the coinsurance points and place the values in the list of points.

H. Determine the total points after the deduction for deductible and coinsurance.

I. Determine the deduction for coordination and nonduplication of benefits.

J. Determine the number of points for the limit on "out-of-pocket" expenses, well baby care, emergency accident,

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supplemental accident, and student dependents.

K. Calculate the grand total.

L. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

Subp. 2. **Superimposed major medical plans.** The following govern superimposed major medical plans:

A. Follow steps outlined in subpart 1, items A to D for basic health plan benefits.

B. Total the points for the basic plan.

C. Utilize part 2740.9964, subparts 23, 24, and 25 to determine the point value of a Minnesota qualified plan superimposed over the basic plan with the deductible and benefit period of the plan at hand, interpolating as necessary. Put the points in the point column.

D. Compare the benefits in the superimposed major medical plan with the benefit structure of a Minnesota qualified plan:

(1) $250,000 lifetime maximum.

(2) 80/20 coinsurance.

(3) $3,000 annual per person out-of-pocket maximum.

(4) Eligible expenses are usual and customary expenses for:

(a) hospital services;

(b) physician care;

(c) prescription drugs;

(d) nursing home care of up to 120 days in one year, commencing within 14 days of hospitalization of at least three days;

(e) home health care;

(f) radium and radioactive therapy;

(g) oxygen;

(h) anesthetics;

(i) prostheses;

(j) rental or purchase of durable medical equipment;

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(k) diagnostic x rays and laboratory tests;

(l) oral surgery on impacted teeth, on tooth roots, or on gums and tissues of the mouth when not performed in connection with tooth extraction;

(m) physical therapy;

(n) maternity same as any illness;

(o) Minnesota statutorily-mandated benefits; and

(p) coordination of benefits.

E. Consult the tables for point adjustments (usually negative for Minnesota qualified plan benefits not in the superimposed major medical plan being tested). Put the adjustments in the point column.

F. Calculate the total by adding the points for the basic plan (item B), the superimposed major medical plan (item C), and the adjustments (item E).

G. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

2740.9929 BENEFIT VARIATIONS NOT COVERED BY TABLES.

Only those plan variations that are most common are recognized. For instance, comprehensive plan coinsurance was assumed normally not to exceed 20 percent. Therefore, no points are shown for 25 percent. However, points for such missing benefit variations can be extrapolated or estimated.

2740.9934 USE OF TABLES.

Subpart 1. **Certification of plans.** Any insurer, self-insurer, or policyholder may use the test for actuarial equivalence as a guide. To obtain certification of any plan of health benefits as qualified, it must be submitted to the commissioner.

Subp. 2. **Filing with commissioner.** The following should be sent to the commissioner:

A. The plan document if an uninsured plan or the policy form if an insured plan.

B. A statement of the grand total from part 2740.9924.

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C. A certification that the plan is qualified as either a plan 1, 2, or 3, or is nonqualified, by using the test of actuarial equivalence in part 2740.9949. The certification must be by a principal or officer, or by a member of the Academy of Actuaries.

D. If the plan is not a qualified plan by using the test of actuarial equivalence, and the insurer or self-insurer desires to have it certified as a qualified plan, a statement of the specific reasons for the desired qualification.

Subp. 3. **Certification by commissioner.** If the documents required by subpart 2 are filed and the plan is a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be deemed certified as filed. If the documents required by subpart 2 are filed and the plan is not a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be qualified if, and when, the commissioner certifies it as a qualified plan.

2740.9939 UPDATE OF TABLES.

Periodically, the tables may be revised as health care costs change. The commissioner may revalue the actuarial equivalence of any plan or policy at any time deemed appropriate. Also, as health care costs change, a plan may automatically lose or change its qualification. Annual revaluation of plans is required. When a plan is revalued and its qualification status changes, the filing procedures in part 2740.9934 will be followed.

2740.9944 MISUSE OF TABLES.

The tables of equivalent points are not intended for any other use, especially not for premium calculations. They represent a composite of data and were adjusted to be useable for testing actuarial equivalence. No other use is contemplated.

2740.9949 TEST FOR ACTUARIAL EQUIVALENCE FOR PLANS OTHER THAN MEDICARE SUPPLEMENT PLANS.

Subpart 1. **Table for 1984.**

Then that Plan is

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If the Grand Total of any Plan is:	the Actuarial Equivalent of Minnesota Qualified Plan No.
1192 + points	3
911 + points	2
767 + points	1
Less than 767 points	Nonqualified

Subp. 2. **Effect of inflation.** Each year the number of points required for each qualified plan will increase due to the effects of inflation on the benefits. Particular care should be taken to revalue any policy form which contains scheduled benefits or other policy forms which have different deductible or coinsurance provisions.

2740.9954 WORKSHEET FOR OTHER THAN MEDICARE SUPPLEMENT PLANS.

Comprehensive Health Insurance

Test for Actuarial Equivalence

Other than Medicare Supplement Plans

Subparts of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board			
2.	Hospital extras			
3.	Surgery			
4.	Physician care-home, office			
5.	Physician care-hospital			
6.	Maternity			
7.	Diagnostic X-ray and lab			
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility			
11.	Home health care			
12.	Physical therapy			
12.	Oxygen			
12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty nursing			
12.	Ambulance			
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			
	Subtotal reasonable and customary medical services			

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16. Deductible
16. Coinsurance
Subtotal net of deductible and coinsurance
17. Adjust (Comb. medical/dental deductible)
18. COB/No-Fault
19. Limit on "out-of-pocket" expenses
20. Well baby care
21. Emergency and supplemental accident
22. Student dependents
23.-25. Superimposed major medical
Grand Total
Combined Basic and Superimposed XXX XXX

Equivalent to Minnesota qualified plan number___ nonqualified___

Date_____ By_____

2740.9959 LOCATION OF TABLES OF EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS.

Subparts of part 2740.9964	Other than Medicare Supplement Plans Name
1.	Hospital room and board
2.	Hospital extras
3.	Surgery
4.	Home and office physician care
5.	In-hospital physician care
6.	Maternity
7.	Diagnostic X-ray and laboratory
8.	Drugs and medicine
9.	Radioactive therapy
10.	Nursing or convalescent - home care
11.	Home health care agency service
12.	Physical therapy
12.	Oxygen
12.	Prostheses
12.	Durable medical equipment
12.	Second opinion surgery
12.	Private duty nursing
12.	Ambulance
13.	Hospital room and board in full
14.	All hospital charges in full
15.	Major medical maximums
16.	Coinsurance and deductibles
17.	Combined dental and health insurance deductible
18.	Coordination and nonduplication of benefits
19.	Limit on "out-of-pocket" expenses
20.	Well baby care
21.	Emergency and supplement accident
22.	Student dependents
23.	Superimposed major medical
24.	Superimposed major medical
25.	Superimposed major medical

2740.9964 EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS; NOT TO BE USED FOR MEDICARE SUPPLEMENT PLANS.

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Subpart 1. **Hospital room and board.**

Maximum Days	Room & Board
31	327
70	347
120	351
365	359
Unlimited	363

A. Room and board is defined to include a semi-private room, or charges for a private room if prescribed as medically necessary by a physician. If the policy does not pay the additional charges for a private room, then deduct three points from hospital room and board.

B. If the policy pays the private room charge even though not medically necessary, then add ten points if average charge per day is four percent greater than the average semi-private room and board charge.

C. If the policy pays the hospital room and board charge up to a maximum daily benefit which is less than the average semi-private room and board charge in the area, then multiply the points for the semi-private room and board at the indicated maximum days by the ratio of the scheduled amount to the ASP value in the area for the year.

Subp. 2. **Hospital extras.** Hospital extras such as hospital services, special hospital services, ancillary services, and hospital therapeutics.

Maximum Amount*	Anesthesia** Included	Not Included
$ 500	130	130
1,000	217	216
2,000	317	312
5,000	413	401
10,000	454	433
15,000	469	444
Unlimited	480	451

*Before entering this table, divide the maximum amount in the policy by the ASP factor for the year.

**Anesthesia does not include the administration of anesthesia.

This is for miscellaneous hospital services and includes the cost for inpatient hospital care, the cost for outpatient hospital treatment and the excess cost of intensive care unit or

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coronary care unit over the average semi-private room and board.

Subp. 3. **Surgery.**

Limit	Administration of Anesthesia Included	Not Included
Prevailing Fee with Assistant Surgeon	243	206
Prevailing Fee without Assistant Surgeon	244	187

If the policy pays the reasonable and customary charges up to a maximum in a schedule, then multiply the points for the prevailing fee by the ratio of the value of the schedule used in the policy to the SURG value for the year.

Subp. 4. **Home and office physician care.**

Annual Maximum*	First Visit Accident First Visit Sickness	Third Visit Sickness
$ 200	111	63
500	141	72
1,000	165	93
Unlimited	215	118

*Before entering this table, divide the annual maximum in the policy by SURG factor for the year.

Subp. 5. **In-hospital physician care.**

Maximum Number of Visits	Prevailing Fee
31	46
70	49
120	49
365	50
Unlimited	51

A. This benefit pays the reasonable and customary charge to the physician (other than the surgeon, assistant surgeon, or anesthetist) while confined in the hospital for medical or surgical reasons.

B. If the policy pays the greater of this benefit or the surgical benefit, then reduce these points by 30 percent.

C. A number of policies pay a limited amount per visit (limited to one visit per day) which is less than or equal to the cost for a routine follow-up visit in the hospital. If it is equal to the cost for a routine follow-up visit (assumed to be $24.20*/day in 1984), then deduct 14 points from the above points. If it is less than that, then use a proportional part

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of the points determined as if the maximum was equal to the cost for a routine follow-up visit.

*Multiply the indicated value by the SURG factor for the year.

Subp. 6. **Maternity.**

A. complications only:

limited to some specified list	20
any complications	25

B. full maternity (including complications):

Maximum Limit*	Deductible	Flat Maternity	Obstetrics	Hospital Maternity
$ 300	None	-	23	28
600	None	49	44	55
1,000	None	81	59	80
2,000	None	149	-	-
Unlimited	None	173	63	110

*Before entering this table, divide maximum limit in the policy by the ASP factor for the year.

Subp. 7. **X rays and laboratory tests (out of hospital).**

Maximum*	Scheduled (Any Scheduled)	Unscheduled
$100	56	70
200	67	89
500	74	101
Unlimited	77	105

*Before entering this table, divide the maximum in the policy by the ASP factor for the year.

Subp. 8. **Prescription drugs and medicine (out of hospital).**

Deductible* Per Prescription	
$4.00	69
2.00	86
None	100

*Before entering this table, divide the deductible per prescription by the SURG factor for the year.

Subp. 9. **Radioactive therapy (out of hospital).**

Scheduled (Any Schedule)	10
Unscheduled	15

Subp. 10. **Nursing or convalescent home care (within 14 days of hospital confinement of at least three days).**

Maximum Days	

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120 or More	16
Less than 120	0

Subp. 11. **Home health care agency services.**

Maximum Visits/Year	
180 or More	8
Less than 180	0

Subp. 12. **Miscellaneous.**

A. physical therapy (out of hospital), 10;

B. oxygen (out of hospital), 4;

C. prostheses (out of hospital), 5;

D. durable medical equipment rental or purchase (out of hospital), 5;

E. second opinion surgery, 2;

F. private duty nursing (in hospital only), 2; and

G. ambulance, 3.

Subp. 13. **Hospital room and board in full to indicated limit (basic and comprehensive major medical plans).** Add these points to the points in subpart 1 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

	Plan Deductible* On All	Limit*			
Plan	Benefits	$1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0 - 300	58	60	66	79
Comprehensive	301 - 600	61	63	69	82
Comprehensive	601 - 900	66	68	74	87
Comprehensive	901 - 1200	74	76	82	95

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the policyholder pays 20 percent after the deductible. If the policyholder pays a different percentage, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that hospital room and board will be paid at 100 percent and that the deductible will not be applied to it. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining

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deductible will not be applied but the coinsurance will be applied, to the hospital room and board benefits.

Subp. 14. **All hospital charges in full to indicated limit (basic and comprehensive major medical plans).** Add these points to the total points in subparts 1 and 2 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

Plan	Plan Deductible* On All Benefits	LIMIT* $1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0- 300	70	110	121	177
Comprehensive	301- 600	171	151	162	218
Comprehensive	601- 900	198	238	249	305
Comprehensive	901-1200	343	383	394	450

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is 1800. If the percentage being paid by the insured is not 20 percent, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that the hospital room and board and hospital services will be paid at 100 percent and that the deductible will not be applied to them. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining deductible will not be applied but the coinsurance will be applied, to either hospital room and board or hospital services benefits.

Subp. 15. **Major medical maximum (comprehensive and superimposed plans).**

Maximum*	Add (+) or Subtract (-)
$ 100,000	-27
250,000	-12
500,000	- 7
1,000,000	- 2

* Before entering the table, divide the maximum in the policy by

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the COMP factor for the year.

The smallest maximum in a qualified plan is $250,000. The $100,000 maximum as provided should be used in future years to help determine the reduction for a $250,000 plan.

Subp. 16. **Coinsurance and deductibles (comprehensive major medical plans).**

A. This table assumes that the point values for all medical services and supplies are approximately 1800 points before deduction for the maximum on total benefits. If the total points are significantly greater or smaller, then the point values must be adjusted.

Deductible*	Deducted Points
$ 0	0
50	85
100	170
150	245
200	310
500	622
1,000	820

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

B. To determine the deduction for the coinsurance, subtract the points deducted for the deductible from the total point value for the benefits and then multiply the result by the coinsurance percentage.

Subp. 17. **Combined dental and health insurance deductible (comprehensive major medical plans).**

Deductible*	Added Points
$ 50	75
100	60
150	43
200	38
500	35
1,000	15

* Before entering this table, divide the deductible in the policy by the COMP factor for the year.

Subp. 18. **Coordination and nonduplication of benefits (all plans).**

A. The following percentage of points after deduction for deductible and coinsurance should be subtracted if the policy coordinates benefits with other plans and its pricing assumes that a number of insured will have other policies in

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force.

(1) with other health plans, 4.0 percent;

(2) with no fault, 2.5 percent;

(3) with both subitems (1) and (2), 6.5 percent; and

(4) with neither, 0.

B. The percentage should be applied to the total points after deduction for deductible and coinsurance.

Subp. 19. **Limit on "out-of-pocket" expenses (maximum copayment and deductible per benefit year) -- comprehensive and superimposed major medical plans.**

Maximum Claim When Out-of-Pocket is reached*	Points
$ 500	236
1,000	196
2,000	158
3,000	130
4,000	110
11,000	45
13,000	36
14,400	30

*Before entering this table, divide the maximum claim when out-of-pocket limit by the COMP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is about 1800. If the percentage of claims being paid by the insured is other than 20 percent, multiply the number of points above by the ratio of the coinsurance being paid by the insured to 20 percent.

B. The above table assumes that the amounts paid by the policyholder for deductible and coinsurance are included in determining the out-of-pocket limitation.

Subp. 20. **Well baby care.**

Deductible*	Points
$ 0	17
150	8
500	2
1,000	0

*Before entering this table, multiply the deductible in the

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policy by the COMP factor for the year.

The above benefit assumes that the deductible and coinsurance are applied to the costs of the newborn.

Subp. 21. **Emergency and supplemental accident (basic plans only).**

Maximum*	Emergency	Supplemental
$ 50	10	--
100	15	20
300	--	30
500	--	35
1,000	--	40
Unlimited	20	--

*Before entering this table, divide the maximum in the policy by the SURG factor for the year.

Subp. 22. **Student dependents.**

Student Extension Beyond Age 19	
None	0
To age 21	2
To age 23	4
To age 25	5

Subp. 23. **Superimposed major medical plans--over basic health plans with less than 500 points.**

A. Calculate point value of a comprehensive major medical plan by using deductible* $200 greater than actual.

B. Add basic health plan points.

* Before entering the table, divide the deductible in the policy by the COMP factor for the year before adding $200. Do not make any further adjustments to the deductible.

Subp. 24. **Superimposed major medical plans--80/20 coinsurance--over basic health plans with 500-799 points.**

	Calendar Year Plan		Two year benefit period plan	
Deductible*	Individual	2 x family	Individual	2 x family
a. Corridor				
$ 100	740	780	745	765
200	665	705	680	700
300	615	655	630	650
500	543	582	558	578
1,000	385	425	400	420
b. Integrated				
$1,000	615	635	650	670
2,000	515	525	535	545

Note: Points assume major medical contains Minnesota

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qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

Subp. 25. **Superimposed major medical plans--80/20 coinsurance--over basic health plans with 800 or more points.**

	Add to Basic Plan Points			
	Calendar Year Plan		Two year benefit period plan	
Deductible*	Individual	2 x family	Individual	2 x family
a. Corridor				
$ 100	515	545	525	535
200	445	475	455	465
300	405	435	415	425
500	339	369	349	359
1,000	215	245	225	235
b. Integrated				
$1,000	505	525	530	550
2,000	405	415	420	430

Note: Points assume major medical contains Minnesota qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

2740.9979 BASIC BACKGROUND FOR EXAMPLES.

Subpart 1. **Inflation assumptions for 1985.** The examples which follow assume that the actuarial equivalence of a series of plans is being calculated for calendar year 1985. Inflation was assumed to be 15.5 percent and 8.0 percent for hospital related and all other services, respectively.

Subp. 2. **Values published by commissioner for 1985.**

ASP value for 1984	190*
ASP value for current year (1985*)	220*
SURG value for 1984	4,000.00
SURG value for current year (1985*)	4,320.00*
ASP factor for 1985*	1.155*
SURG factor for 1985*	1.080*
COMP factor for 1985*	1.121*

*Estimated. Please substitute the actual values.

Subp. 3. **Point values for qualified plans in 1985.** The following are the revised point values used to determine plans which are actuarially equivalent to qualified plans 1, 2, and 3

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for 1985.

Qualified Plan Number	If plan has the indicated number of points then plan is actuarially equivalent to the qualified plan in: 1984	1985
3	1192 + points	1216 + points
2	911 + points	957 + points
1	767 + points	847 + points
Nonqualified	Less than 767	Less than 847

2740.9991 EXAMPLE I.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Surgery	Includes Assistant Surgeon and Administration of Anesthesia
Deductible:	$100
Coinsurance:	80/20
Maximum:	$250,000
Maternity:	Any complications
Student dependents:	To age 23
Limits on specified benefits	Outpatient mental limited to Minnesota
Required benefits	--
Excluded care	Home health care
Out-of-pocket limit	$3,000 per year
Coordination of benefits	Yes, but no COB for no-fault.

B. Answer (calculated January 1, 1985): test result is 1186 points. This plan is a Minnesota qualified plan number 2.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subparts of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board			363
2.	Hospital extras			480
3.	Surgery			243
4.	Physician care-home, office			215
5.	Physician care-hospital			51
6.	Maternity			25
7.	Diagnostic X-ray and lab			105
8.	Drugs and medicine			100
9.	Radioactive therapy			15
10.	Nursing/convalescent facility			16
11.	Home health care			0

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12.	Physical therapy	10
12.	Oxygen	4
12.	Prostheses	5
12.	Durable medical equipment	5
12.	Second opinion surgery	2
12.	Private duty nursing	2
12.	Ambulance	3
13.	Hospital room and board in full	
14.	All hospital expenses in full	
15.	Major medical maximums	-12
	Subtotal reas. and cust. med. services	1632
16.	Deductible	-138
16.	Coinsurance	-299
	Subtotal net of ded. and coin.	1195
17.	Adjust (comb. medical/dental ded)	
18.	COB/No-fault	-48
19.	Limit on "out-of-pocket expenses"	35
20.	Well baby care	
21.	Emergency and supplemental accident	
22.	Student dependents	4
23.-25.	Superimposed major medical	
	Grand Total	1186
	Combined basic and superimposed XXX	XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) The maximum in the policy ($250,000) divided by the COMP factor (1.121) is $223,015. This is 82.01 percent of the difference between the $100,000 and $250,000 maximums in part 2740.9964, subpart 15. The points would be minus 27 plus .8201 times 15 or -14.70 points.

(2) The deductible in the policy ($100) divided by the COMP factor (1.121) is 89.21. This is 78.41 percent of the difference between the $50 and $100 deductibles in part 2740.9964, subpart 16. Points deducted for the deductible would be 85 plus .7841 times 85 or 151.65. Since the total points in the policy before the deductible is significantly less than 1800, multiply 151.65 by (1632/1800). The result is 137.50.

(3) The out-of-pocket maximum is $3,000. The maximum claim when the out-of-pocket is reached is $14,600. This divided by the COMP factor (1.121) is 13,024. This is

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10.29 percent of the difference between the $13,000 and $14,400 maximum claim when out-of-pocket is reached. The adjustment for the out-of-pocket limit is 36 minus .1029 times 6 or 35.38.

2740.9992 EXAMPLE II.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital:	$170 per day, 365 days; 80 percent of misc. extras, the cost of anesthesia is included. The policy does not pay for private room even if medically necessary.
Surgery:	$3,000 maximum surgical schedule. Add 15 percent for the administration of anesthesia.
In hospital physicians calls:	$25 per day - 365 day maximum
Maternity:	Any complications
X-ray and lab tests (out of hospital):	$500 maximum - unscheduled

B. Answer (calculated January 1, 1985): test result is 1004 points. This plan is a Minnesota qualified plan number two.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subpart of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Comprehensive
1.	Hospital room and board	275		
2.	Hospital extras (80 percent)	384		
3.	Surgery	189		
4.	Physician care - home, office			
5.	Physician care - hospital	33		
6.	Maternity	25		
7.	Diagnostic X-ray and lab	98		
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility			
11.	Home health care			
12.	Physical therapy			
12.	Oxygen			

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	12.	Prostheses		
	12.	Durable medical equipment		
	12.	Second opinion surgery		
	12.	Private duty nursing		
	12.	Ambulance		
	13.	Hospital room and board in full		
	14.	All hospital expenses in full		
	15.	Major medical maximums		
		Subtotal reas. and cust. med. services		
	16.	Deductible		
	16.	Coinsurance		
		Subtotal net of ded. and coin.		
	17.	Adjust (comb. medical/dental ded)		
	18.	COB/No-fault		
	19.	Limit on "out-of-pocket expenses"		
	20.	Well baby care		
	21.	Emergency and supplemental accident		
	22.	Student dependents		
	23.-25.	Superimposed major medical		
		Grand Total	1004	
		Combined basic and superimposed	XXX	XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) Policy does not pay extra for private room even if medically necessary. Deduct three points from the 359. Since the ASP value in 1985 is 220, the number of points will be 356 times the ratio of 170 to 220 or 275.09 points.

(2) The surgical table was evaluated as 3,680.02 points. The points not including administration of anesthesia is 206 times the ratio of 3680.02 to 4620.00 or 164.09 points. For administration of anesthesia, the points are 164 times .15 or 24.6 points.

(3) Since the maximum per diem cost of in-hospital physicians calls is less than the cost for routine follow-up (24.20 times 1.08 or 26.14), subtract 14 points from the number of points for prevailing fee with 365-day maximum. The result is 35 points. Multiply the 35 points by the ratio of $25 to 26.14 or 33.47 points.

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(4) Since the ASP factor is 1.15, the $200 and $500 maximum shown in part 2740.9964, subpart 7 is now 230 and 575 respectively. Thus the $500 maximum is 78.26 percent of the way between the two maximums. Therefore the point value equals 89 plus .7826 times (101-89) or 98.39 points.

2740.9993 EXAMPLE III.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital:	$80 per day, 120 days, $2,000 extras.
Surgery:	$1,500 maximum surgical schedule, add ten percent for administration of anesthesia.
Coordination of benefits	Yes, does not include no-fault
Superimposed major medical:	
Deductible:	$200 corridor per calendar year
Coinsurance:	80/20
Maximum:	$250,000
Maternity:	Any complications
Student dependents:	No
Out-of-pocket limit:	$3,000
Excluded care:	Home health care and skilled nursing care
Limits on specified benefits:	
1. Room and board	$200 less basic benefits. Unlimited days
Coordination of benefits	Yes, does not include no-fault

B. Answer (calculated January 1, 1985): test result is 1147 points. This plan is a Minnesota qualified plan number two.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

Subpart of part 2740.9964	Benefit	Basic	Major medical Superimposed	Major medical Comprehensive
1.	Hospital room and board	128	-26	
2.	Hospital extras	290		
3.	Surgery	114		
4.	Physician care - home, office			
5.	Physician care - hospital			
6.	Maternity			
7.	Diagnostic X-ray and lab			

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8.	Drugs and medicine				
9.	Radioactive therapy				
10.	Nursing/convalescent facility		-13		
11.	Home health care		-6		
12.	Physical therapy				
12.	Oxygen				
12.	Prostheses				
12.	Durable medical equipment				
12.	Second opinion surgery				
12.	Private duty nursing				
12.	Ambulance				
13.	Hospital room and board in full				
14.	All hospital expenses in full				
15.	Major medical maximums				
	Subtotal reas. and cust. med. serv.	532			
16.	Deductible				
16.	Coinsurance				
	Subtotal net of ded. and coin.				
17.	Adjust (comb. medical/dental ded)				
18.	COB/no-fault	21			
19.	Limit on "out-of-pocket expenses"				
20.	Well baby care				
21.	Emergency and supplemental accident				
22.	Student dependents				
23.-25.	Superimposed major medical		681		
	Grand Total	511	636		
	Combined basic and superimposed	1147	XXX		XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) Since the room and board limit is less than the ASP factor, the number of points will equal 351 times the ratio of 80 to 220.

(2) The $2,000 maximum divided by 1.155 is 1731.60. This is 73.16 percent of the difference between the $1,000 and $2,000 maximums in the table. The points would be 217 plus .7316 times (317 - 217) or 290.16 points.

(3) The surgical schedule is the same as in example II in part 2740.9992 value. The value of the table is 1840.1 for the $1,500 maximum. The points excluding administration of anesthesia is 243 times 1840.1 divided by

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4320.00 or 103.51 points. The administration of anesthesia would add 10.35 points.

(4) The $200 corridor deductible would be adjusted before entering part 2740.9964, subpart 24. The adjusted deductible would be 200 divided by 1.121 or 178.41. Since this is 78.41 percent of the way between the $100 and $200 deductibles, the points would be 740 minus .7841 times (740-665) or 681.19 points.

(5) Home health care and skilled nursing home care are excluded. Therefore we should deduct 80 percent of their points shown in part 2740.9964, subparts 10 and 11.

(6) Hospital room and board is limited to $200 per day less what the basic benefit pays. The adjustment should equal .8 (363 times 20 divided by 220) or 26.4 points.

REPEALER. Minnesota Rules, parts 2740.2300; 2740.9905; 2740.9910; 2740.9915; 2740.9920; 2740.9925; 2740.9930; 2740.9935; 2740.9940; 2740.9945; 2740.9950; 2740.9955; 2740.9960; 2740.9965; 2740.9970; 2740.9981; 2740.9982; 2740.9983; 2740.9984; 2740.9985; and 2740.9986 are repealed.

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STATE OF MINNESOTA
DEPARTMENT OF COMMERCE

In the Matter of the Proposed Adoption of Rules Relating to Comprehensive Health Insurance Association.

SUPPLEMENTAL FINDINGS OF FACT, CONCLUSIONS AND ORDER ADOPTING RULE.

Findings of Fact, Conclusions of Law and Order Adopting Rule were issued by the Commissioner of Commerce on the 14th day of June, 1985. Pursuant to Minnesota Statute 14.26 the proposed rules were submitted to the Attorney General's office. The Attorney General's office determined that certain provisions of the rules were not in compliance with Chapter 14 of Minnesota Statutes. Accordingly, the proposed rules were amended to correct the deficiences noted by the Attorney General's office. The Attorney General's office noted the following changes were necessary:

Part 2740.9914 subpart 1 is a statement of philosophy as to why values are developed annually. Accordingly it is not a rule as defined by Chapter 14 of Minnesota Statutes and must be deleted. Subsequent subparts shall be renumbered accordingly. The deleted subpart reads as follows:

" Subpart 1. Why develop values annually. Many companies issue policies with scheduled benefits. Due to inflation the value of scheduled benefits declines each year in relation to reasonable and customary charges. It would be best if the test of actuarial equivalence would automatically adjust for inflation and thus would more accurately value these types of benefits."

Part 2740.9934, subpart 2, states as follows: "Subpart 2. Filing with commissioner. The following should be sent to the commissioner:.." The word "should" in that sentence is not appropriate since its use makes it unclear that this rule compels the filing of the enumerated documents. Accordingly the word "must" will replace the word "should".

Part 2740.9934, subpart 3, the last sentence of said subpart states: "If the documents required by subpart 2 are filed and the plan is not a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be qualified if, and when, the commissioner certifies it as a qualified plan." The part of that sentence that states how the commissioner certifies the plan as a qualified plan is vague and confusing. Accordingly everything in that sentence after the clause.."then the plan will be qualified.." shall be deleted and replaced with the words.."upon certification by the Commissioner".

Part 2740.9939 contains the sentence "The Commissioner may revalue the actuarial equivalance of any plan or policy at any time deemed appropriate". That sentence is vague and sets no standards as to when reevaluation would be necessary. Accordingly this sentence shall be deleted.

Part 2740.9949, subpart 2, the second sentence of that subpart reads: "Particular care should be taken to revalue any policy form which contains scheduled benefits or other policy forms which have different deductible or coinsurance provisions." The word "should" used in that sentence is inappropriate and vague. It does not completely an act to be performed as was the intent. Accordingly the word "must" is to be substituted for it.

Part 2740.9959, subpart 15, the last sentence thereof states:"The $100,000 maximum as provided should be used in future years to help determine the reduction for a $250,000 plan." The word"should" used in that context is vague and inappropriate. It does not convey that this is a mandatory requirement as intended. Accordingly the word "must" shall be substituted for it.

Part 2740.9959, subpart 18, item A, the first sentence thereof states: "The following percentage of points after deduction for deductible and coinsurance should be subtracted if the policy coordinates benefits with other plans and its pricing assumes that number of insured will have other policies in force". The word "should" used in that item is inappropriate and vague and does not clearly show that this is a mandatory requirement as intended. Accordingly the word "must" is substituted for it.

Part 2740.9959, subpart 18, item B, states as follows: "The percentage should be applied to the total points after deduction for deductible and coinsurance". The word "should" contained in that item is vague and inappropriate . It does not convey the intent of the rule to make this a mandatory requirement. Accordingly the word "must" shall be substituted for it.

The forgoing changes are not substantial in nature and are clearly within the original intent and scope of the rules as published. Accordingly the changes noted are not substantial changes.

The above captioned rules as modified are needed and reasonable.

NOW THEREFORE IT IS ORDERED that the rules identified as Rules Relating to the Comprehensive Health Insurance Association are adopted this 16th day of July 1985 as modified by this Supplemental Findings of Fact, Conclusions and Order Adopting Rule and the previous Findings of Facts, Conclusions and Order Adopting Rule pursuant to the authority vested in by Minnesota Statute Section 62E.09 (i).

Michael A. Hatch
Commissioner of Commerce

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE

In the Matter of the Proposed Adoption of Rules Relating to the Comprehensive Health Insurance Association

FINDINGS OF FACT, CONCLUSIONS, AND ORDER ADOPTING RULE ADOPTED WITHOUT PUBLIC HEARING

Notice of the Commissioner's proposed adoption of the above-entitled rule was published in the State Register on April 1, 1985 at page 2146 and was sent by United States mail to all persons on the list maintained by the agency pursuant to Minnesota Statutes, sections 14.14, subdivision 1, paragraph (a) and 14.22 on March 28, 1985.

All persons were given the opportunity to submit comments on the rule for 30 days after notice of proposed rulemaking. Fewer than 25 written requests for hearing within the 30-day comment period were received.

No submissions or comments on the rule or requests for notice of submission to the attorney general were received by the department.

Based on the comments and evidence in the record before the agency, I find the following:

Part 2740.3100 Minimum Benefits of Comprehensive Health Insurance Plans. Subpart 3 of this part relates to benefits of a qualified Medicare supplement plan and the proposed Rules incorporate changes intended to bring the Rules into compliance with the Medicare supplement insurance law, Minnesota Statutes, section 62A.31 et seq. The changes incorporated in the proposed Rules (as published in the State Register April 1, 1985) properly reflect the new statutory requirements with the exception of subitem (5) of item A of this Subpart. The Medicare supplement insurance law was amended in 1983 to require coverage of at least 100% of the Medicare calendar year Part B deductible; the Rule as proposed carries forward the original 1981 requirement of at least 50% of the Medicare calendar year Part B deductible. This subitem should be corrected to read as follows:

> "Subp. 3. Benefits of qualified medicare supplement plan. Benefits of a qualified medicare supplement plan shall meet or exceed the following minimum standards.
>
> A. The plan shall provide benefits to covered persons by supplementing Medicare through provision of:
>
> . . .
>
> (5) coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of at least 100 percent of the medicare calendar year part B deductible..."

As the rule could not provide for anything not in compliance with the Medicare supplement insurance law this change is not substantial as no one would have anticipated that anything but a rule in compliance with this law would be adopted. The subject matter of the rule is still the same, the only change is that the rule now complies with the applicable law. Accordingly, this is not a substantial change.

The above-captioned rule as modified is needed and reasonable.

NOW, THEREFORE, IT IS ORDERED that the rule identified as Rules Relating to the Comprehensive Health Insurance Association is adopted this 14th day of June, 1985 pursuant to authority vested in me by Minnesota Statutes, sections 62E.09 (i).

MICHAEL A. HATCH
Commissioner of Commerce

State of Minnesota
Department of Commerce

Notice of Intent to Solicit Outside Opinion Regarding Proposed Amendments to Rules Relating to the Minnesota Comprehensive Health Insurance Act including the Impact of the Rules on Small Businesses

Notice is hereby given that the Department of Commerce is seeking information or opinions from persons outside the agency in preparing to promulgate amendments to rules relating to the Minnesota Comprehensive Health Insurance Act. Promulgation of these rules is authorized by Minnesota Statutes, section 62E.09(i).

Outside opinion is also being solicited as to how these rules will affect small businesses as defined by Minnesota Laws 1983, ch. 188, codified as Minnesota Statutes § 14.115, subd. 1.

The Department of Commerce requests information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit statements of information or comment orally or in writing to: John Ingrassia, Department of Commerce, 500 Metro Square Building, St. Paul, MN 55101, (612) 296-9434.

All statements of information and comment shall be accepted until July 11, 1984. Any written material received by the Department of Commerce shall become part of the record in the event that the rules are promulgated.

Michael A. Hatch
Commissioner of Commerce

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE

In the Matter of the Proposed
Rules Relating to Comprenensive Health
Insurance Association

ORDER FOR NOTICE
OF INTENT TO ADOPT
RULES WITHOUT PUBLIC HEARING

IT IS ORDERED this 18th day of March , 1984 that Notice of Intent to Adopt Rules Without Public Hearing in the above-entitled matter be given to all persons who have registered their names with the Department of Commerce for that purpose and be published in the State Register.

Michael A. Hatch
Commissioner of Commerce

In the Matter of the Proposed Adoption of
Rules Relating to Comprehensive Health Insurance
Association

AFFIDAVIT OF
MAILING

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Rose T. Weiner, being first duly sworn, deposes and says:

That on the 28th day of March, 1985, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Intent to Adopt Rules without a public hearing by depositing in the State of Minnesota Central Mail System for United States mailing at said City of St. Paul, a copy properly prepared with first-class postage prepaid, on all persons and associations who have requested that their names be placed on file with the Department of Commerce for the purpose of receiving notice of the proposed adoption of rules.

A copy of the proposed rules is attached.

Rose T. Weiner
Rose T. Weiner

Subscribed and sworn to before me this
3rd day of April, 1985.

Nancy I. Link
Notary Public

NANCY I. LINK
NOTARY PUBLIC-MINNESOTA
HENNEPIN COUNTY
MY COMMISSION EXPIRES DECEMBER 3, 1990

State of Minnesota
Department of Commerce

In the Matter of the Proposed Adoption of
Rules Relating to Comprehensive Health
Insurance Association

Notice of Intent to Adopt Rules Without a Public Hearing

Notice is hereby given that the Department of Commerce proposes to adopt the above-entitled rules without a public hearing. The Commissioner of Commerce has determined that the proposed adoption of these rules will be noncontroversial in nature and has elected to follow the procedures set forth in Minnesota Statutes, § 14.21.

Persons interested in these rules shall have 30 days to submit comments in support of or in opposition to the rules. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed. The proposed rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change.

No public hearing will be held unless twenty-five (25) or more persons make a written request for a hearing within the 30-day comment period. In the event a public hearing is required, the agency will proceed according to the provisions of Minnesota Statutes, §14.14, subd. 1.

Persons who wish to submit comments or a written request for a public hearing should submit them to Richard G. Gomsrud, General Counsel, Department of Commerce, 500 Metro Square Building, St. Paul, MN 55101. Any person requesting a public hearing should state her/his name and address, identify the portion of the proposed rule addressed, the reason for the request and any change proposed and send this information to the above address.

Authority for the adoption of these rules is contained in Minnesota Statutes, § 62E.09(1) . Additionally, a Statement of Need and Reasonableness describing the need for and reasonableness of each provision and identifying the data and information relied upon to support the proposed rules has been prepared and is available upon request.

Pursuant to Minn. Laws 1983, ch.188 codified as Minn. Stat. § 14.115, subd. 2, the impact on small business has been considered in the promulgation of the rules. Anyone wishing to present evidence or argument as to the rules' effect on small business may do so. The Department's position regarding the impact of the rules on small business is set forth in the Statement of Need and Reasonableness.

Upon adoption of the final rules without a public hearing, the proposed rules, this Notice, the Statement of Need and Reasonableness, all written comments received, and the final Rules as Adopted will be delivered to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the final rules as proposed for adoption, should submit a written statement of such request to Richard Gomsrud Department of Commerce, 500 Metro Square Bldg., St. Paul, MN 55101.

A copy of the proposed rules is attached to this Notice. Copies of this Notice and the proposed rules are available and may be obtained by contacting Rose Weiner at the above address.

Michael A. Hatch
Commissioner of Commerce

Rules as Proposed

2740.0100 DEFINITIONS.

Subpart 1. to 12. [Unchanged.]

Subp. 13. **Covered expenses.** "Covered expenses" means the usual and customary charges for the services and articles listed in Minnesota Statutes, section 62E.06, or, with respect to qualified plans, the actuarial equivalence thereof, when prescribed for a covered person by a physician and when ~~such~~ the expenses are incurred during a period in which the ~~state plan~~ policy or contract is in effect.

Subp. 14. to 28. [Unchanged.]

Subp. 29. **Licensed and tested insurance agent or ~~solicitor~~ insurance agent.** "Licensed and tested insurance agent or ~~solicitor~~" "insurance agent" means an insurance agent ~~or solicitor~~ as defined in Minnesota Statutes, section 60A.02, subdivision 7 ~~or 8~~, and licensed as such by the commissioner ~~under Minnesota Statutes, section 60A.17 to act as an agent or solicitor for accident and health insurance as defined in Minnesota Statutes, section 60A.06, subdivision 1, clause (5)(a)~~.

Subp. 30. and 31. [Unchanged.]

Subp. 32. **Net gains.** "Net gains" means the excess of premiums or contract charges over claims expenses, after the writing carrier's expenses and agent referral fees ~~(~~, not to exceed ~~12-1/2~~ 15 percent of premiums or contract charges~~)~~, have been paid as provided in part 2740.4400, subpart 4.

Subp. 33. to 44. [Unchanged.]

Subp. 44a. **Qualified medicare supplement plan.** "Qualified medicare supplement plan" means a plan of health coverage meeting the requirements of Minnesota Statutes, sections 62A.31, 62A.32, 62E.02, subdivision 5, and 62E.07.

Subp. 45. to 52. [Unchanged.]

Subp. 53. **Rejection.** "Rejection," for the purpose of state plan eligibility, means refusal by any association member, or any authorized representative, including any insurance agent, acting on behalf of any association member, to issue a qualified

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plan or a qualified medicare supplement plan to a person who completes an application for coverage under such qualified plan, or a qualified medicare supplement plan, as determined by the board.

Subp. 54. to 56. [Unchanged.]

Subp. 56a. **Self-insurer.** "Self-insurer" means an entity defined by Minnesota Statutes, section 62E.02, subdivision 21, which is a "governmental plan" as defined by United States Code, title 29, section 1002(32) or a "church plan" as defined by United States Code, title 29, section 1002(33)(A) or which is otherwise exempt from or outside of the scope of the provisions of the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001 to 1381, as amended.

Subp. 57. [Unchanged.]

Subp. 58. **Total cost of self-insurance.** "Total cost of self-insurance" includes any direct and indirect administrative expenses incurred that are related to the operation of a plan ~~or~~ of self-insurance, plus the sum of any payment made to or on behalf of Minnesota residents for costs or charges for health benefits by a self-insurer under a plan of health coverage, ~~regardless-of-the-amount-incurred-or-relationship-of-the-cost-to-an-insured-or-partially-insured-plan-of-health-coverage,~~ which is not counted as premium by an insurer, except to the extent of such payments made for coverage of the types described in Minnesota Statutes, section 62E.02, subdivision 11, clauses (1) to (8).

Subp. 59. [Unchanged.]

2740.1100 DUTIES OF EMPLOYERS.

Subpart 1. **Duty to make available a qualified plan.** An employer shall be deemed to have made available a qualified plan to its employees as required in Minnesota Statutes, section 62E.03, subdivision 1 when participation under a number 2 or number 3 qualified plan or a health maintenance plan is offered to the employee ~~directly~~ by a self-insurer or through an insurer or health maintenance organization ~~and~~, without regard to whether the cost of such participation is paid directly or

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indirectly by the employer or by the employee or by their joint payment.

Subp. 2. [Unchanged.]

Subp. 3. **Frequency of required offer.** Except as provided in subpart 2, an employer shall be deemed to have complied with the requirements of Minnesota Statutes, section 62E.03, subdivision 1 if ~~he~~ the employer makes available to ~~his~~ the employer's employees a plan of health coverage which is certified as a number 2 or number 3 qualified plan or a health maintenance plan at least once during each accounting period utilized by the employer for Minnesota income tax purposes.

2740.1200 DUTIES OF INSURERS AND FRATERNALS.

Subpart 1. [Unchanged.]

Subp. 2. **Timing of required offer of a qualified plan or qualified medicare supplement plan.** Timing of required offer of a qualified plan or qualified medicare supplement plan is as follows:

A. The offer of each type of qualified plan (that is, a number 1, number 2, and number 3 qualified plan) that is required when an insurer or fraternal is offering an individual policy of accident and health insurance shall occur no later than the date of delivery of such policy to the applicant.

B. to E. [Unchanged.]

Subp. 3. [Unchanged.]

Subp. 4. **Duty to offer major medical coverage.** Each insurer and fraternal shall affirmatively offer, subject to its underwriting standards, coverage of major medical expenses to every applicant for a new unqualified policy at the time of application and annually thereafter to every holder of an unqualified policy of accident and health insurance renewed by the insurer or fraternal as required by Minnesota Statutes, section 62E.04, subdivision 4. "Affirmatively offer" shall mean written advice to the applicant for, or the holder of, an unqualified policy of accident and health insurance, of the availability of coverage for major medical expenses. Such written advice of the availability of the coverage for major

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medical expenses may be satisfied by a contractual provision in the unqualified policy that gives the insured the contractual right to apply to the insurer or fraternal for a new policy or a rider on an existing unqualified policy that provides coverage for 80 percent of the covered expenses for services listed in Minnesota Statutes, section 62E.06, subdivision 1 or the actuarial equivalence thereof subject to a $5,000 deductible for out-of-pocket expenses, subject to the insurer's or fraternal's underwriting requirements.

Subp. 5. and 6. [Unchanged.]

Subp. 7. **Exceptions to duties for certain policies and contracts.** Exceptions to duties for certain policies and contracts are as follows:

A. [Unchanged.]

B. The issuance or renewal by an insurer or fraternal on or after June 3, 1977, of ~~the~~ a policy or contract that is designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis, shall not be subject to Minnesota Statutes, section 62E.04, except for policies and contracts sold by an insurer to provide payments on a hospital indemnity basis if such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue.

Subp. 8. [Unchanged.]

2740.1600 TERMINATION OF COVERAGE; CONVERSION PRIVILEGES.

Subpart 1. and 2. [Unchanged.]

Subp. 3. **Due notice of cancellation or termination.** An insurer, health maintenance organization, or self-insurer shall be deemed to have provided "due notice of cancellation or termination" as required in Minnesota Statutes, section 62E.16 if the insurer, health maintenance organization, or self-insurer notifies in writing those employees at their respective addresses as provided to the insurer, health maintenance organization, or self-insurer by the employer pursuant to the terms of Minnesota Statutes, section 62E.16.

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2740.2100 DEFINITIONS.

Subpart 1. **Accident and health insurance business.** "Accident and health insurance business" means the issuance or renewal of any accident and health insurance policy as defined in Minnesota Statutes, section 62E.02, subdivision 11.

A. [Unchanged.]

B. Such business shall not include the issuance or renewal of policies or contracts providing coverage that is:

(1) to (8) [Unchanged.]

(9) limited to accident-only coverage issued by ~~a licensed and tested~~ an insurance agent ~~or solicitor~~ and that provides reasonable benefits in relation to the cost of covered services.

Subp. 2. and 3. [Unchanged.]

Subp. 4. **Self-insurance business.** "Self-insurance business" means the provision, directly or indirectly, of a plan of health coverage by a self-insurer. "Self-insurance business" does not include the direct provision of health care services to employees at no charge to them by an employer engaged in the business of providing health care services to the public, nor does it include provision of benefits that, if provided by an insurer doing accident and health insurance business, would be excluded under subpart 1, item B. "Directly or indirectly" for the purposes of parts 2740.2100 to ~~2740.2600~~ 2740.5500 means that the ~~employer or employee welfare benefit plan~~ self-insurer funds the plan of health coverage in any amount or collects any employee contributions which are used to pay for the plan of health coverage.

2740.2400 ASSESSMENTS.

Contributing members~~, according to the assessment agreement,~~ will be assessed for their proportionate share of the operating and administrative expenses of the association, incurred or estimated to be incurred, together with losses, if any, incurred by the association as a result of operation of the state plan. The total amount of operating and administrative expenses and losses:

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A. [Unchanged.]

B. may, at the recommendation of the board, subject to the approval of the commissioner, consist of a reasonable estimate of the operating and administrative expenses of the association for the succeeding fiscal year, which amount shall be adjusted at the end of the succeeding fiscal year to the amount of actual operating and administrative expenses, and contributing members shall be entitled to credit for any excess or shall be assessed for any deficit in these expenses in ~~the next annual fiscal year end assessment~~ future assessments.

2740.2500 LEVY OF ASSESSMENTS.

Subpart 1. **Annual.** The association shall make an annual determination of each contributing member's liability, if any, and may levy assessments following each fiscal year end. The fiscal year ends on December 31 unless the association establishes a different fiscal year end. Assessments are due and payable 30 days after receipt of a written assessment notice.

Subp. 2. **Interim.** The association may also, upon approval of the commissioner, levy interim assessments when deemed necessary to assure the financial capability of the association to meet the incurred or estimated operating and administrative expenses of the association and losses resulting from the state plan. Interim assessments shall be due and payable within 30 days of receipt by a contributing member of a written interim assessment notice.

Subp. 3. **Member share.** The association shall levy each contributing member's share of the total assessment based on the ratio of: the contributing member's total ~~accident and health insurance~~ premium~~, subscriber contract charges, or health maintenance organization contract charges (the preceding defined as charges~~ for accident and health insurance business as defined in part 2740.2100, subparts 1 and 2~~)~~, received from or on behalf of residents of Minnesota, ~~or total cost of self insurance,~~ as determined by the commissioner; to the total premium for accident and health insurance business for all contributing members ~~of premiums, contract charges, and benefit plan costs~~

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reported.

Subp. 4. **Costs and charges.** The costs and charges referred to in the ratio in subpart 3 shall, to the extent possible, be determined by reference to a form issued by the association or the commissioner which all contributing members shall submit to the commissioner annually for the preceding calendar year.

A. [Unchanged.]

B. The commissioner shall have the authority to audit the accounts and records of any contributing member ~~and any agent, trust, third-party administrator, or other entity administering all or any portion of a plan of health coverage with or on behalf of a self-insurer~~ for the purpose of obtaining information necessary to levy an assessment.

Subp. 5. **Discretionary waiver.** The board may, in its discretion, decline to levy assessments against contributing members that owe ~~up to $5~~ $10 or less in a given year.

2740.2600 FAILURE TO ~~EXECUTE ASSESSMENT AGREEMENT OR TO~~ PAY ASSESSMENTS.

~~The names of all insurers, self-insurers, fraternals, and health maintenance organizations that are required under the act to be members of the association, but which fail to execute an assessment agreement, will be forwarded by the association to the commissioner for appropriate action within the discretion of the commissioner.~~ Any contributing members that fail to pay annual or interim assessments when such assessments become payable will be reported by the association to the commissioner for appropriate action within the discretion of the commissioner.

2740.2900 DETERMINATION OF MEMBER'S VOTING RIGHTS.

Subpart 1. [Unchanged.]

Subp. 2. **Weighted vote.** A member's vote shall be a weighted vote based on the member's total cost of self-insurance, accident and health insurance premiums, subscriber contract charges, or health maintenance contract charges derived from or on behalf of residents of Minnesota in

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the previous calendar year, as determined by the commissioner. To the extent possible, this figure shall be determined by reference to the annual reporting form submitted by contributing members to the commissioner in accordance with part 2740.2500, subpart 4, and similar forms showing all other members' total accident and health insurance premiums, subscriber contract charges (defined as charges for business specified in part 2740.2100, subparts 1 and 2) received from or on behalf of residents of Minnesota, or total cost of self-insurance, as defined in part 2740.0100, subpart 58, as determined by the commissioner.

If the necessary information is not available to the commissioner on the form described in this subpart at the time that voting rights must be determined, the commissioner may estimate the member's weighted vote based on other information available to the commissioner.

Subp. 3. **Voting procedures.** Members are entitled to vote in person, by proxy, or by mail as determined by the board.

When a member elects to vote in person at a members' meeting, the representative casting the vote shall present credentials as required pursuant to the bylaws or operating rules of the association.

When a member elects to vote by proxy, the proxy statement as approved by the board ~~and by the commissioner~~ shall be returned on or before the date indicated in the meeting notice sent to the members.

Voting by mail may be permitted as authorized by the bylaws or operating rules of the association, and the meeting notice to members shall so indicate.

2740.3100 MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLANS.

Subpart 1. [Unchanged.]

Subp. 2. **Benefits of number 1 and number 2 qualified plan.** Benefits shall meet or exceed the requirements of Minnesota Statutes, section 62E.06 or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence

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tables ~~set-forth~~ in parts 2740.9905 to 2740.9986, except where substitution of an actuarially equivalent benefit is not permissible under the act.

A. [Unchanged.]

B. Coverage shall include an annual (calendar year) limitation of not more than $3,000 per covered person on total out-of-pocket expenses, which out-of-pocket expenses shall include the deductible under the state plan policy or contract, and which ~~benefit (copayment)~~ out-of-pocket expense limitation is not subject to substitution of an actuarially equivalent benefit ~~(copayment)~~.

C. Coverage shall be subject to a maximum lifetime benefit of not less than $250,000 per covered person, less any amount paid to or on behalf of the covered person under any other ~~state~~ qualified plan ~~policy or contract~~ of the state plan . This benefit is not subject to substitution of an actuarially equivalent benefit.

Subp. 3. **Benefits of qualified medicare supplement plan.** Benefits of a qualified medicare supplement plan shall meet or exceed the following minimum standards ~~or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables set forth in parts 2740.9905 to 2740.9986~~.

A. The plan shall provide benefits to covered persons ~~who are 65 years of age or older~~ by supplementing medicare through provision of ~~50 percent of the deductible and copayment required under medicare~~:

(1) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare to at least 50 percent of the deductible and copayment required under medicare for the first 60 days of any medicare benefit period;

(2) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period;

(3) coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days to the extent not

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covered by medicare;

(4) upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of at least 50 percent of the medicare calendar year part B deductible.

B. The plan shall provide 80 percent of the covered charges for expenses as provided in Minnesota Statutes, section 62E.06 ~~or the actuarial equivalence thereof~~, which charges are not paid or payable under medicare or would not have been paid or payable had the covered person who is or was entitled or eligible to enroll in medicare been so enrolled or which charges are not paid or payable under item A.

C. Coverage shall include an annual limitation of $1,000 total out-of-pocket expenses per covered person for covered ~~expenses~~ charges, provided that an annual deductible of not more than $200 is permissible for those covered charges not paid or payable under medicare or otherwise included in item A or B.

D. Coverage ~~may not~~ shall be subject to a maximum lifetime benefit of not less than $100,000~~, or the unused portion of the maximum lifetime benefit under any policy or contract of the state plan under which the person was previously covered, whichever is less~~ per covered person, less any amount paid to or on behalf of the covered person under any other qualified medicare supplement plan of the state plan.

E. The minimum coverage of a qualified medicare supplement plan required by this subpart is not subject to substitution of actuarially equivalent benefits.

Subp. 4. and 5. [Unchanged.]

2740.3600 ENROLLMENT.

Subp. 1. [Unchanged.]

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Subp. 2. Eligible person. "Eligible person," as used in subpart 1, means a resident of Minnesota who submits or on whose behalf is submitted a complete certificate of eligibility and enrollment form to the association or its writing carrier and who is not already covered by another state plan policy or contract.

A. A complete certificate of eligibility and enrollment form may provide:

(1) name, address, age, ~~sex,~~ and length of time as a resident of Minnesota;

(2) [Unchanged.]

(3) evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, by ~~at least two~~ one association ~~members~~ member, or by an authorized representative, including an insurance agent, acting on behalf of an association member, within six months of the date of application. "Substantially reduce coverage from that received by a person who is considered a standard risk" includes any restriction on coverage as a result of an illness, condition, or risk which the association deems substantial, any increase in rates for an applicant based on an illness, condition, or risk, which the association deems substantial, and any preexisting conditions limitation which the association deems substantial.

B. In lieu of evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, as required by item A, subitem (3), a complete certificate of eligibility and enrollment form may provide evidence which meets the requirements of an operating rule adopted by the association of a proposed covered person having been treated within three years of the date of the certificate of eligibility and enrollment form for one or more conditions listed in the operating rule.

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C. Before a person is determined to be an eligible person, the board may require that any items listed in ~~item~~ items A and B or, if acting pursuant to provisions of the association's operating rules, other necessary information be submitted to the association or its writing carrier and may also investigate the authenticity of information submitted as a part of the certificate of eligiblity.

~~C.~~ D. If a covered person, under a qualified plan of the state plan, upon reaching age 65, or becoming enrolled in medicare, wishes to purchase a state plan qualified medicare supplement plan, the requirement that the person obtain ~~two rejections~~ one rejection, restrictive rider, rate-up, or preexisting conditions limitation on a qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, from ~~members~~ one member of the association, or from an authorized representative, including an insurance agent acting on behalf of an association member, within the preceding six months may be waived by the board if acting pursuant to provisions of the association's operating rules.

~~D.~~ E. A person who is age 65 or older shall be eligible for coverage only under the state plan's qualified medicare supplement plan and when an insured person under a qualified plan reaches age 65, the board may, if acting pursuant to provisions of the association's operating rules, terminate or refuse to renew coverage under the qualified plan. A person under age 65 who is otherwise eligible for coverage under the state plan and is enrolled in medicare shall be permitted to purchase a qualified plan 1 or 2 or the qualified medicare supplement plan of the state plan.

~~E.~~ F. An applicant or any person proposed to be covered under a qualified plan of the state plan who has previously been covered ~~by a~~ under one or more qualified plans of the state plan ~~policy or contract~~ and who has exhausted the $250,000 maximum lifetime benefit ~~under the state plan~~ shall not be an eligible person for coverage under a qualified plan of the

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state plan~~,-provided-that~~; an applicant ~~for~~ or any person proposed to be covered under a qualified medicare supplement ~~policy-or-contract~~ plan of the state plan who has previously been covered under one or more qualified medicare supplement plans of the state plan ~~shall-be-eligible-for-a-maximum-benefit under-the-qualified-medicare-supplement-policy-or-contract-of $100,000,-or-the-unused-portion-of-the-maximum-lifetime-benefit under-any-policy-or-contract-of-the-state-plan-under-which-the person-was-previously-covered,-whichever-is-less~~ and who has exhausted the $100,000 maximum lifetime benefit shall not be an eligible person for coverage under a qualified medicare supplement plan of the state plan.

~~F.~~ G. When a covered person under the state plan no longer meets one or more of the requirements for eligibility for coverage under the state plan, the board may, if acting pursuant to the association's operating rules, terminate or refuse to renew coverage under the state plan.

2740.3700 ASSOCIATION'S RESPONSE.

Subpart 1. **Time limitation.** Within 30 days of receipt of a complete certificate of eligibility and enrollment form pursuant to part 2740.3600, subpart 2, items A ~~and~~, B, and C, the association or the writing carrier shall accept the certificate of eligibility or shall reject the certificate of eligibility for failure to meet the eligibility requirements.

Subp. 2. **Acceptance.** If the association or its writing carrier accepts the certificate of eligibility, it shall forward a notice of acceptance, billing information, and a policy or contract or certificate that shall evidence coverage under the state plan.

A. [Unchanged.]

B. When the state plan premium is received by the association or its writing carrier for the first billing period and accepted in accordance with this part, the coverage shall be effective retroactive to the date of receipt by the association or its writing carrier of the completed certificate of eligibility pursuant to part 2740.3600, subpart 2, items A ~~and~~,

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B, and C unless otherwise requested by the insured person and approved by the board.

Subp. 3. **Nonacceptance.** If the association does not accept the certificate of eligibility, the applicant shall be informed of the reason for the rejection and shall have the opportunity to submit additional information to substantiate eligibility for coverage under the state plan and to request reconsideration of the decision. The board ~~shall~~ may establish a review mechanism for reviewing requests for reconsideration of rejected certificates of eligibility. The association shall give notice of a final determination of ineligibility to the applicant stating the reasons therefor and advising the applicant of the right to appeal to the commissioner within a reasonable period of time.

2740.3900 ~~SOLICITATION OF ELIGIBLE PERSONS~~ DISSEMINATION OF INFORMATION CONCERNING STATE PLAN.

Subpart 1. **Plan.** The association shall develop a plan for use by the association, upon approval by the commissioner, to publicize the existence of the state plan~~,~~ and the eligibility requirements~~,~~ and procedures for enrollment, and to maintain public awareness of and participation in the state plan.

Subp. 2. **Forms and instructions.** The association shall prepare and make available certificate of eligibility forms and enrollment instruction forms to members, insurance ~~solicitors,~~ agents and brokers, and to the general public in Minnesota.

Subp. 3. **Referral fee.** The association shall require the writing carrier to pay a referral fee of ~~$25~~ $50 for any certificate of eligibility accepted by the association or its writing carrier~~.--The referral fee shall be paid to the licensed agent whose signature appears as the agent on the accepted certificate of eligibility~~ if the referring agent is licensed by the commissioner as an insurance agent and if the referring agent's signature appears as the agent on the accepted certificate of eligibility. The referral fee shall be paid from the premium received for the state plan. Referring agents shall not be authorized to interpret, amend, or alter the terms of the

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state plan policy or contract, nor shall referring agents be authorized to bind the association in any way. Referring agents shall not be agents of the association for any purpose, and the association shall not bear responsibility for acts of referring agents.

2740.4400 OPERATIONS OF THE WRITING CARRIER.

Subpart 1. **Administrative and claims payment functions.** The writing carrier shall perform all administrative and claims payment functions relating to the state plan.

A. [Unchanged.]

B. The writing carrier shall perform all necessary functions to assure timely payment of benefits to covered persons under the state plan.

(1) to (3) [Unchanged.]

(4) The writing carrier shall exercise reasonable efforts to advise covered persons, within ~~15 working~~ 60 business days of receipt of a properly completed and executed proof of loss, whether the submitted claim was accepted or rejected by the writing carrier, unless sooner settled.

(5) The writing carrier ~~shall~~ may establish an appeals procedure approved by the board to review claims that are denied in whole or in part. When a claim or any portion thereof is denied, the writing carrier shall inform the covered person of the existence of the procedure, including the right to appeal to the commissioner within a reasonable period of time.

Subp. 2. [Unchanged.]

Subp. 3. **Claims expenses.** The writing carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the state plan. If the writing carrier's payments for claims expenses exceed the portion of the state plan premiums allocated by the board for payment of claims expenses, the association shall provide to the writing carrier additional funds for payment of claims expenses. Not less than ~~87 1/2~~ 85 percent of the state plan premium, as determined by the board, shall be used to pay claims expenses, and not more than ~~12 1/2~~ 15 percent of the state plan premium shall be used

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to pay agent referral fees (authorized by Minnesota Statutes, section 62E.15, subdivision 3) and to pay the writing carrier's direct and indirect expenses, as defined and authorized in Minnesota Statutes, section 62E.13, subdivision 7 and described in ~~parts 2740.4300 to 2740.4500~~ subpart 5.

Subp. 4. **Direct and indirect expense reimbursement.** The writing carrier shall be paid from time to time as provided in the association's contract with the writing carrier for its direct and indirect expenses incurred in the performance of its services from the state plan premiums received in an amount not to exceed the lesser of:

A. ~~12-1/2~~ 15 percent of the state plan premium, less agent referral fees payable under part 2740.3900, subpart 3;

B. and C. [Unchanged.]

Subp. 5. **Direct and indirect expenses.** Direct and indirect expenses shall include that portion of the writing carrier's actual administrative, printing, claims administration, management, building overhead expenses, and other actual operating and administrative expenses approved by the board as allocable to the administration of the state plan.

Subp. 6. and 7. [Unchanged.]

2740.5200 REINSURANCE PLAN.

Subpart 1. [Unchanged.]

Subp. 2. **Application and acceptance.** Insurer or fraternal members wishing to participate in the pool shall apply to the association for participation in the pool, specifying the categories of coverage that the member desires to reinsure.

Members Each member entering into a reinsurance pooling agreement for a particular category or categories of coverage shall offer to place in the pool all policies and contracts that it issues in the category or categories listed in part 2740.5100 that it wishes to reinsure.

Only policies and contracts acceptable to the association or its reinsurance administrator may be accepted for reinsurance. The association is under no obligation to accept any but standard risks in the reinsurance plan.

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Subp. 3. to 5. [Unchanged.]

Rules as Proposed (all new material)

2740.9904 PURPOSE.

Minnesota Statutes, section 62E.02, defines "qualified plans" as health benefit plans that provide the benefits required in Minnesota Statutes, section 62E.06 or "the actuarial equivalent of those benefits." Minnesota Statutes, section 62E.06 describes three qualified plans. These statutes require all plans of health coverage subject to Minnesota Statutes, section 62E.06 to be labeled as qualified or non-qualified. The commissioner may be requested to determine whether a plan is qualified and may take up to 90 days to make that determination. Minnesota Statutes, section 62E.02 defines a qualified medicare supplement plan as one which has been certified by the commissioner as providing the minimum benefits required by Minnesota Statutes, section 62E.07. Since the definition does not allow the option of an actuarial equivalent plan, the current rules do not include actuarial equivalent tables for medicare supplement policies.

2740.9909 COMPOSITE POINT VALUES FOR QUALIFIED PLAN NUMBER THREE.

The composite point values for a qualified plan number three for 1984 are as shown herein.

Composite Point Values for Minnesota Qualified Plan No. 3

Points	Benefit
363	Hospital room and board, unlimited days, semi-private.
480	Hospital extras (i.e., hospital services, hospital miscellaneous, hospital special services, or ancillary services) including anesthesia.
243	Surgery, including administration of anesthesia, assistant surgeon and oral surgery but no tooth repair or extractions.
215	Home and office physician care, unlimited.
51	Physician care in hospital, unlimited.
63	Obstetrics, unlimited.
110	Hospital maternity, unlimited.
105	X rays and laboratory tests, outpatient and out of hospital.
100	Prescription drugs and medicine, outpatient and out of hospital.
15	Radioactive therapy, outpatient and out of hospital.
16	Nursing or convalescent facility.
8	Home health agency care.
10	Physical therapy.

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4	Oxygen.
5	Prostheses.
5	Durable medical equipment rental or purchase.
2	Second opinion surgery.
2	Private duty nursing.
3	Ambulance.
-12	Adjustment for major medical maximum.
1788	Total reasonable and customary medical services
-245	$150 deductible.
-309	20 percent coinsurance.
1234	Total after deductions for deductible and coinsurance
-49	Coordination of benefits.
-31	Nonduplication with no-fault.
30	3,000 annual "out-of-pocket" expense limit.
8	Well baby care.
0	Emergency accident.
0	Supplement accident.
0	Student dependents.
1192	Grand Total

2740.9914 DETERMINATION OF AVERAGE SEMI-PRIVATE HOSPITAL ROOM AND BOARD LEVEL OF SURGICAL CHARGES.

Subpart 1. **Why develop values annually.** Many companies issue policies with scheduled benefits. Due to inflation the value of scheduled benefits declines each year in relation to reasonable and customary charges. It would be best if the test of actuarial equivalence would automatically adjust for inflation and thus would more accurately value these types of benefits.

Subp. 2. **When values determined.** In December of each year, the commissioner will publish the following values:

A. the average semi-private hospital room and board (ASP value);

B. the value of surgical charges (SURG value);

C. the ratios of the average semi-private hospital room and board for the year to that in 1984 (ASP factor);

D. the ratio of the value of surgical charges for the year to that in 1984 (SURG factor); and

E. the composite ratio of medical care for the year to that in 1984 (COMP factor).

The commissioner may appoint a service agency to calculate these values on a consistent basis each year.

Subp. 3. **How values determined.** Values will be determined

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as follows:

A. The ASP value will be the weighted bed average of semi-private room and board charges for acute hospitals in Minnesota. The information will be derived from each hospital's latest room and board charge filed with the commissioner or the service agency. A semi-private room will be defined as a room with two beds.

B. The SURG value will be the sum of the product of the average charge, filed with the commissioner or the service agency, for each of the surgical operations shown below times the factor shown for that operation. The surgical operations and their factors are shown in part 2740.9919.

C. The ASP factor will be the ASP value to be published for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

D. The SURG factor is the ratio of the SURG value for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

E. The COMP factor is the composite factor for medical care. This equals 54 percent times the ASP factor for the year plus 46 percent times the SURG factor for the year.

2740.9919 TABLE OF SURGICAL FACTORS TO DEVELOP SURG VALUE.

CPT4 Code	Surgical Factor	Description
SKIN		
10060	.7710	Abscess, incision, and drainage, simple
11400	2.0161	Benign lesion removal of (up to 0.5 cm.)
11750	.4368	Nail, permanent removal of
12011	1.9732	Simple wound, simple repair (up to 2.5 cm.)
17100	4.6520	Benign skin lesion, destruction of
MUSCULOSKELETAL		
20610	1.9226	Major joint or bursa, injection or aspiration of
27130	.1565	Total hip joint replacement, simple
29425	1.0286	Application walking cast
CARDIOVASCULAR		
33512	.1111	Coronary bypass, three arteries
93547	.2166	Left heart catheterization with coronary angiogram
DIGESTIVE SYSTEM		
43235	.4514	Gastroscopy, diagnostic
43844	.0569	Stomach bypass for morbid obesity
44950	.2618	Appendectomy
45300	2.7170	Proctosigmoidoscopy, diagnostic

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47600	.3765	Gallbladder, removal of
49505	.3086	Inquinal hernia repair, unilateral
URINARY SYSTEM		
52601	.1579	Prostate resection (TUR), complete
53670	3.5273	Urinary bladder catheterization
MALE GENITAL		
54150	.8509	Circumcision by clamp, newborn
FEMALE GENITAL		
58120	.8470	Uterus, dilation and curettage (D & C), nonobstetrical
58150	.4792	Uterus, removal of
58980	.9455	Laparoscopy, diagnostic
NERVOUS SYSTEM		
63030	.0694	Laminotomy herniated disc, lumbar
64721	.1988	Carpal tunnel symdrome repair
EYE		
66980	.2003	Cataract removal, intraocular lens insertion
EAR		
69437	.3934	Tympanostomy with ventilating tube insertion

2740.9924 HOW TO USE THE LIST.

Subpart 1. **Basic and comprehensive major medical plans.** The list is used in the following manner:

A. Determine the ASP value, SURG value, ASP factor, SURG factor, and COMP factor for the calendar year. This is published annually by the commissioner.

B. List the plan benefits, ignoring deductibles, coinsurance, well baby care, emergency accident, supplemental accident, and student dependents. Include the plan maximum in the plan benefits.

C. For each benefit, find the appropriate table of equivalent points for basic and major medical plans.

D. Extract the appropriate point value for the benefit from the table, interpolating as necessary or indicated, and place it opposite the listed benefit. Ignore benefits for which no table exists.

E. Total the points for these benefits.

F. List deductible and coinsurance if the plan is a comprehensive major medical plan.

G. Determine the appropriate point values for deductible, interpolating as necessary, and place the value in the list of points. Calculate the coinsurance points and place the values in the list of points.

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H. Determine the total points after the deduction for deductible and coinsurance.

I. Determine the deduction for coordination and nonduplication of benefits.

J. Determine the number of points for the limit on "out-of-pocket" expenses, well baby care, emergency accident, supplemental accident, and student dependents.

K. Calculate the grand total.

L. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

Subp. 2. **Superimposed major medical plans.** The following govern superimposed major medical plans:

A. Follow steps outlined in subpart 1, items A to D for basic health plan benefits.

B. Total the points for the basic plan.

C. Utilize part 2740.9964, subparts 23, 24, and 25 to determine the point value of a Minnesota qualified plan superimposed over the basic plan with the deductible and benefit period of the plan at hand, interpolating as necessary. Put the points in the point column.

D. Compare the benefits in the superimposed major medical plan with the benefit structure of a Minnesota qualified plan:

(1) $250,000 lifetime maximum.

(2) 80/20 coinsurance.

(3) $3,000 annual per person out-of-pocket maximum.

(4) Eligible expenses are usual and customary expenses for:

(a) hospital services;

(b) physician care;

(c) prescription drugs;

(d) nursing home care of up to 120 days in one year, commencing within 14 days of hospitalization of at least three days;

(e) home health care;

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(f) radium and radioactive therapy;

(g) oxygen;

(h) anesthetics;

(i) prostheses;

(j) rental or purchase of durable medical equipment;

(k) diagnostic x rays and laboratory tests;

(l) oral surgery on impacted teeth, on tooth roots, or on gums and tissues of the mouth when not performed in connection with tooth extraction;

(m) physical therapy;

(n) maternity same as any illness;

(o) Minnesota statutorily-mandated benefits; and

(p) coordination of benefits.

E. Consult the tables for point adjustments (usually negative for Minnesota qualified plan benefits not in the superimposed major medical plan being tested). Put the adjustments in the point column.

F. Calculate the total by adding the points for the basic plan (item B), the superimposed major medical plan (item C), and the adjustments (item E).

G. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

2740.9929 BENEFIT VARIATIONS NOT COVERED BY TABLES.

Only those plan variations that are most common are recognized. For instance, comprehensive plan coinsurance was assumed normally not to exceed 20 percent. Therefore, no points are shown for 25 percent. However, points for such missing benefit variations can be extrapolated or estimated.

2740.9934 USE OF TABLES.

Subpart 1. **Certification of plans.** Any insurer, self-insurer, or policyholder may use the test for actuarial equivalence as a guide. To obtain certification of any plan of health benefits as qualified, it must be submitted to the

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commissioner.

Subp. 2. **Filing with commissioner.** The following should be sent to the commissioner:

A. The plan document if an uninsured plan or the policy form if an insured plan.

B. A statement of the grand total from part 2740.9924.

C. A certification that the plan is qualified as either a plan 1, 2, or 3, or is nonqualified, by using the test of actuarial equivalence in part 2740.9949. The certification must be by a principal or officer, or by a member of the Academy of Actuaries.

D. If the plan is not a qualified plan by using the test of actuarial equivalence, and the insurer or self-insurer desires to have it certified as a qualified plan, a statement of the specific reasons for the desired qualification.

Subp. 3. **Certification by commissioner.** If the documents required by subpart 2 are filed and the plan is a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be deemed certified as filed. If the documents required by subpart 2 are filed and the plan is not a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be qualified if, and when, the commissioner certifies it as a qualified plan.

2740.9939 UPDATE OF TABLES.

Periodically, the tables may be revised as health care costs change. The commissioner may revalue the actuarial equivalence of any plan or policy at any time deemed appropriate. Also, as health care costs change, a plan may automatically lose or change its qualification. Annual revaluation of plans is required. When a plan is revalued and its qualification status changes, the filing procedures in part 2740.9934 will be followed.

2740.9944 MISUSE OF TABLES.

The tables of equivalent points are not intended for any other use, especially not for premium calculations. They

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represent a composite of data and were adjusted to be useable for testing actuarial equivalence. No other use is contemplated.

2740.9949 TEST FOR ACTUARIAL EQUIVALENCE FOR PLANS OTHER THAN MEDICARE SUPPLEMENT PLANS.

Subpart 1. **Table for 1984.**

If the Grand Total of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualified Plan No.
1192 + points	3
911 + points	2
767 + points	1
Less than 767 points	Nonqualified

Subp. 2. **Effect of inflation.** Each year the number of points required for each qualified plan will increase due to the effects of inflation on the benefits. Particular care should be taken to revalue any policy form which contains scheduled benefits or other policy forms which have different deductible or coinsurance provisions.

2740.9954 WORKSHEET FOR OTHER THAN MEDICARE SUPPLEMENT PLANS.

Comprehensive Health Insurance

Test for Actuarial Equivalence

Other than Medicare Supplement Plans

Subparts of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board			
2.	Hospital extras			
3.	Surgery			
4.	Physician care-home, office			
5.	Physician care-hospital			
6.	Maternity			
7.	Diagnostic X-ray and lab			
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility			
11.	Home health care			
12.	Physical therapy			
12.	Oxygen			
12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty			

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		nursing
	12.	Ambulance
	13.	Hospital room and board in full
	14.	All hospital expenses in full
	15.	Major medical maximums
		Subtotal reasonable and customary medical services
	16.	Deductible
	16.	Coinsurance
		Subtotal net of deductible and coinsurance
	17.	Adjust (Comb. medical/dental deductible)
	18.	COB/No-Fault
	19.	Limit on "out-of-pocket" expenses
	20.	Well baby care
	21.	Emergency and supplemental accident
	22.	Student dependents
	23.-25.	Superimposed major medical
		Grand Total Combined Basic and Superimposed

Equivalent to Minnesota qualified plan number___ XXX nonqualified___ XXX

Date_____ By_____

2740.9959 LOCATION OF TABLES OF EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS.

Subparts of part 2740.9964	Other than Medicare Supplement Plans Name
1.	Hospital room and board
2.	Hospital extras
3.	Surgery
4.	Home and office physician care
5.	In-hospital physician care
6.	Maternity
7.	Diagnostic X-ray and laboratory
8.	Drugs and medicine
9.	Radioactive therapy
10.	Nursing or convalescent - home care
11.	Home health care agency service
12.	Physical therapy
12.	Oxygen
12.	Prostheses
12.	Durable medical equipment
12.	Second opinion surgery
12.	Private duty nursing
12.	Ambulance
13.	Hospital room and board in full
14.	All hospital charges in full
15.	Major medical maximums
16.	Coinsurance and deductibles
17.	Combined dental and health insurance deductible
18.	Coordination and nonduplication of benefits
19.	Limit on "out-of-pocket" expenses

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20.	Well baby care
21.	Emergency and supplement accident
22.	Student dependents
23.	Superimposed major medical
24.	Superimposed major medical
25.	Superimposed major medical

2740.9964 EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS; NOT TO BE USED FOR MEDICARE SUPPLEMENT PLANS.

Subpart 1. Hospital room and board.

Maximum Days	Room & Board
31	327
70	347
120	351
365	359
Unlimited	363

A. Room and board is defined to include a semi-private room, or charges for a private room if prescribed as medically necessary by a physician. If the policy does not pay the additional charges for a private room, then deduct three points from hospital room and board.

B. If the policy pays the private room charge even though not medically necessary, then add ten points if average charge per day is four percent greater than the average semi-private room and board charge.

C. If the policy pays the hospital room and board charge up to a maximum daily benefit which is less than the average semi-private room and board charge in the area, then multiply the points for the semi-private room and board at the indicated maximum days by the ratio of the scheduled amount to the ASP value in the area for the year.

Subp. 2. Hospital extras. Hospital extras such as hospital services, special hospital services, ancillary services, and hospital therapeutics.

Maximum Amount*	Anesthesia** Included	Not Included
$ 500	130	130
1,000	217	216
2,000	317	312
5,000	413	401
10,000	454	433
15,000	469	444
Unlimited	480	451

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*Before entering this table, divide the maximum amount in the policy by the ASP factor for the year.

**Anesthesia does not include the administration of anesthesia.

This is for miscellaneous hospital services and includes the cost for inpatient hospital care, the cost for outpatient hospital treatment and the excess cost of intensive care unit or coronary care unit over the average semi-private room and board.

Subp. 3. **Surgery.**

Limit	Administration of Anesthesia Included	Not Included
Prevailing Fee with Assistant Surgeon	243	206
Prevailing Fee without Assistant Surgeon	244	187

If the policy pays the reasonable and customary charges up to a maximum in a schedule, then multiply the points for the prevailing fee by the ratio of the value of the schedule used in the policy to the SURG value for the year.

Subp. 4. **Home and office physician care.**

Annual Maximum*	First Visit Accident First Visit Sickness	Third Visit Sickness
$ 200	111	63
500	141	72
1,000	165	93
Unlimited	215	118

*Before entering this table, divide the annual maximum in the policy by SURG factor for the year.

Subp. 5. **In-hospital physician care.**

Maximum Number of Visits	Prevailing Fee
31	46
70	49
120	49
365	50
Unlimited	51

A. This benefit pays the reasonable and customary charge to the physician (other than the surgeon, assistant surgeon, or anesthetist) while confined in the hospital for medical or surgical reasons.

B. If the policy pays the greater of this benefit or the surgical benefit, then reduce these points by 30 percent.

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C. A number of policies pay a limited amount per visit (limited to one visit per day) which is less than or equal to the cost for a routine follow-up visit in the hospital. If it is equal to the cost for a routine follow-up visit (assumed to be $24.20*/day in 1984), then deduct 14 points from the above points. If it is less than that, then use a proportional part of the points determined as if the maximum was equal to the cost for a routine follow-up visit.

*Multiply the indicated value by the SURG factor for the year.

Subp. 6. **Maternity.**

A. complications only:

limited to some specified list	20
any complications	25

B. full maternity (including complications):

Maximum Limit*	Deductible	Flat Maternity	Obstetrics	Hospital Maternity
$ 300	None	-	23	28
600	None	49	44	55
1,000	None	81	59	80
2,000	None	149	-	-
Unlimited	None	173	63	110

*Before entering this table, divide maximum limit in the policy by the ASP factor for the year.

Subp. 7. **X rays and laboratory tests (out of hospital).**

Maximum*	Scheduled (Any Scheduled)	Unscheduled
$100	56	70
200	67	89
500	74	101
Unlimited	77	105

*Before entering this table, divide the maximum in the policy by the ASP factor for the year.

Subp. 8. **Prescription drugs and medicine (out of hospital).**

Deductible* Per Prescription	
$4.00	69
2.00	86
None	100

*Before entering this table, divide the deductible per prescription by the SURG factor for the year.

Subp. 9. **Radioactive therapy (out of hospital).**

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Scheduled (Any Schedule)	10
Unscheduled	15

Subp. 10. **Nursing or convalescent home care (within 14 days of hospital confinement of at least three days).**

Maximum Days	
120 or More	16
Less than 120	0

Subp. 11. **Home health care agency services.**

Maximum Visits/Year	
180 or More	8
Less than 180	0

Subp. 12. **Miscellaneous.**

A. physical therapy (out of hospital), 10;

B. oxygen (out of hospital), 4;

C. prostheses (out of hospital), 5;

D. durable medical equipment rental or purchase (out of hospital), 5;

E. second opinion surgery, 2;

F. private duty nursing (in hospital only), 2; and

G. ambulance, 3.

Subp. 13. **Hospital room and board in full to indicated limit (basic and comprehensive major medical plans).** Add these points to the points in subpart 1 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

	Plan Deductible* On All	Limit*			
Plan	Benefits	$1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0 - 300	58	60	66	79
Comprehensive	301 - 600	61	63	69	82
Comprehensive	601 - 900	66	68	74	87
Comprehensive	901 - 1200	74	76	82	95

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the policyholder pays 20 percent after the deductible. If the policyholder pays a

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different percentage, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that hospital room and board will be paid at 100 percent and that the deductible will not be applied to it. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining deductible will not be applied but the coinsurance will be applied, to the hospital room and board benefits.

Subp. 14. **All hospital charges in full to indicated limit (basic and comprehensive major medical plans).** Add these points to the total points in subparts 1 and 2 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

Plan	Plan Deductible* On All Benefits	LIMIT* $1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0- 300	70	110	121	177
Comprehensive	301- 600	171	151	162	218
Comprehensive	601- 900	198	238	249	305
Comprehensive	901-1200	343	383	394	450

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is 1800. If the percentage being paid by the insured is not 20 percent, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that the hospital room and board and hospital services will be paid at 100 percent and that the deductible will not be applied to them. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining deductible will not be applied but the coinsurance will be applied, to either hospital room and board or hospital services benefits.

Subp. 15. **Major medical maximum (comprehensive and superimposed plans).**

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Maximum*	Add (+) or Subtract (-)
$ 100,000	-27
250,000	-12
500,000	- 7
1,000,000	- 2

* Before entering the table, divide the maximum in the policy by the COMP factor for the year.

The smallest maximum in a qualified plan is $250,000. The $100,000 maximum as provided should be used in future years to help determine the reduction for a $250,000 plan.

Subp. 16. **Coinsurance and deductibles (comprehensive major medical plans).**

A. This table assumes that the point values for all medical services and supplies are approximately 1800 points before deduction for the maximum on total benefits. If the total points are significantly greater or smaller, then the point values must be adjusted.

Deductible*	Deducted Points
$ 0	0
50	85
100	170
150	245
200	310
500	622
1,000	820

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

B. To determine the deduction for the coinsurance, subtract the points deducted for the deductible from the total point value for the benefits and then multiply the result by the coinsurance percentage.

Subp. 17. **Combined dental and health insurance deductible (comprehensive major medical plans).**

Deductible*	Added Points
$ 50	75
100	60
150	43
200	38
500	35
1,000	15

* Before entering this table, divide the deductible in the policy by the COMP factor for the year.

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Subp. 18. **Coordination and nonduplication of benefits (all plans).**

A. The following percentage of points after deduction for deductible and coinsurance should be subtracted if the policy coordinates benefits with other plans and its pricing assumes that a number of insured will have other policies in force.

(1) with other health plans, 4.0 percent;

(2) with no fault, 2.5 percent;

(3) with both subitems (1) and (2), 6.5 percent; and

(4) with neither, 0.

B. The percentage should be applied to the total points after deduction for deductible and coinsurance.

Subp. 19. **Limit on "out-of-pocket" expenses (maximum copayment and deductible per benefit year) -- comprehensive and superimposed major medical plans.**

Maximum Claim When Out-of-Pocket is reached*	Points
$ 500	236
1,000	196
2,000	158
3,000	130
4,000	110
11,000	45
13,000	36
14,400	30

*Before entering this table, divide the maximum claim when out-of-pocket limit by the COMP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is about 1800. If the percentage of claims being paid by the insured is other than 20 percent, multiply the number of points above by the ratio of the coinsurance being paid by the insured to 20 percent.

B. The above table assumes that the amounts paid by the policyholder for deductible and coinsurance are included in determining the out-of-pocket limitation.

Subp. 20. **Well baby care.**

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Deductible*	Points
$ 0	17
150	8
500	2
1,000	0

*Before entering this table, multiply the deductible in the policy by the COMP factor for the year.

The above benefit assumes that the deductible and coinsurance are applied to the costs of the newborn.

Subp. 21. **Emergency and supplemental accident (basic plans only).**

Maximum*	Emergency	Supplemental
$ 50	10	--
100	15	20
300	--	30
500	--	35
1,000	--	40
Unlimited	20	--

*Before entering this table, divide the maximum in the policy by the SURG factor for the year.

Subp. 22. **Student dependents.**

Student Extension Beyond Age 19	
None	0
To age 21	2
To age 23	4
To age 25	5

Subp. 23. **Superimposed major medical plans--over basic health plans with less than 500 points.**

A. Calculate point value of a comprehensive major medical plan by using deductible* $200 greater than actual.

B. Add basic health plan points.

* Before entering the table, divide the deductible in the policy by the COMP factor for the year before adding $200. Do not make any further adjustments to the deductible.

Subp. 24. **Superimposed major medical plans--80/20 coinsurance--over basic health plans with 500-799 points.**

	Calendar Year Plan		Two year benefit period plan	
Deductible*	Individual	2 x family	Individual	2 x family
a. Corridor				
$ 100	740	780	745	765

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200	665	705	680	700
300	615	655	630	650
500	543	582	558	578
1,000	385	425	400	420
b. Integrated				
$1,000	615	635	650	670
2,000	515	525	535	545

Note: Points assume major medical contains Minnesota qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

Subp. 25. **Superimposed major medical plans--80/20 coinsurance--over basic health plans with 800 or more points.**

	Add to Basic Plan Points			
	Calendar Year Plan		Two year benefit period plan	
Deductible*	Individual	2 x family	Individual	2 x family
a. Corridor				
$ 100	515	545	525	535
200	445	475	455	465
300	405	435	415	425
500	339	369	349	359
1,000	215	245	225	235
b. Integrated				
$1,000	505	525	530	550
2,000	405	415	420	430

Note: Points assume major medical contains Minnesota qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

2740.9979 BASIC BACKGROUND FOR EXAMPLES.

Subpart 1. **Inflation assumptions for 1985.** The examples which follow assume that the actuarial equivalence of a series of plans is being calculated for calendar year 1985. Inflation was assumed to be 15.5 percent and 8.0 percent for hospital related and all other services, respectively.

Subp. 2. **Values published by commissioner for 1985.**

ASP value for 1984	190*
ASP value for current year (1985*)	220*
SURG value for 1984	4,000.00
SURG value for current year (1985*)	4,320.00*
ASP factor for 1985*	1.155*

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SURG factor for 1985*	1.080*
COMP factor for 1985*	1.121*

*Estimated. Please substitute the actual values.

Subp. 3. **Point values for qualified plans in 1985.** The following are the revised point values used to determine plans which are actuarially equivalent to qualified plans 1, 2, and 3 for 1985.

Qualified Plan Number	If plan has the indicated number of points then plan is actuarially equivalent to the qualified plan in: 1984	1985
3	1192 + points	1216 + points
2	911 + points	957 + points
1	767 + points	847 + points
Nonqualified	Less than 767	Less than 847

2740.9991 EXAMPLE I.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Surgery	Includes Assistant Surgeon and Administration of Anesthesia
Deductible:	$100
Coinsurance:	80/20
Maximum:	$250,000
Maternity:	Any complications
Student dependents:	To age 23
Limits on specified benefits	Outpatient mental limited to Minnesota
Required benefits	--
Excluded care	Home health care
Out-of-pocket limit	$3,000 per year
Coordination of benefits	Yes, but no COB for no-fault.

B. Answer (calculated January 1, 1985): test result is 1186 points. This plan is a Minnesota qualified plan number 2.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subparts of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Comprehensive
1.	Hospital room and board			363
2.	Hospital extras			480
3.	Surgery			243

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4.	Physician care-home, office	215
5.	Physician care-hospital	51
6.	Maternity	25
7.	Diagnostic X-ray and lab	105
8.	Drugs and medicine	100
9.	Radioactive therapy	15
10.	Nursing/convalescent facility	16
11.	Home health care	0
12.	Physical therapy	10
12.	Oxygen	4
12.	Prostheses	5
12.	Durable medical equipment	5
12.	Second opinion surgery	2
12.	Private duty nursing	2
12.	Ambulance	3
13.	Hospital room and board in full	
14.	All hospital expenses in full	
15.	Major medical maximums	-12
	Subtotal reas. and cust. med. services	1632
16.	Deductible	-138
16.	Coinsurance	-299
	Subtotal net of ded. and coin.	1195
17.	Adjust (comb. medical/dental ded)	
18.	COB/No-fault	-48
19.	Limit on "out-of-pocket expenses"	35
20.	Well baby care	
21.	Emergency and supplemental accident	
22.	Student dependents	4
23.-25.	Superimposed major medical	
	Grand Total	1186
	Combined basic and superimposed XXX	XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) The maximum in the policy ($250,000) divided by the COMP factor (1.121) is $223,015. This is 82.01 percent of the difference between the $100,000 and $250,000 maximums in part 2740.9964, subpart 15. The points would be minus 27 plus .8201 times 15 or -14.70 points.

(2) The deductible in the policy ($100) divided by the COMP factor (1.121) is 89.21. This is 78.41 percent of the difference between the $50 and $100 deductibles in part 2740.9964, subpart 16. Points deducted for the deductible would

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be 85 plus .7841 times 85 or 151.65. Since the total points in the policy before the deductible is significantly less than 1800, multiply 151.65 by (1632/1800). The result is 137.50.

(3) The out-of-pocket maximum is $3,000. The maximum claim when the out-of-pocket is reached is $14,600. This divided by the COMP factor (1.121) is 13,024. This is 10.29 percent of the difference between the $13,000 and $14,400 maximum claim when out-of-pocket is reached. The adjustment for the out-of-pocket limit is 36 minus .1029 times 6 or 35.38.

2740.9992 EXAMPLE II.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital:	$170 per day, 365 days; 80 percent of misc. extras, the cost of anesthesia is included. The policy does not pay for private room even if medically necessary.
Surgery:	$3,000 maximum surgical schedule. Add 15 percent for the administration of anesthesia.
In hospital physicians calls:	$25 per day - 365 day maximum
Maternity:	Any complications
X-ray and lab tests (out of hospital):	$500 maximum - unscheduled

B. Answer (calculated January 1, 1985): test result is 1004 points. This plan is a Minnesota qualified plan number two.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subpart of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board	275		
2.	Hospital extras (80 percent)	384		
3.	Surgery	189		
4.	Physician care - home, office			

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5.	Physician care - hospital	33		
6.	Maternity	25		
7.	Diagnostic X-ray and lab	98		
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility			
11.	Home health care			
12.	Physical therapy			
12.	Oxygen			
12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty nursing			
12.	Ambulance			
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			
	Subtotal reas. and cust. med. services			
16.	Deductible			
16.	Coinsurance			
	Subtotal net of ded. and coin.			
17.	Adjust (comb. medical/dental ded)			
18.	COB/No-fault			
19.	Limit on "out-of-pocket expenses"			
20.	Well baby care			
21.	Emergency and supplemental accident			
22.	Student dependents			
23.-25.	Superimposed major medical			
	Grand Total	1004		
	Combined basic and superimposed		XXX	XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) Policy does not pay extra for private room even if medically necessary. Deduct three points from the 359. Since the ASP value in 1985 is 220, the number of points will be 356 times the ratio of 170 to 220 or 275.09 points.

(2) The surgical table was evaluated as 3,680.02 points. The points not including administration of anesthesia is 206 times the ratio of 3680.02 to 4620.00 or 164.09 points. For administration of anesthesia, the points are 164 times .15 or 24.6 points.

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(3) Since the maximum per diem cost of in-hospital physicians calls is less than the cost for routine follow-up (24.20 times 1.08 or 26.14), subtract 14 points from the number of points for prevailing fee with 365-day maximum. The result is 35 points. Multiply the 35 points by the ratio of $25 to 26.14 or 33.47 points.

(4) Since the ASP factor is 1.15, the $200 and $500 maximum shown in part 2740.9964, subpart 7 is now 230 and 575 respectively. Thus the $500 maximum is 78.26 percent of the way between the two maximums. Therefore the point value equals 89 plus .7826 times (101-89) or 98.39 points.

2740.9993 EXAMPLE III.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital:	$80 per day, 120 days, $2,000 extras.
Surgery:	$1,500 maximum surgical schedule, add ten percent for administration of anesthesia.
Coordination of benefits	Yes, does not include no-fault
Superimposed major medical:	
Deductible:	$200 corridor per calendar year
Coinsurance:	80/20
Maximum:	$250,000
Maternity:	Any complications
Student dependents:	No
Out-of-pocket limit:	$3,000
Excluded care:	Home health care and skilled nursing care
Limits on specified benefits:	
1. Room and board	$200 less basic benefits. Unlimited days
Coordination of benefits	Yes, does not include no-fault

B. Answer (calculated January 1, 1985): test result is 1147 points. This plan is a Minnesota qualified plan number two.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

Subpart of part	Major medical

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2740.9964	Benefit	Basic	Superimposed	Comprehensive
1.	Hospital room and board	128	-26	
2.	Hospital extras	290		
3.	Surgery	114		
4.	Physician care - home, office			
5.	Physician care - hospital			
6.	Maternity			
7.	Diagnostic X-ray and lab			
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility		-13	
11.	Home health care		-6	
12.	Physical therapy			
12.	Oxygen			
12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty nursing			
12.	Ambulance			
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			
	Subtotal reas. and cust. med. serv.	532		
16.	Deductible			
16.	Coinsurance			
	Subtotal net of ded. and coin.			
17.	Adjust (comb. medical/dental ded)			
18.	COB/no-fault	21		
19.	Limit on "out-of-pocket expenses"			
20.	Well baby care			
21.	Emergency and supplemental accident			
22.	Student dependents			
23.-25.	Superimposed major medical		681	
	Grand Total	511	636	
	Combined basic and superimposed	1147	XXX	XXX

Equivalent to Minnesota qualified plan number __2__
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) Since the room and board limit is less than the ASP factor, the number of points will equal 351 times the ratio of 80 to 220.

(2) The $2,000 maximum divided by 1.155 is 1731.60. This is 73.16 percent of the difference between the

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$1,000 and $2,000 maximums in the table. The points would be 217 plus .7316 times (317 - 217) or 290.16 points.

(3) The surgical schedule is the same as in example II in part 2740.9992 value. The value of the table is 1840.1 for the $1,500 maximum. The points excluding administration of anesthesia is 243 times 1840.1 divided by 4320.00 or 103.51 points. The administration of anesthesia would add 10.35 points.

(4) The $200 corridor deductible would be adjusted before entering part 2740.9964, subpart 24. The adjusted deductible would be 200 divided by 1.121 or 178.41. Since this is 78.41 percent of the way between the $100 and $200 deductibles, the points would be 740 minus .7841 times (740-665) or 681.19 points.

(5) Home health care and skilled nursing home care are excluded. Therefore we should deduct 80 percent of their points shown in part 2740.9964, subparts 10 and 11.

(6) Hospital room and board is limited to $200 per day less what the basic benefit pays. The adjustment should equal .8 (363 times 20 divided by 220) or 26.4 points.

REPEALER. Minnesota Rules, parts 2740.2300; 2740.9905; 2740.9910; 2740.9915; 2740.9920; 2740.9925; 2740.9930; 2740.9935; 2740.9940; 2740.9945; 2740.9950; 2740.9955; 2740.9960; 2740.9965; 2740.9970; 2740.9981; 2740.9982; 2740.9983; 2740.9984; 2740.9985; and 2740.9986 are repealed.

ROVED IN THE
EVISOR OF STATUTES
OFFICE BY:

OFFICE OF THE REVISOR OF STATUTES

Proposed Rule

RD549

Agency: Department of Commerce

Division:

Agency Contact: Richard G. Gomsrud

Minnesota Rules: Parts 2740.0100; 2740.1100; 2740.1200; 2740.1600; 2740.2100; 2740.2400; 2740.2500; 2740.2600; 2740.2900; 2740.3100; 2740.3600; 2740.3700; 2740.3900; 2740.4400; 2740.5200; 2740.9904; 2740.9909; 2740.9914; 2740.9919; 2740.9924; 2740.9929; 2740.9934; 2740.9939; 2740.9944; 2740.9949; 2740.9954; 2740.9959; 2740.9964; 2740.9979; 2740.9991 to 2740.9993

Title: Proposed Rules Relating to the Comprehensive Health Insurance Association

Type of Rules: Permanent

Steven C. Cross
Revisor of Statutes

Paul M. Marinac
Assistant Deputy Revisor
Phone: 296-0948

Date: March 6, 1985

STATE OF MINNESOTA

COUNTY OF RAMSEY

CERTIFICATE

In the Matter of the Proposed Adoption of
Rules Relating to Comprehensive Health
Insurance Association

I hereby certify that the list of persons, associations, and other interested groups who have requested, pursuant to Minnesota Statutes, Sec. 14.14, subd. 1a, that their names be placed on file with and maintained by the Department of Commerce for the purpose of receiving notice of the proposed adoption of rules is accurate and complete as of 12:00 P.M., this 28th day of March 1985.

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ROSE T. WEINER

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STATE REGISTER

STATE OF MINNESOTA



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CONTENTS

MCAR AMENDMENTS AND ADDITIONS

Issue 40, cumulative 2142

MINNESOTA RULES AMENDMENTS AND ADDITIONS

Issue 40, cumulative 2143

PROPOSED RULES

Commerce Department
Proposed Rules Prohibiting Sex Discrimination in Insurance Contracts 2144
Proposed Rules Relating to the Comprehensive Health Insurance Association 2146
Withdrawal of Proposed Rules Relating to Broker-Dealer Licensing Exemptions for Certain Financial Institutions 2170

Education State Board
Education Department
Partnership Division
Withdrawal of Proposed Rule Relating to Minimum Secondary Vocational Course Offerings 2170

Labor and Industry Department
Occupational Safety and Health Division
Proposed Revisions to the Occupational Safety and Health Standards 2171

Labor and Industry Department
Workers' Compensation Division
Proposed Rules Relating to Rehabilitation Consultant Qualifying 2172

Secretary of State's Office
Proposed Rules Relating to Financing Statements 2173

ADOPTED RULES

Housing Finance Agency
Adopted Rule Governing the Rental Rehabilitation Program 2174
Adopted Rules Governing the Amount and Eligibility for Home Improvement Grants or Rental Rehabilitation Loans 2174

Human Services Department
Extension of Emergency Rules Governing AFDC 2175
Extension of Emergency Rules Governing County Board Responsibility for Providing Case Management Services to Persons with Mental Retardation 2175
Extension of Emergency Rules Governing Exemption from Work and Registration Requirements 2175
Extension of Emergency Rules Governing General Assistance 2176
Extension of Emergency Rules Governing Medical Assistance Prepaid Demonstration Project 2176
Extension of Emergency Rules Governing Prior Authorization for Health Services and Second Surgical Opinion as a Condition of MA and GAMC Reimbursement 2176
Extension of Emergency Rules Governing Special Needs Rate Exception for Very Dependent Persons with Special Needs 2176
Extension of Emergency Rules Governing the Relocation of Nursing Home Residents 2177
Extension of Emergency Rules Relating to General Assistance 2177
Extension of Emergency Rules Relating to Medical Assistance Funding and Administration of Home and Community-Based Services for Persons Who Are Mentally Retarded 2178

OFFICIAL NOTICES

Commerce Department
Outside Opinion Sought Regarding Proposed Rules Relating to Prohibiting Discrimination in Insurance Due to Blindness Including the Impact of the Rules on Small Businesses 2178

Finance Department
Maximum Interest Rate for Municipal Obligations, April, 1985 2179

Metropolitan Council
Notice of Review Schedule, Interim Policy Report—Prescription for Health: Promoting Health and Preventing Disease in the Twin Cities Metropolitan Area 2179
Public Hearing on Interim Policy Report—Prescription for Health: Promoting Health and Preventing Disease in the Twin Cities Metropolitan Area 2179

Metropolitan Waste Control Commission
Meeting Schedule, April-December, 1985 2180

Public Utilities Commission
Outside Opinion Sought Concerning the Provision of Extended Area Service in the Post-Divestiture Environment 2181

STATE CONTRACTS

Administration Department
Procurement Division
Commodities Contracts and Requisitions Currently Open for Bidding 2183

Administration Department
State Building Construction Division
Contracts Available for Architects, Engineers and Landscape Architects 2184
Contracts Available for Registered Professional Testing Services 2185

Corrections Department
Minnesota Correctional Facility—Red Wing
Contracts Available for Medical Clinic Services, Psychological Evaluation Services, Volunteer Services Coordinate, Dietetic Services, Catholic Chaplain, and Certified Driver Education Instruction Services 2185

Education Department
Executive Division
Request for Proposals for Programming, Systems Analysis and Consulting Services 2186

Energy and Economic Development Department
Community Development Division
Juvenile Justice Grants Available 2187

Energy and Economic Development Department
Energy Finance Division
Request for Proposals for Presentation and Promotional Services 2187

Health Department
Health Resources Division
Emergency Medical Services Section
Request for Proposals for Minnesota Poison Information Center 2188

Health Department
Maternal and Child Health Division
Services for Children with Handicaps
Contracts Available for Medical and Related Services for Handicapped 2189

Legal Services Advisory Committee
Request for Proposals for Legal Services for Low-Income People 2189

Metropolitan Waste Control Commission
Public Notice for Prequalifications for the Preparation of a Design for a New Rosemount Wastewater Treatment Plant 2189

Supreme Court
Lawyer Trust Account Board
Notice of Grant Cycle—July 1, 1985 to June 30, 1985 2190

Transportation Department
Contract Available for Lime Sludge Recycling and Site Restoration 2190

Transportation Department
Technical Services Division
Request for Proposals for Logo Sign Franchise for Highway Program 2191

SUPREME COURT

Decisions Filed Friday, March 22, 1985 2216

TAX COURT

Orders Dated March 18-25, 1985 2217

K. limiting the amount of coverage an insured or prospective insured may purchase based upon the insured's or prospective insured's marital status unless the limitation is for the purpose of defining persons eligible for dependent benefits.

Department of Commerce

Proposed Rules Relating to the Comprehensive Health Insurance Association

Notice of Intent to Adopt Rules without a Public Hearing

Notice is hereby given that the Department of Commerce proposes to adopt the above-entitled rules without a public hearing. The Commissioner of Commerce has determined that the proposed adoption of these rules will be noncontroversial in nature and has elected to follow the procedures set forth in Minnesota Statutes, § 14.21.

Persons interested in these rules shall have 30 days to submit comments in support of or in opposition to the rules. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed. The proposed rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change.

No public hearing will be held unless twenty-five (25) or more persons make a written request for a hearing within the 30-day comment period. In the event a public hearing is required, the agency will proceed according to the provisions of Minnesota Statutes, § 14.14, subd. 1.

Persons who wish to submit comments or a written request for a public hearing should submit them to Richard G. Gomsrud, General Counsel, Department of Commerce, 500 Metro Square Building, St. Paul, MN 55101. Any person requesting a public hearing should state her/his name and address, identify the portion of the proposed rule addressed, the reason for the request and any change proposed and send this information to the above address.

Authority for the adoption of these rules is contained in Minnesota Statutes, § 62E.09(i). Additionally, a Statement of Need and Reasonableness describing the need for and reasonableness of each provision and identifying the data and information relied upon to support the proposed rules has been prepared and is available upon request.

Pursuant to Minn. Laws 1983, ch. 188 codified as Minn. Stat. § 14.115, subd. 2, the impact on small business has been considered in the promulgation of the rules. Anyone wishing to present evidence or argument as to the rules' effect on small business may do so. The Department's position regarding the impact of the rules on small business is set forth in the Statement of Need and Reasonableness.

Upon adoption of the final rules without a public hearing, the proposed rules, this notice, the Statement of Need and Reasonableness, all written comments received, and the final Rules as Adopted will be delivered to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the final rules as proposed for adoption, should submit a written statement of such request to Richard Gomsrud, Department of Commerce, 500 Metro Square Bldg., St. Paul, MN 55101.

A copy of the proposed rules is attached to this notice. Copies of this notice and the proposed rules are available and may be obtained by contacting Rose Weiner at the above address.

Michael A. Hatch
Commissioner of Commerce

Rules as Proposed

2740.0100 DEFINITIONS.

Subpart 1. to 12. [Unchanged.]

Subp. 13. Covered expenses. "Covered expenses" means the usual and customary charges for the services and articles listed in Minnesota Statutes, section 62E.06, or, with respect to qualified plans, the actuarial equivalence thereof, when prescribed for a covered person by a physician and when ~~such~~ the expenses are incurred during a period in which the ~~state plan~~ policy or contract is in effect.

Subp. 14. to 28. [Unchanged.]

Subp. 29. Licensed and tested insurance agent or ~~solicitor~~ insurance agent. "Licensed and tested insurance agent or ~~solicitor~~" "insurance agent" means an insurance agent ~~or solicitor~~ as defined in Minnesota Statutes, section 60A.02, subdivision 7 ~~or 8~~, and licensed as such by the commissioner ~~under Minnesota Statutes, section 60A.17 to act as an agent or solicitor for accident and health insurance as defined in Minnesota Statutes, section 60A.06, subdivision 1, clause (5)(a)~~.

Subp. 30. and 31. [Unchanged.]

Subp. 32. Net gains. "Net gains" means the excess of premiums or contract charges over claims expenses, after the writing carrier's expenses and agent referral fees ~~(~~, not to exceed ~~12 1/2~~ 15 percent of premiums or contract charges~~)~~, have been paid as provided in part 2740.4400, subpart 4.

Subp. 33. to 44.[Unchanged.]

Subp. 44a. Qualified medicare supplement plan. "Qualified medicare supplement plan" means a plan of health coverage meeting the requirements of Minnesota Statutes, sections 62A.31, 62A.32, 62E.02, subdivision 5, and 62E.07.

Subp. 45. to 52. [Unchanged.]

Subp. 53. Rejection. "Rejection," for the purpose of state plan eligibility, means refusal by any association member, or any authorized representative, including any insurance agent, acting on behalf of any association member, to issue a qualified plan or a qualified medicare supplement plan to a person who completes an application for coverage under such qualified plan, or a qualified medicare supplement plan, as determined by the board.

Subp. 54. to 56. [Unchanged.]

Subp. 56a. Self-insurer. "Self-insurer" means an entity defined by Minnesota Statutes, section 62E.02, subdivision 21, which is a "governmental plan" as defined by United States Code, title 29, section 1002(32) or a "church plan" as defined by United States Code, title 29, section 1002(33)(A) or which is otherwise exempt from or outside of the scope of the provisions of the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001 to 1381, as amended.

Subp. 57. [Unchanged.]

Subp. 58. Total cost of self-insurance. "Total cost of self-insurance" includes any direct and indirect administrative expenses incurred that are related to the operation of a plan ~~or~~ of self-insurance, plus the sum of any payment made to or on behalf of Minnesota residents for costs or charges for health benefits by a self-insurer under a plan of health coverage, ~~regardless of the amount incurred or relationship of the cost to an insured or partially insured plan of health coverage,~~ which is not counted as premium by an insurer, except to the extent of such payments made for coverage of the types described in Minnesota Statutes, section 62E.02, subdivision 11, clauses (1) to (8).

Subp. 59. [Unchanged.]

2740.1100 DUTIES OF EMPLOYERS.

Subpart 1. Duty to make available a qualified plan. An employer shall be deemed to have made available a qualified plan to its employees as required in Minnesota Statutes, section 62E.03, subdivision 1 when participation under a number 2 or number 3 qualified plan or a health maintenance plan is offered to the employee ~~directly~~ by a self-insurer or through an insurer or health maintenance organization ~~and~~, without regard to whether the cost of such participation is paid directly or indirectly by the employer or by the employee or by their joint payment.

Subp. 2. [Unchanged.]

Subp. 3. Frequency of required offer. Except as provided in subpart 2, an employer shall be deemed to have complied with the requirements of Minnesota Statutes, section 62E.03, subdivision 1 if ~~he~~ the employer makes available to ~~his~~ the employer's employees a plan of health coverage which is certified as a number 2 or number 3 qualified plan or a health maintenance plan at least once during each accounting period utilized by the employer for Minnesota income tax purposes.

2740.1200 DUTIES OF INSURERS AND FRATERNALS.

Subpart 1. [Unchanged.]

Subp. 2. Timing of required offer of a qualified plan or qualified medicare supplement plan. Timing of required offer of a qualified plan or qualified medicare supplement plan is as follows:

A. The offer of each type of qualified plan (that is, a number 1, number 2, and number 3 qualified plan) that is required when an insurer or fraternal is offering an individual policy of accident and health insurance shall occur no later than the date of delivery of such policy to the applicant.

B. to E. [Unchanged.]

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Subp. 3. [Unchanged.]

Subp. 4. Duty to offer major medical coverage. Each insurer and fraternal shall affirmatively offer, subject to its underwriting standards, coverage of major medical expenses to every applicant for a new unqualified policy at the time of application and annually thereafter to every holder of an unqualified policy of accident and health insurance renewed by the insurer or fraternal as required by Minnesota Statutes, section 62E.04, subdivision 4. "Affirmatively offer" shall mean written advice to the applicant for, or the holder of, an unqualified policy of accident and health insurance, of the availability of coverage for major medical expenses. Such written advice of the availability of the coverage for major medical expenses may be satisfied by a contractual provision in the unqualified policy that gives the insured the contractual right to apply to the insurer or fraternal for a new policy or a rider on an existing unqualified policy that provides coverage for 80 percent of the covered expenses for services listed in Minnesota Statutes, section 62E.06, subdivision 1 or the actuarial equivalence thereof subject to a $5,000 deductible for out-of-pocket expenses, subject to the insurer's or fraternal's underwriting requirements.

Subp. 5. and 6. [Unchanged.]

Subp. 7. Exceptions to duties for certain policies and contracts. Exceptions to duties for certain policies and contracts are as follows:

A. [Unchanged.]

B. The issuance or renewal by an insurer or fraternal on or after June 3, 1977, of ~~the~~ a policy or contract that is designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis, shall not be subject to Minnesota Statutes, section 62E.04, except for policies and contracts sold by an insurer to provide payments on a hospital indemnity basis if such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue.

Subp. 8. [Unchanged.]

2740.1600 TERMINATION OF COVERAGE; CONVERSION PRIVILEGES.

Subpart 1. and 2. [Unchanged.]

Subp. 3. Due notice of cancellation or termination. An insurer, health maintenance organization, or self-insurer shall be deemed to have provided "due notice of cancellation or termination" as required in Minnesota Statutes, section 62E.16 if the insurer, health maintenance organization, or self-insurer notifies in writing those employees at their respective addresses as provided to the insurer, health maintenance organization, or self-insurer by the employer pursuant to the terms of Minnesota Statutes, section 62E.16.

2740.2100 DEFINITIONS.

Subpart 1. Accident and health insurance business. "Accident and health insurance business" means the issuance or renewal of any accident and health insurance policy as defined in Minnesota Statutes, section 62E.02, subdivision 11.

A. [Unchanged.]

B. Such business shall not include the issuance or renewal of policies or contracts providing coverage that is:

(1) to (8) [Unchanged.]

(9) limited to accident-only coverage issued by ~~a licensed and tested~~ an insurance agent ~~or solicitor~~ and that provides reasonable benefits in relation to the cost of covered services.

Subp. 2. and 3. [Unchanged.]

Subp. 4. Self-insurance business. "Self-insurance business" means the provision, directly or indirectly, of a plan of health coverage by a self-insurer. "Self-insurance business" does not include the direct provision of health care services to employees at no charge to them by an employer engaged in the business of providing health care services to the public, nor does it include provision of benefits that, if provided by an insurer doing accident and health insurance business, would be excluded under subpart 1, item B. "Directly or indirectly" for the purposes of parts 2740.2100 to ~~2740.2600~~ 2740.5500 means that the ~~employer or employee welfare benefit plan~~ self-insurer funds the plan of health coverage in any amount or collects any employee contributions which are used to pay for the plan of health coverage.

2740.2400 ASSESSMENTS.

Contributing members~~, according to the assessment agreement,~~ will be assessed for their proportionate share of the operating and administrative expenses of the association, incurred or estimated to be incurred, together with losses, if any, incurred by the association as a result of operation of the state plan. The total amount of operating and administrative expenses and losses:

A. [Unchanged.]

B. may, at the recommendation of the board, subject to the approval of the commissioner, consist of a reasonable estimate of

the operating and administrative expenses of the association for the succeeding fiscal year, which amount shall be adjusted at the end of the succeeding fiscal year to the amount of actual operating and administrative expenses, and contributing members shall be entitled to credit for any excess or shall be assessed for any deficit in these expenses in ~~the next annual fiscal year end assessment~~ future assessments.

2740.2500 LEVY OF ASSESSMENTS.

Subpart 1. Annual. The association shall make an annual determination of each contributing member's liability, if any, and may levy assessments following each fiscal year end. The fiscal year ends on December 31 unless the association establishes a different fiscal year end. Assessments are due and payable 30 days after receipt of a written assessment notice.

Subp. 2. Interim. The association may also, upon approval of the commissioner, levy interim assessments when deemed necessary to assure the financial capability of the association to meet the incurred or estimated operating and administrative expenses of the association and losses resulting from the state plan. Interim assessments shall be due and payable within 30 days of receipt by a contributing member of a written interim assessment notice.

Subp. 3. Member share. The association shall levy each contributing member's share of the total assessment based on the ratio of: the contributing member's total ~~accident and health insurance~~ premium~~, subscriber contract charges, or health maintenance organization contract charges (the preceding defined as charges~~ for accident and health insurance business as defined in part 2740.2100, subparts 1 and 2~~)~~, received from or on behalf of residents of Minnesota, ~~or total cost of self insurance,~~ as determined by the commissioner; to the total premium for accident and health insurance business for all contributing members ~~of premiums, contract charges, and benefit plan costs reported~~.

Subp. 4. Costs and charges. The costs and charges referred to in the ratio in subpart 3 shall, to the extent possible, be determined by reference to a form issued by the association or the commissioner which all contributing members shall submit to the commissioner annually for the preceding calendar year.

A. [Unchanged.]

B. The commissioner shall have the authority to audit the accounts and records of any contributing member ~~and any agent, trust, third party administrator, or other entity administering all or any portion of a plan of health coverage with or on behalf of a self insurer~~ for the purpose of obtaining information necessary to levy an assessment.

Subp. 5. Discretionary waiver. The board may, in its discretion, decline to levy assessments against contributing members that owe ~~up to $5~~ $10 or less in a given year.

2740.2600 FAILURE TO ~~EXECUTE ASSESSMENT AGREEMENT OR TO~~ PAY ASSESSMENTS.

~~The names of all insurers, self insurers, fraternals, and health maintenance organizations that are required under the act to be members of the association, but which fail to execute an assessment agreement, will be forwarded by the association to the commissioner for appropriate action within the discretion of the commissioner.~~ Any contributing members that fail to pay annual or interim assessments when such assessments become payable will be reported by the association to the commissioner for appropriate action within the discretion of the commissioner.

2740.2900 DETERMINATION OF MEMBER'S VOTING RIGHTS.

Subpart 1. [Unchanged.]

Subp. 2. Weighted vote. A member's vote shall be a weighted vote based on the member's total cost of self-insurance, accident and health insurance premiums, subscriber contract charges, or health maintenance contract charges derived from or on behalf of residents of Minnesota in the previous calendar year, as determined by the commissioner. To the extent possible, this figure shall be determined by reference to the annual reporting form submitted by contributing members to the commissioner in accordance with part 2740.2500, subpart 4, and similar forms showing all other members' total accident and health insurance premiums, subscriber contract charges (defined as charges for business specified in part 2740.2100, subparts 1 and 2) received from or on behalf of residents of Minnesota, or total cost of self-insurance, as defined in part 2740.0100, subpart 58, as determined by the commissioner.

If the necessary information is not available to the commissioner on the form described in this subpart at the time that voting rights must be determined, the commissioner may estimate the member's weighted vote based on other information available to the commissioner.

Subp. 3. Voting procedures. Members are entitled to vote in person, by proxy, or by mail as determined by the board.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

When a member elects to vote in person at a members' meeting, the representative casting the vote shall present credentials as required pursuant to the bylaws or operating rules of the association.

When a member elects to vote by proxy, the proxy statement as approved by the board ~~and by the commissioner~~ shall be returned on or before the date indicated in the meeting notice sent to the members.

Voting by mail may be permitted as authorized by the bylaws or operating rules of the association, and the meeting notice to members shall so indicate.

2740.3100 MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLANS.

Subpart 1. [Unchanged.]

Subp. 2. Benefits of number 1 and number 2 qualified plan. Benefits shall meet or exceed the requirements of Minnesota Statutes, section 62E.06 or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables ~~set forth~~ in parts 2740.9905 to 2740.9986, except where substitution of an actuarially equivalent benefit is not permissible under the act.

A. [Unchanged.]

B. Coverage shall include an annual (calendar year) limitation of not more than $3,000 per covered person on total out-of-pocket expenses, which out-of-pocket expenses shall include the deductible under the state plan policy or contract, and which ~~benefit (copayment)~~ out-of-pocket expense limitation is not subject to substitution of an actuarially equivalent benefit ~~(copayment)~~.

C. Coverage shall be subject to a maximum lifetime benefit of not less than $250,000 per covered person, less any amount paid to or on behalf of the covered person under any other ~~state~~ qualified plan ~~policy or contract~~ of the state plan. This benefit is not subject to substitution of an actuarially equivalent benefit.

Subp. 3. Benefits of qualified medicare supplement plan. Benefits of a qualified medicare supplement plan shall meet or exceed the following minimum standards ~~or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables set forth in parts 2740.9905 to 2740.9986~~.

A. The plan shall provide benefits to covered persons ~~who are 65 years of age or older~~ by supplementing medicare through provision of ~~50 percent of the deductible and copayment required under medicare~~:

(1) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare to at least 50 percent of the deductible and copayment required under medicare for the first 60 days of any medicare benefit period;

(2) coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period;

(3) coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days to the extent not covered by medicare;

(4) upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of at least 50 percent of the medicare calendar year part B deductible.

B. The plan shall provide 80 percent of the covered charges for expenses as provided in Minnesota Statutes, section 62E.06 ~~or the actuarial equivalence thereof~~, which charges are not paid or payable under medicare or would not have been paid or payable had the covered person who is or was entitled or eligible to enroll in medicare been so enrolled or which charges are not paid or payable under item A.

C. Coverage shall include an annual limitation of $1,000 total out-of-pocket expenses per covered person for covered ~~expenses~~ charges, provided that an annual deductible of not more than $200 is permissible for those covered charges not paid or payable under medicare or otherwise included in item A or B.

D. Coverage ~~may not~~ shall be subject to a maximum lifetime benefit of not less than $100,000~~, or the unused portion of the maximum lifetime benefit under any policy or contract of the state plan under which the person was previously covered, whichever is less~~ per covered person, less any amount paid to or on behalf of the covered person under any other qualified medicare supplement plan of the state plan.

E. The minimum coverage of a qualified medicare supplement plan required by this subpart is not subject to substitution of actuarially equivalent benefits.

Subp. 4. and 5. [Unchanged.]

2740.3600 ENROLLMENT.

Subp. 1. [Unchanged.]

Subp. 2. Eligible person. "Eligible person," as used in subpart 1, means a resident of Minnesota who submits or on whose behalf is submitted a complete certificate of eligibility and enrollment form to the association or its writing carrier and who is not already covered by another state plan policy or contract.

A. A complete certificate of eligibility and enrollment form may provide:

(1) name, address, age, ~~sex,~~ and length of time as a resident of Minnesota;

(2) [Unchanged.]

(3) evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, by ~~at least two~~ one association ~~members~~ member, or by an authorized representative, including an insurance agent, acting on behalf of an association member, within six months of the date of application. "Substantially reduce coverage from that received by a person who is considered a standard risk" includes any restriction on coverage as a result of an illness, condition, or risk which the association deems substantial, any increase in rates for an applicant based on an illness, condition, or risk, which the association deems substantial, and any preexisting conditions limitation which the association deems substantial.

B. In lieu of evidence of rejection, or a requirement of a restrictive rider, rate-up, or preexisting conditions limitation on a qualified plan or qualified medicare supplement plan, as required by item A, subitem (3), a complete certificate of eligibility and enrollment form may provide evidence which meets the requirements of an operating rule adopted by the association of a proposed covered person having been treated within three years of the date of the certificate of eligibility and enrollment form for one or more conditions listed in the operating rule.

C. Before a person is determined to be an eligible person, the board may require that any items listed in ~~item~~ items A and B or, if acting pursuant to provisions of the association's operating rules, other necessary information be submitted to the association or its writing carrier and may also investigate the authenticity of information submitted as a part of the certificate of eligibility.

~~C.~~ D. If a covered person, under a qualified plan of the state plan, upon reaching age 65, or becoming enrolled in medicare, wishes to purchase a state plan qualified medicare supplement plan, the requirement that the person obtain ~~two rejections~~ one rejection, restrictive rider, rate-up, or preexisting conditions limitation on a qualified medicare supplement plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, from ~~members~~ one member of the association, or from an authorized representative, including an insurance agent acting on behalf of an association member, within the preceding six months may be waived by the board if acting pursuant to provisions of the association's operating rules.

~~D.~~ E. A person who is age 65 or older shall be eligible for coverage only under the state plan's qualified medicare supplement plan and when an insured person under a qualified plan reaches age 65, the board may, if acting pursuant to provisions of the association's operating rules, terminate or refuse to renew coverage under the qualified plan. A person under age 65 who is otherwise eligible for coverage under the state plan and is enrolled in medicare shall be permitted to purchase a qualified plan 1 or 2 or the qualified medicare supplement plan of the state plan.

~~E.~~ F. An applicant or any person proposed to be covered under a qualified plan of the state plan who has previously been covered ~~by a~~ under one or more qualified plans of the state plan ~~policy or contract~~ and who has exhausted the $250,000 maximum lifetime benefit ~~under the state plan~~ shall not be an eligible person for coverage under a qualified plan of the state plan~~, provided that;~~ an applicant ~~for~~ or any person proposed to be covered under a qualified medicare supplement ~~policy or contract~~ plan of the state plan who has previously been covered under one or more qualified medicare supplement plans of the state plan ~~shall be eligible for a maximum benefit under the qualified medicare supplement policy or contract of $100,000, or the unused portion of the maximum lifetime benefit under any policy or contract of the state plan under which the person was previously covered, whichever is less~~ and who has exhausted the $100,000 maximum lifetime benefit shall not be an eligible person for coverage under a qualified medicare supplement plan of the state plan.

~~F.~~ G. When a covered person under the state plan no longer meets one or more of the requirements for eligibility for coverage under the state plan, the board may, if acting pursuant to the association's operating rules, terminate or refuse to renew coverage under the state plan.

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2740.3700 ASSOCIATION'S RESPONSE.

Subpart 1. Time limitation. Within 30 days of receipt of a complete certificate of eligibility and enrollment form pursuant to part 2740.3600, subpart 2, items A ~~and~~, B, and C, the association or the writing carrier shall accept the certificate of eligibility or shall reject the certificate of eligibility for failure to meet the eligibility requirements.

Subp. 2. Acceptance. If the association or its writing carrier accepts the certificate of eligibility, it shall forward a notice of acceptance, billing information, and a policy or contract or certificate that shall evidence coverage under the state plan.

A. [Unchanged.]

B. When the state plan premium is received by the association or its writing carrier for the first billing period and accepted in accordance with this part, the coverage shall be effective retroactive to the date of receipt by the association or its writing carrier of the completed certificate of eligibility pursuant to part 2740.3600, subpart 2, items A ~~and~~, B, and C unless otherwise requested by the insured person and approved by the board.

Subp. 3. Nonacceptance. If the association does not accept the certificate of eligibility, the applicant shall be informed of the reason for the rejection and shall have the opportunity to submit additional information to substantiate eligibility for coverage under the state plan and to request reconsideration of the decision. The board ~~shall~~ may establish a review mechanism for reviewing requests for reconsideration of rejected certificates of eligibility. The association shall give notice of a final determination of ineligibility to the applicant stating the reasons therefor and advising the applicant of the right to appeal to the commissioner within a reasonable period of time.

2740.3900 ~~SOLICITATION OF ELIGIBLE PERSONS~~ DISSEMINATION OF INFORMATION CONCERNING STATE PLAN.

Subpart 1. Plan. The association shall develop a plan for use by the association, upon approval by the commissioner, to publicize the existence of the state plan~~,~~ and the eligibility requirements~~,~~ and procedures for enrollment, and to maintain public awareness of and participation in the state plan.

Subp. 2. Forms and instructions. The association shall prepare and make available certificate of eligibility forms and enrollment instruction forms to members, insurance ~~solicitors,~~ agents and brokers, and to the general public in Minnesota.

Subp. 3. Referral fee. The association shall require the writing carrier to pay a referral fee of ~~$25~~ $50 for any certificate of eligibility accepted by the association or its writing carrier~~. The referral fee shall be paid to the licensed agent whose signature appears as the agent on the accepted certificate of eligibility~~ if the referring agent is licensed by the commissioner as an insurance agent and if the referring agent's signature appears as the agent on the accepted certificate of eligibility. The referral fee shall be paid from the premium received for the state plan. Referring agents shall not be authorized to interpret, amend, or alter the terms of the state plan policy or contract, nor shall referring agents be authorized to bind the association in any way. Referring agents shall not be agents of the association for any purpose, and the association shall not bear responsibility for acts of referring agents.

2740.4400 OPERATIONS OF ~~THE~~ WRITING CARRIER.

Subpart 1. Administrative and claims payment functions. The writing carrier shall perform all administrative and claims payment functions relating to the state plan.

A. [Unchanged.]

B. The writing carrier shall perform all necessary functions to assure timely payment of benefits to covered persons under the state plan.

(1) to (3) [Unchanged.]

(4) The writing carrier shall exercise reasonable efforts to advise covered persons, within ~~15 working~~ 60 business days of receipt of a properly completed and executed proof of loss, whether the submitted claim was accepted or rejected by the writing carrier, unless sooner settled.

(5) The writing carrier ~~shall~~ may establish an appeals procedure approved by the board to review claims that are denied in whole or in part. When a claim or any portion thereof is denied, the writing carrier shall inform the covered person of the existence of the procedure, including the right to appeal to the commissioner within a reasonable period of time.

Subp. 2. [Unchanged.]

Subp. 3. Claims expenses. The writing carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the state plan. If the writing carrier's payments for claims expenses exceed the portion of the state plan premiums allocated by the board for payment of claims expenses, the association shall provide to the writing carrier additional funds for payment of claims expenses. Not less than ~~87 1/2~~ 85 percent of the state plan premium, as determined by the board, shall be used to pay claims expenses, and not more than ~~12 1/2~~ 15 percent of the state plan premium shall be used to pay agent referral fees

(authorized by Minnesota Statutes, section 62E.15, subdivision 3) and to pay the writing carrier's direct and indirect expenses, as defined and authorized in Minnesota Statutes, section 62E.13, subdivision 7 and described in ~~parts 2740.4300 to 2740.4500~~ subpart 5.

Subp. 4. Direct and indirect expense reimbursement. The writing carrier shall be paid from time to time as provided in the association's contract with the writing carrier for its direct and indirect expenses incurred in the performance of its services from the state plan premiums received in an amount not to exceed the lesser of:

A. ~~12 1/2~~ 15 percent of the state plan premium, less agent referral fees payable under part 2740.3900, subpart 3;

B. and C. [Unchanged.]

Subp. 5. Direct and indirect expenses. Direct and indirect expenses shall include that portion of the writing carrier's actual administrative, printing, claims administration, management, building overhead expenses, and other actual operating and administrative expenses approved by the board as allocable to the administration of the state plan.

Subp. 6 and 7. [Unchanged.]

2740.5200 REINSURANCE PLAN.

Subpart 1. [Unchanged.]

Subp. 2. Application and acceptance. Insurer or fraternal members wishing to participate in the pool shall apply to the association for participation in the pool, specifying the categories of coverage that the member desires to reinsure.

~~Members~~ Each member entering into a reinsurance pooling agreement for a particular category or categories of coverage shall offer to place in the pool all policies and contracts that it issues in the category or categories listed in part 2740.5100 that it wishes to reinsure.

Only policies and contracts acceptable to the association or its reinsurance administrator may be accepted for reinsurance. The association is under no obligation to accept any but standard risks in the reinsurance plan.

Subp. 3. to 5. [Unchanged.]

Rules as Proposed (all new material)

2740.9904 PURPOSE.

Minnesota Statutes, section 62E.02, defines "qualified plans" as health benefit plans that provide the benefits required in Minnesota Statutes, section 62E.06 or "the actuarial equivalent of those benefits." Minnesota Statutes, section 62E.06 describes three qualified plans. These statutes require all plans of health coverage subject to Minnesota Statutes, section 62E.06 to be labeled as qualified or non-qualified. The commissioner may be requested to determine whether a plan is qualified and may take up to 90 days to make that determination. Minnesota Statutes, section 62E.02 defines a qualified medicare supplement plan as one which has been certified by the commissioner as providing the minimum benefits required by Minnesota Statutes, section 62E.07. Since the definition does not allow the option of an actuarial equivalent plan, the current rules do not include actuarial equivalent tables for medicare supplement policies.

2740.9909 COMPOSITE POINT VALUES FOR QUALIFIED PLAN NUMBER THREE.

The composite point values for a qualified plan number three for 1984 are as shown herein.

Composite Point Values for Minnesota Qualified Plan No. 3

Points	Benefit
363	Hospital room and board, unlimited days, semi-private.
480	Hospital extras (i.e., hospital services, hospital miscellaneous, hospital special services, or ancillary services) including anesthesia.
243	Surgery, including administration of anesthesia, assistant surgeon and oral surgery but no tooth repair or extractions.
215	Home and office physician care, unlimited.
51	Physician care in hospital, unlimited.
63	Obstetrics, unlimited.

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110	Hospital maternity, unlimited.
105	X rays and laboratory tests, outpatient and out of hospital.
100	Prescription drugs and medicine, outpatient and out of hospital.
15	Radioactive therapy, outpatient and out of hospital.
16	Nursing or convalescent facility.
8	Home health agency care.
10	Physical therapy.
4	Oxygen.
5	Prostheses.
5	Durable medical equipment rental or purchase.
2	Second opinion surgery.
2	Private duty nursing.
3	Ambulance.
−12	Adjustment for major medical maximum.
1788	Total reasonable and customary medical services
−245	$150 deductible.
−309	20 percent coinsurance.
1234	Total after deductions for deductible and coinsurance
−49	Coordination of benefits.
−31	Nonduplication with no-fault.
30	3,000 annual "out-of-pocket" expense limit.
8	Well baby care.
0	Emergency accident.
0	Supplement accident.
0	Student dependents.
1192	Grand Total

2740.9914 DETERMINATION OF AVERAGE SEMI-PRIVATE HOSPITAL ROOM AND BOARD LEVEL OF SURGICAL CHARGES.

Subpart 1. Why develop values annually. Many companies issue policies with scheduled benefits. Due to inflation the value of scheduled benefits declines each year in relation to reasonable and customary charges. It would be best if the test of actuarial equivalence would automatically adjust for inflation and thus would more accurately value these types of benefits.

Subp. 2. When values determined. In December of each year, the commissioner will publish the following values:

A. the average semi-private hospital room and board (ASP value);

B. the value of surgical charges (SURG value);

C. the ratios of the average semi-private hospital room and board for the year to that in 1984 (ASP factor);

D. the ratio of the value of surgical charges for the year to that in 1984 (SURG factor); and

E. the composite ratio of medical care for the year to that in 1984 (COMP factor).

The commissioner may appoint a service agency to calculate these values on a consistent basis each year.

Subp. 3. How values determined. Values will be determined as follows:

A. The ASP value will be the weighted bed average of semi-private room and board charges for acute hospitals in Minnesota. The information will be derived from each hospital's latest room and board charge filed with the commissioner or the service agency. A semi-private room will be defined as a room with two beds.

B. The SURG value will be the sum of the product of the average charge, filed with the commissioner or the service agency, for each of the surgical operations shown below times the factor shown for that operation. The surgical operations and their factors are shown in part 2740.9919.

C. The ASP factor will be the ASP value to be published for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

D. The SURG factor is the ratio of the SURG value for the year divided by that published for 1984. For 1984, this will be 1.000 by definition.

E. The COMP factor is the composite factor for medical care. This equals 54 percent times the ASP factor for the year plus 46 percent times the SURG factor for the year.

2740.9919 TABLE OF SURGICAL FACTORS TO DEVELOP SURG VALUE.

CPT4 Code	Surgical Factor	Description
SKIN		
10060	.7710	Abscess, incision, and drainage, simple
11400	2.0161	Benign lesion removal of (up to 0.5 cm.)
11750	.4368	Nail, permanent removal of
12011	1.9732	Simple wound, simple repair (up to 2.5 cm.)
17100	4.6520	Benign skin lesion, destruction of
MUSCULOSKELETAL		
20610	1.9226	Major joint or bursa, injection or aspiration of
27130	.1565	Total hip joint replacement, simple
29425	1.0286	Application walking cast
CARDIOVASCULAR		
33512	.1111	Coronary bypass, three arteries
93547	.2166	Left heart catheterization with coronary angiogram
DIGESTIVE SYSTEM		
43235	.4514	Gastroscopy, diagnostic
43844	.0569	Stomach bypass for morbid obesity
44950	.2618	Appendectomy
45300	2.7170	Proctosigmoidoscopy, diagnostic
47600	.3765	Gallbladder, removal of
49505	.3086	Inguinal hernia repair, unilateral
URINARY SYSTEM		
52601	.1579	Prostate resection (TUR), complete
53670	3.5373	Urinary bladder catheterization
MALE GENITAL		
54150	.8509	Circumcision by clamp, newborn
FEMALE GENITAL		
58120	.8470	Uterus, dilation and curettage (D & C), nonobstetrical
58150	.4792	Uterus, removal of
58980	.9455	Laparoscopy, diagnostic
NERVOUS SYSTEM		
63030	.0694	Laminotomy herniated disc, lumbar
64721	.1988	Carpal tunnel syndrome repair
EYE		
66980	.2003	Cataract removal, intraocular lens insertion
EAR		
69437	.3934	Tympanostomy with ventilating tube insertion

2740.9924 HOW TO USE THE LIST.

Subpart 1. Basic and comprehensive major medical plans. The list is used in the following manner:

A. Determine the ASP value, SURG value, ASP factor, SURG factor, and COMP factor for the calendar year. This is published annually by the commissioner.

B. List the plan benefits, ignoring deductibles, coinsurance, well baby care, emergency accident, supplemental accident, and student dependents. Include the plan maximum in the plan benefits.

C. For each benefit, find the appropriate table of equivalent points for basic and major medical plans.

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D. Extract the appropriate point value for the benefit from the table, interpolating as necessary or indicated, and place it opposite the listed benefit. Ignore benefits for which no table exists.

E. Total the points for these benefits.

F. List deductible and coinsurance if the plan is a comprehensive major medical plan.

G. Determine the appropriate point values for deductible, interpolating as necessary, and place the value in the list of points. Calculate the coinsurance points and place the values in the list of points.

H. Determine the total points after the deduction for deductible and coinsurance.

I. Determine the deduction for coordination and nonduplication of benefits.

J. Determine the number of points for the limit on "out-of-pocket" expenses, well baby care, emergency accident, supplemental accident, and student dependents.

K. Calculate the grand total.

L. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

Subp. 2. Superimposed major medical plans. The following govern superimposed major medical plans:

A. Follow steps outlined in subpart 1, items A to D for basic health plan benefits.

B. Total the points for the basic plan.

C. Utilize part 2740.9964, subparts 23, 24, and 25 to determine the point value of a Minnesota qualified plan superimposed over the basic plan with the deductible and benefit period of the plan at hand, interpolating as necessary. Put the points in the point column.

D. Compare the benefits in the superimposed major medical plan with the benefit structure of a Minnesota qualified plan:

(1) $250,000 lifetime maximum.

(2) 80/20 coinsurance.

(3) $3,000 annual per person out-of-pocket maximum.

(4) Eligible expenses are usual and customary expenses for:

(a) hospital services;

(b) physician care;

(c) prescription drugs;

(d) nursing home care of up to 120 days in one year, commencing within 14 days of hospitalization of at least three days;

(e) home health care;

(f) radium and radioactive therapy;

(g) oxygen;

(h) anesthetics;

(i) prostheses;

(j) rental or purchase of durable medical equipment;

(k) diagnostic x rays and laboratory tests;

(l) oral surgery on impacted teeth, on tooth roots, or on gums and tissues of the mouth when not performed in connection with tooth extraction;

(m) physical therapy;

(n) maternity same as any illness;

(o) Minnesota statutorily-mandated benefits; and

(p) coordination of benefits.

E. Consult the tables for point adjustments (usually negative for Minnesota qualified plan benefits not in the superimposed major medical plan being tested). Put the adjustments in the point column.

F. Calculate the total by adding the points for the basic plan (item B), the superimposed major medical plan (item C), and the adjustments (item E).

G. To determine qualification, utilize the grand total in the test for actuarial equivalence in part 2740.9949.

2740.9929 BENEFIT VARIATIONS NOT COVERED BY TABLES.

Only those plan variations that are most common are recognized. For instance, comprehensive plan coinsurance was assumed normally not to exceed 20 percent. Therefore, no points are shown for 25 percent. However, points for such missing benefit variations can be extrapolated or estimated.

2740.9934 USE OF TABLES.

Subpart 1. Certification of plans. Any insurer, self-insurer, or policyholder may use the test for actuarial equivalence as a guide. To obtain certification of any plan of health benefits as qualified, it must be submitted to the commissioner.

Subp. 2. Filing with commissioner. The following should be sent to the commissioner:

A. The plan document if an uninsured plan or the policy form if an insured plan.

B. A statement of the grand total from part 2740.9924.

C. A certification that the plan is qualified as either a plan 1, 2, or 3, or is nonqualified, by using the test of actuarial equivalence in part 2740.9949. The certification must be by a principal or officer, or by a member of the Academy of Actuaries.

D. If the plan is not a qualified plan by using the test of actuarial equivalence, and the insurer or self-insurer desires to have it certified as a qualified plan, a statement of the specific reasons for the desired qualification.

Subp. 3. Certification by commissioner. If the documents required by subpart 2 are filed and the plan is a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be deemed certified as filed. If the documents required by subpart 2 are filed and the plan is not a qualified plan by using the test of actuarial equivalence in part 2740.9949, then the plan will be qualified if, and when, the commissioner certifies it as a qualified plan.

2740.9939 UPDATE OF TABLES.

Periodically, the tables may be revised as health care costs change. The commissioner may revalue the actuarial equivalence of any plan or policy at any time deemed appropriate. Also, as health care costs change, a plan may automatically lose or change its qualification. Annual revaluation of plans is required. When a plan is revalued and its qualification status changes, the filing procedures in part 2740.9934 will be followed.

2740.9944 MISUSE OF TABLES.

The tables of equivalent points are not intended for any other use, especially not for premium calculations. They represent a composite of data and were adjusted to be useable for testing actuarial equivalence. No other use is contemplated.

2740.9949 TEST FOR ACTUARIAL EQUIVALENCE FOR PLANS OTHER THAN MEDICARE SUPPLEMENT PLANS.

Subpart 1. Table for 1984.

If the Grand Total of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualified Plan No.
1192 + points	3
911 + points	2
767 + points	1
Less than 767 points	Nonqualified

Subp. 2. Effect of inflation. Each year the number of points required for each qualified plan will increase due to the effects of inflation on the benefits. Particular care should be taken to revalue any policy form which contains scheduled benefits or other policy forms which have different deductible or coinsurance provisions.

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2740.9954 WORKSHEET FOR OTHER THAN MEDICARE SUPPLEMENT PLANS.

Comprehensive Health Insurance
Test for Actuarial Equivalence
Other than Medicare Supplement Plans

Subparts of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Comprehensive
1.	Hospital room and board			
2.	Hospital extras			
3.	Surgery			
4.	Physician care-home, office			
5.	Physician care-hospital			
6.	Maternity			
7.	Diagnostic X-ray and lab			
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility			
11.	Home health care			
12.	Physical therapy			
12.	Oxygen			
12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty nursing			
12.	Ambulance			
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			
	Subtotal reasonable and customary medical services			
16.	Deductible			
16.	Coinsurance			
	Subtotal net of deductible and coinsurance			
17.	Adjust (Comb. medical/dental deductible)			
18.	COB/No-Fault			
19.	Limit on "out-of-pocket" expenses			
20.	Well baby care			
21.	Emergency and supplemental accident			
22.	Student dependents			
23.-25.	Superimposed major medical			
	Grand Total Combined Basic and Superimposed		XXX	XXX

Equivalent to Minnesota qualified plan number _____ nonqualified _____
Date_____ By _____

2740.9959 LOCATION OF TABLES OF EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS.

Subparts of part 2740.9964	Other than Medicare Supplement Plans Name
1.	Hospital room and board
2.	Hospital extras
3.	Surgery
4.	Home and office physician care
5.	In-hospital physician care

6.	Maternity
7.	Diagnostic X-ray and laboratory
8.	Drugs and medicine
9.	Radioactive therapy
10.	Nursing or convalescent-home care
11.	Home health care agency service
12.	Physical therapy
12.	Oxygen
12.	Prostheses
12.	Durable medical equipment
12.	Second opinion surgery
12.	Private duty nursing
12.	Ambulance
13.	Hospital room and board in full
14.	All hospital charges in full
15.	Major medical maximums
16.	Coinsurance and deductibles
17.	Combined dental and health insurance deductible
18.	Coordination and nonduplication of benefits
19.	Limit on "out-of-pocket" expenses
20.	Well baby care
21.	Emergency and supplement accident
22.	Student dependents
23.	Superimposed major medical
24.	Superimposed major medical
25.	Superimposed major medical

2740.9964 EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS; NOT TO BE USED FOR MEDICARE SUPPLEMENT PLANS.

Subpart 1. Hospital room and board.

Maximum Days	Room & Board
31	327
70	347
120	351
365	359
Unlimited	363

A. Room and board is defined to include a semi-private room, or charges for a private room if prescribed as medically necessary by a physician. If the policy does not pay the additional charges for a private room, then deduct three points from hospital room and board.

B. If the policy pays the private room charge even though not medically necessary, then add ten points if average charge per day is four percent greater than the average semi-private room and board charge.

C. If the policy pays the hospital room and board charge up to a maximum daily benefit which is less than the average semi-private room and board charge in the area, then multiply the points for the semi-private room and board at the indicated maximum days by the ratio of the scheduled amount to the ASP value in the area for the year.

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Subp. 2. Hospital extras. Hospital extras such as hospital services, special hospital services, ancillary services, and hospital therapeutics.

Maximum Amount*	Anesthesia** Included	Anesthesia** Not Included
$ 500	130	130
1,000	217	216
2,000	317	312
5,000	413	401
10,000	454	433
15,000	469	444
Unlimited	480	451

*Before entering this table, divide the maximum amount in the policy by the ASP factor for the year.

**Anesthesia does not include the administration of anesthesia.

This is for miscellaneous hospital services and includes the cost for inpatient hospital care, the cost for outpatient hospital treatment and the excess cost of intensive care unit or coronary care unit over the average semi-private room and board.

Subp. 3. Surgery.

Limit	Administration of Anesthesia Included	Administration of Anesthesia Not Included
Prevailing Fee with Assistant Surgeon	243	206
Prevailing Fee without Assistant Surgeon	244	187

If the policy pays the reasonable and customary charges up to a maximum in a schedule, then multiply the points for the prevailing fee by the ratio of the value of the schedule used in the policy to the SURG value for the year.

Subp. 4. Home and office physician care.

Annual Maximum*	First Visit Accident First Visit Sickness	First Visit Accident Third Visit Sickness
$ 200	111	63
500	141	72
1,000	165	93
Unlimited	215	118

*Before entering this table, divide the annual maximum in the policy by SURG factor for the year.

Subp. 5. In-hospital physician care.

Maximum Number of Visits	Prevailing Fee
31	46
70	49
120	49
365	50
Unlimited	51

A. This benefit pays the reasonable and customary charge to the physician (other than the surgeon, assistant surgeon, or anesthetist) while confined in the hospital for medical or surgical reasons.

B. If the policy pays the greater of this benefit or the surgical benefit, then reduce these points by 30 percent.

C. A number of policies pay a limited amount per visit (limited to one visit per day) which is less than or equal to the cost for a routine follow-up visit in the hospital. If it is equal to the cost for a routine follow-up visit (assumed to be $24.20*/day in 1984), then deduct 14 points from the above points. If it is less than that, then use a proportional part of the points determined as if the maximum was equal to the cost for a routine follow-up visit.

*Multiply the indicated value by the SURG factor for the year.

Subp. 6. Maternity.

A. complications only:

limited to some specified list	20
any complications	25

B. full maternity (including complications):

Maximum Limit*	Deductible	Flat Maternity	Obstetrics	Hospital Maternity
$ 300	None	—	23	28
600	None	49	44	55
1,000	None	81	59	80
2,000	None	149	—	—
Unlimited	None	173	63	110

*Before entering this table, divide maximum limit in the policy by the ASP factor for the year.

Subp. 7. X rays and laboratory tests (out of hospital).

Maximum*	Scheduled (Any Scheduled)	Unscheduled
$100	56	70
200	67	89
500	74	101
Unlimited	77	105

*Before entering this table, divide the maximum in the policy by the ASP factor for the year.

Subp. 8. Prescription drugs and medicine (out of hospital).

Deductible* Per Prescription	
$4.00	69
2.00	86
None	100

*Before entering this table, divide the deductible per prescription by the SURG factor for the year.

Subp. 9. Radioactive therapy (out of hospital).

Scheduled (Any Schedule)	10
Unscheduled	15

Subp. 10. Nursing or convalescent home care (within 14 days of hospital confinement of at least three days).

Maximum Days	
120 or More	16
Less than 120	0

Subp. 11. Home health care agency services.

Maximum Visits/Year	
180 or More	8
Less than 180	0

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Subp. 12. Miscellaneous.

A. physical therapy (out of hospital), 10;

B. oxygen (out of hospital), 4;

C. prostheses (out of hospital), 5;

D. durable medical equipment rental or purchase (out of hospital), 5;

E. second opinion surgery, 2;

F. private duty nursing (in hospital only), 2; and

G. ambulance, 3.

Subp. 13. Hospital room and board in full to indicated limit (basic and comprehensive major medical plans). Add these points to the points in subpart 1 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

Plan	Plan Deductible* On All Benefits	Limit* $1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0- 300	58	60	66	79
Comprehensive	301- 600	61	63	69	82
Comprehensive	601- 900	66	68	74	87
Comprehensive	901-1200	74	76	82	95

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the policyholder pays 20 percent after the deductible. If the policyholder pays a different percentage, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that hospital room and board will be paid at 100 percent and that the deductible will not be applied to it. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining deductible will not be applied but the coinsurance will be applied, to the hospital room and board benefits.

Subp. 14. All hospital charges in full to indicated limit (basic and comprehensive major medical plans). Add these points to the total points in subparts 1 and 2 if the maximum hospital room and board is the semi-private room and board. If it is less than the semi-private room and board, make an appropriate adjustment.

Plan	Plan Deductible* On All Benefits	LIMIT* $1,000	$2,000	$5,000	Unlimited
Comprehensive	$ 0- 300	70	110	121	177
Comprehensive	301- 600	171	151	162	218
Comprehensive	601- 900	198	238	249	305
Comprehensive	901-1200	343	383	394	450

*Before entering the table, divide the deductible and the "in full limit" by the ASP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is 1800. If the percentage being paid by the insured is not 20 percent, multiply the above points by the ratio of the percentage being paid by the insured to 20 percent.

B. This benefit assumes that the hospital room and board and hospital services will be paid at 100 percent and that the deductible will not be applied to them. The deductible will be applied to the other covered expenses. After the limit is attained, any remaining deductible will not be applied but the coinsurance will be applied, to either hospital room and board or hospital services benefits.

Subp. 15. Major medical maximum (comprehensive and superimposed plans).

Maximum*	Add (+) or Subtract (−)
$ 100,000	−27
250,000	−12
500,000	− 7
1,000,000	− 2

*Before entering the table, divide the maximum in the policy by the COMP factor for the year.

The smallest maximum in the qualified plan is $250,000. The $100,000 maximum as provided should be used in future years to help determine the reduction for a $250,000 plan.

Subp. 16. Coinsurance and deductibles (comprehensive major medical plans).

A. This table assumes that the point values for all medical services and supplies are approximately 1800 points before deduction for the maximum on total benefits. If the total points are significantly greater or smaller, then the point values must be adjusted.

Deductible*	Deducted Points
$ 0	0
50	85
100	170
150	245
200	310
500	622
1,000	820

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

B. To determine the deduction for the coinsurance, subtract the points deducted for the deductible from the total point value for the benefits and then multiply the result by the coinsurance percentage.

Subp. 17. Combined dental and health insurance deductible (comprehensive major medical plans).

Deductible*	Added Points
$ 50	75
100	60
150	43
200	38
500	35
1,000	15

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

Subp. 18. Coordination and nonduplication of benefits (all plans).

A. The following percentage of points after deduction for deductible and coinsurance should be subtracted if the policy coordinates benefits with other plans and its pricing assumes that a number of insured will have other policies in force.

(1) with other health plans, 4.0 percent;

(2) with no fault, 2.5 percent;

(3) with both subitems (1) and (2), 6.5 percent; and

(4) with neither, 0.

B. The percentage should be applied to the total points after deduction for deductible and coinsurance.

Subp. 19. Limit on "out-of-pocket" expenses (maximum copayment and deductible per benefit year)—comprehensive and superimposed major medical plans.

Maximum Claim When Out-of-Pocket is reached*	Points
$ 500	236
1,000	196
2,000	158
3,000	130
4,000	110

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11,000	45
13,000	36
14,400	30

*Before entering this table, divide the maximum claim when out-of-pocket limit by the COMP factor for the year.

A. The above table assumes that the insured pays 20 percent of the costs after the deductible and that the number of points before the deductible and coinsurance is about 1800. If the percentage of claims being paid by the insured is other than 20 percent, multiply the number of points above by the ratio of the coinsurance being paid by the insured to 20 percent.

B. The above table assumes that the amounts paid by the policyholder for deductible and coinsurance are included in determining out-of-pocket limitation.

Subp. 20. Well baby care.

Deductible*	Points
$ 0	17
150	8
500	2
1,000	0

*Before entering this table, multiply the deductible in the policy by the COMP factor for the year.

The above benefit assumes that the deductible and coinsurance are applied to the costs of the newborn.

Supb. 21. Emergency and supplemental accident (basic plans only).

Maximum*	Emergency	Supplemental
$ 50	10	—
100	15	20
300	—	30
500	—	35
1,000	—	40
Unlimited	20	—

*Before entering this table, divide the maximum in the policy by the SURG factor for the year.

Subp. 22. Student dependents.

Student Extension Beyond Age 19	
None	0
To age 21	2
To age 23	4
To age 25	5

Subp. 23. Superimposed major medical plans—over basic health plans with less than 500 points.

A. Calculate point value of a comprehensive major medical plan by using deductible* $200 greater than actual.

B. Add basic health plan points.

*Before entering the table, divide the deductible in the policy by the COMP factor for the year before adding $200. Do not make any further adjustments to the deductible.

Subp. 24. Superimposed major medical plans—80/20 coinsurance—over basic health plans with 500-799 points.

	Calendar Year Plan		Two year benefit period plan	
Deductible*	Individual	2 × family	Individual	2 × family
a. Corridor				
$ 100	740	780	745	765
200	665	705	680	700
300	615	655	630	650
500	543	582	558	578
1,000	385	425	400	420
b. Integrated				
$1,000	615	635	650	670
2,000	515	525	535	545

Note: Points assume major medical contains Minnesota qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

Subp. 25. Superimposed major medical plans—80/20 coinsurance—over basic health plans with 800 or more points.

	Add to Basic Plan Points			
	Calendar Year Plan		Two year benefit period plan	
Deductible*	Individual	2 × family	Individual	2 × family
a. Corridor				
$ 100	515	545	525	535
200	445	475	455	465
300	405	435	415	425
500	339	369	349	359
1,000	215	245	225	235
b. Integrated				
$1,000	505	525	530	550
2,000	405	415	420	430

Note: Points assume major medical contains Minnesota qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

*Before entering this table, divide the deductible in the policy by the COMP factor for the year.

2740.9979 BASIC BACKGROUND FOR EXAMPLES.

Subpart 1. Inflation assumptions for 1985. The examples which follow assume that the actuarial equivalence of a series of plans is being calculated for calendar year 1985. Inflation was assumed to be 15.5 percent and 8.0 percent for hospital related and all other services, respectively.

Subp. 2. Values published by commissioner for 1985.

ASP value for 1984	190*
ASP value for current year (1985*)	220*
SURG value for 1984	4,000.00
SURG value for current year (1985*)	4,320.00*
ASP factor for 1985*	1.155*
SURG factor for 1985*	1.080*
COMP factor for 1985*	1.121*

*Estimated. Please substitute the actual values.

Subp. 3. Point values for qualified plans in 1985. The following are the revised point values used to determine plans which are actuarially equivalent to qualified plans 1, 2, and 3 for 1985.

Qualified Plan Number	If plan has the indicated number of points then plan is actuarially equivalent to the qualified plan in:	
	1984	1985
3	1192 + points	1216 + points
2	911 + points	957 + points
1	767 + points	847 + points
Nonqualified	Less than 767	Less than 847

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2740.9991 EXAMPLE I.

Subpart 1. Use of actuarial equivalence test.

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Surgery	Includes Assistant Surgeon and Administration of Anesthesia
Deductible:	$100
Coinsurance:	80/20
Maximum:	$250,000
Maternity:	Any complications
Student dependents:	To age 23
Limits on specified benefits	Outpatient mental limited to Minnesota
Required benefits	—
Excluded care	Home health care
Out-of-pocket limit	$3,000 per year
Coordination of benefits	Yes, but no COB for no-fault.

B. Answer (calculated January 1, 1985): test result is 1186 points. This plan is a Minnesota qualified plan number 2.

Subp. 2. Worksheet. Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subparts of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board			363
2.	Hospital extras			480
3.	Surgery			243
4.	Physician care—home, office			215
5.	Physician care—hospital			51
6.	Maternity			25
7.	Diagnostic X-ray and lab			105
8.	Drugs and medicine			100
9.	Radioactive therapy			15
10.	Nursing/convalescent facility			16
11.	Home health care			0
12.	Physical therapy			10
12.	Oxygen			4
12.	Prostheses			5
12.	Durable medical equipment			5
12.	Second opinion surgery			2
12.	Private duty nursing			2
12.	Ambulance			3
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			−12
	Subtotal reas. and cust. med. services			1632
16.	Deductible			−138
16.	Coinsurance			−299
	Subtotal net of ded. and coin.			1195
17.	Adjust (comb. medical/dental ded)			
18.	COB/No-fault			−48
19.	Limit on "out-of-pocket expenses"			35
20.	Well baby care			
21.	Emergency and supplemental accident			

22.	Student dependents		4
23.-25.	Superimposed major medical		4
	Grand Total	XXX	1186
	Combined basic and superimposed		XXX

Equivalent to Minnesota qualified plan number ___ 2 ___
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) The maximum in the policy ($250,000) divided by the COMP factor (1.121) is $223,015. This is 82.01 percent of the difference between the $100,000 and $250,000 maximums in part 2740.9964, subpart 15. The points would be minus 27 plus .8201 times 15 or −14.70 points.

(2) The deductible in the policy ($100) divided by the COMP factor (1.121) is 89.21. This is 78.41 percent of the difference between the $50 and $100 deductibles in part 2740.9964, subpart 16. Points deducted for the deductible would be 85 plus .7841 times 85 or 151.65. Since the total points in the policy before the deductible is significantly less than 1800, multiply 151.65 by (1632/1800). The result is 137.50.

(3) The out-of-pocket maximum is $3,000. The maximum claim when the out-of-pocket is reached is $14,600. This divided by the COMP factor (1.121) is 13,024. This is 10.29 percent of the difference between the $13,000 and $14,400 maximum claim when out-of-pocket is reached. The adjustment for the out-of-pocket limit is 36 minus .1029 times 6 or 35.38.

2740.9992 EXAMPLE II.

Subpart 1. Use of actuarial equivalence test.

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital:	$170 per day, 365 days; 80 percent of misc. extras, the cost of anesthesia is included. The policy does not pay for private room even if medically necessary.
Surgery:	$3,000 maximum surgical schedule. Add 15 percent for the administration of anesthesia.
In hospital physicians calls:	$25 per day—365 day maximum
Maternity:	Any complications
X-ray and lab tests (out of hospital):	$500 maximum—unscheduled

B. Answer (calculated January 1, 1985): test result is 1004 points. This plan is a Minnesota qualified plan number two.

Subp. 2. Worksheet. Test for actuarial equivalence other than medicare supplement plans.

A. Worksheet.

Subpart of part 2740.9964	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
1.	Hospital room and board	275		
2.	Hospital extras (80 percent)	384		
3.	Surgery	189		
4.	Physician care—home, office			
5.	Physician care—hospital	33		
6.	Maternity	25		
7.	Diagnostic X-ray and lab	98		
8.	Drugs and medicine			
9.	Radioactive therapy			
10.	Nursing/convalescent facility			

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11.	Home health care			
12.	Physical therapy			
12.	Oxygen			
12.	Prostheses			
12.	Durable medical equipment			
12.	Second opinion surgery			
12.	Private duty nursing			
12.	Ambulance			
13.	Hospital room and board in full			
14.	All hospital expenses in full			
15.	Major medical maximums			
Subtotal reas. and cust. med. services				
16.	Deductible			
16.	Coinsurance			
Subtotal net of ded. and coin.				
17.	Adjust (comb. medical/dental ded)			
18.	COB/No-fault			
19.	Limit on "out-of-pocket expenses"			
20.	Well baby care			
21.	Emergency and supplemental accident			
22.	Student dependents			
23.-25.	Superimposed major medical			
Grand Total		1004		
Combined basic and superimposed			XXX	XXX

Equivalent to Minnesota qualified plan number ___ 2 ___
nonqualified _____

Date _____ By _____

B. Miscellaneous calculations.

(1) Policy does not pay extra for private room even if medically necessary. Deduct three points from the 359. Since th ASP value in 1985 is 220, the number of points will be 356 times the ratio of 170 to 220 or 275.09 points.

(2) The surgical table was evaluated as 3,680.02 points. The points not including administration of anesthesia is 20 times the ratio of 3680.02 to 4620.00 or 164.09 points. For administration of anesthesia, the points are 164 times .15 or 24.6 points

(3) Since the maximum per diem cost of in-hospital physicians calls is less than the cost for routine follow-up (24.2 times 1.08 or 26.14), subtract 14 points from the number of points for prevailing fee with 365-day maximum. The result is 3 points. Multiply the 35 points by the ratio of $25 to 26.14 or 33.47 points.

(4) Since the ASP factor is 1.15, the $200 and $500 maximum shown in part 2740.9964, subpart 7 is now 230 and 57 respectively. Thus the $500 maximum is 78.26 percent of the way between the two maximums. Therefore the point value equals 8 plus .7826 times (101-89) or 98.39 points.

2740.9993 EXAMPLE III.

Subpart 1. Use of actuarial equivalence test.

A. Question: Is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital:	$80 per day, 120 days, $2,000 extras.
Surgery:	$1,500 maximum surgical schedule, add ten percent for administration of anesth sia.
Coordination of benefits	Yes, does not include no-fault
Superimposed major medical:	
Deductible:	$200 corridor per calendar year
Coinsurance:	80/20
Maximum:	$250,000
Maternity:	Any complications
Student dependents:	No

STATE OF MINNESOTA

DEPARTMENT OF COMMERCE

In the Matter of Proposed Adoption of Amendments to Rules Relating to the Minnesota Comprehensive Health Insurance Act of 1976, as Amended.

STATEMENT OF NEED AND REASONABLENESS

NEED AND AUTHORITY

The Minnesota Comprehensive Health Insurance Act of 1976 (hereinafter "Act") was originally enacted in 1976 (1976 Minnesota Laws, chapter 296, article 1) and subsequently amended by 1977 Minnesota Laws, chapter 409, sections 7 through 20; 1978 Minnesota Laws, chapter 793, section 15, subdivision 2; 1979 Minnesota Laws, chapter 174, section 3, and chapter 272; 1980 Minnesota Laws, chapter 496, section 3; 1981 Minnesota Laws, chapter 265, section 2; 1982 Minnesota Laws, chapter 424, section 130, and chapter 426; 1983 Minnesota Laws, chapter 123, section 1; and 1984 Minnesota Laws, chapter 592, sections 48 and 49.

The above-captioned proposed amendments to Rules are proposed by the Commissioner of Commerce (hereinafter "Commissioner") for adoption as permanent Rules. The authority of the Commissioner for promulgation of these Rules is set forth in Minnesota Statutes, section 62E.09(a) and (i). Pursuant to this authority, permanent Rules were promulgated by the Commissioner, were published at 3 State Register 1961 and were effective on May 7, 1979.

These proposed amendments to the Rules relate generally to one of the two primary purposes of the Act--the provision of health coverage through the Minnesota Comprehensive Health Association (hereinafter "Association") for persons otherwise unable to purchase adequate coverage through the existing voluntary health coverage market. The proposed amendments relate primarily to the definitional sections and to the portion of the Rules relating to the Association, Minnesota Rules, parts 2740.2100 through 2740.5500.

As will be more fully shown herein, these proposed amendments to the Rules are intended to more precisely delineate the duties, privileges and relationships created by the Act and, in particular, changes which are required by the above-referenced amendments to the Act as well as certain litigation relating to the Act. (St. Paul Electrical Workers Welfare Fund, et al. v. Markman, et al., 490 F. Supp. 93 (D. Minn. 1980); and Minnesota Mining and Manufacturing Company, et al. v. State of Minnesota, et al., No. 3-78-479 (D. Minn., filed December, 1978). As a result of the resolution of these lawsuits, the provisions of the Act which are preempted by the Employee Retirement Income Security Act of 1974 (hereinafter "ERISA") are no longer enforced against self-insurers.

As more fully indicated below, the proposed amendments to the Rules reasonably address the above-stated changes.

FACTS ESTABLISHING REASONABLENESS

The Rules, as originally promulgated in 1979, were based on the Act as originally enacted in 1976 and as amended in 1977 and 1978. The proposed amendments to the Rules reasonably address the requirements of the subsequent amendments to the Act and other changes, and are a rea-

sonable attempt to further delineate and give effect to the duties, responsiblities and rights set forth in the Act, as amended and as judicially interpreted.

Minnesota Rules, part 27400.0100, subpart 13, is proposed to be amended to make it consistent with the 1981 amendment to Minnesota Statutes, section 62E.02, subdivision 5, which deleted the phrase "or the actuarial equivalent of those benefits" from the end of the definition of "qualified medicare supplement plan," thereby limiting the use of actuarial equivalence to qualified plans. The term "state plan" is also deleted from this definition since the definition is not and never was limited to state plan policies or contracts.

Minnesota Rules, part 2740.0100, subpart 29, is proposed to be amended to take into account the repeal of Minnesota Statutes, section 60A.02, subdivision 8 by 1981 Minnesota Laws, chapter 307, section 22, which had defined the term "solicitor." Since the term is no longer used in Minnesota Statutes, chapter 60A, it is reasonable to omit it from this definition of the phrase "licensed and tested insurance agent or solicitor" which still appears in Minnesota Statutes, section 62E.02, subdivision 11. The term "Insurance Agent" is added, and that term is used in the Rules instead of "Licensed and tested insurance agent or solicitor".

Minnesota Rules, part 2740.0100, subpart 32, is proposed to be amended to change the maximum expenses and agent referral fees of the writing carrier to 15% from 12½% of premiums to make it consistent with Minnesota Statutes, section 62E.11, subdivision 3, which was similarly changed by 1982 Minnesota Laws, chapter 426.

Minnesota Rules, part 2740.0100, subpart 44a, was added to the definitions to make clear that a qualified medicare supplement plan must not only meet the requirements of Minnesota Statutes, sections 62E.02, subdivision 5 and 62E.07, but also Minnesota Statutes, section 62A.32, which was added by 1981 Minnesota Laws, chapter 318, and which is applicable to qualified medicare supplement plans under Minnesota Statutes, section 62E.07.

Minnesota Rules, part 2740.0100, subpart 53, is proposed to be amended to insert the reference to a qualified medicare supplement plan in two places in order to make clear that the refusal by any Association member to issue a qualified medicare supplement plan is a "rejection" under the Rules on the same basis as the refusal to issue a qualified plan constitutes a rejection. This section is also revised to provide that a rejection may be issued by an authorized representative of the member, including an insurance agent, acting on behalf of the Association member. The intent of the change is to facilitate enrollment in the state plan. This change appears consistent with the intent of the Act and reasonable for the efficient administration of the state plan and the business of Association members.

Minnesota Rules, part 2740.0100, subpart 56a, is a new definition which is intended to clarify that the only self-insurers which remain within the scope of the Act after the decision by the Federal District Court in the St. Paul Electricial Workers Welfare Fund litigation are those plans which are exempt from or outside of the scope of the provisions of ERISA.

Minnesota Rules, part 2740.0100, subpart 58, is proposed to be amended to eliminate language which appears unnecessary in the defini-

tion of "total cost of self-insurance."

Minnesota Rules, part 2740.1100, subpart 1, is proposed to be amended to more precisely state the employer's duty to make available a qualified plan to its employees, making clear that coverage may be provided through self insurance.

Minnesota Rules, part 2740.1100, subpart 3, is proposed to be amended to substitute non-sexist references for masculine pronouns.

Minnesota Rules, part 2740.1200, subpart 2, is proposed to be amended to insert the word "and" which was inadvertently omitted from the previously promulgated Rules.

Minnesota Rules, part 2740.1200, subpart 4, is proposed to be amended to add a reference to a policy of accident and health insurance which is "renewed," and to refer to a rider on an unqualified policy, in order to make it consistent with Minnesota Statutes, section 62E.04, subdivision 4 as amended by 1979 Minnesota Laws, chapter 272.

Minnesota Rules, part 2740.1200, subpart 7, item B, is proposed to be amended to substitute the word "a" for the word "the" for clearer meaning.

Minnesota Rules, part 2740.1600, subpart 3, is proposed to be amended to make a grammatical change.

Minnesota Rules, part 2740.1700 is proposed to be amended to give the commissioner more flexibility in determining the timing of revision of the actuarial equivalence tables, which appears reasonable and more feasible in the administration of the department.

Minnesota Rules, part 2740.2100, subpart 1, item B, subitem (9), is proposed to be amended to delete the reference to "licensed and tested insurance agent or solicitor" and substitute a reference to "insurance

agent" for the reason stated above in connection with the amendment proposed to Minnesota Rules, part 2740.0100, subpart 29.

Minnesota Rules, part 2740.2100, subpart 4, is proposed to be amended to substitute the term "self-insurer" for the phrase "employer or employee welfare benefit plan". This change is proposed to take into account the above-referenced litigation and to take into account the newly proposed definition of self-insurer at Minnesota Rules, part 2740.0100, subpart 56a.

Minnesota Rules, part 2740.2400, subpart B, is proposed to be amended to also take into account the amendment referred to in the previous paragraph. Thus the new term "contributing member" is used and references to the assessment agreement are deleted. In addition, a change is made to delete reference to the "next annual fiscal year" and substitute instead a reference to "future assessments" in connection with the offset mechanism for past assessments. This change allows the Association more flexibility in the timing of credits for excess assessments, or additional assessments for previous deficits in assessments, but does not otherwise affect the basic assessment mechanism.

Minnesota Rules, part 2740.2500, subpart 1, is proposed to be amended to clarify the provision concerning the annual assessment and make clear that annual assessments are due and payable within 30 days after receipt of a written assessment (as is already clear under the Rules for interim assessments).

Minnesota Rules, part 2740.2500, subpart 2, is proposed to be amended to use the terminology "contributing members" from the 1979 amendments.

Minnesota Rules, part 2740.2500, subpart 3, is proposed to be amended to make it consistent with the 1979 amendments, including use of the term "contributing member" and deletion of references to amounts other than accident and health insurance premiums which, after the 1979 amendments, is the only base for assessment of a contributing member.

Minnesota Rules, part 2740.2500, subpart 4 is proposed to be amended to use the term "contributing members".

Minnesota Rules, part 2740.2500, subpart 4, item B, is proposed to be amended to delete reference to certain entities administering self-insured plans which is no longer appropriate following the resolution of the St. Paul Electrical Workers Welfare Fund litigation.

Minnesota Rules, part 2740.2500, subpart 5, is proposed to be amended to refer to "contributing members" and to expand the Board's discretion to decline to levy assessments against contributing members which owe $5.00 or less in any given year to permit the Board to decline to levy assessments against contributing members which owe $10.00 or less, which appears more realistic.

Minnesota Rules, part 2740.2600, is proposed to be amended to delete references to the assessment agreement and to also use the term "contributing member."

Minnesota Rules, part 2740.2900, subpart 2, is proposed to be amended to take into account the assessment provision changes in Minnesota Rules, part 2740.2500, and to make the Rules internally consistent.

Minnesota Rules, part 2740.2900, subpart 3, is proposed to be amended to delete reference to the Commissioner in connection with

approval of the proxy statement since this is not required under the Act and does not otherwise appear necessary.

Minnesota Rules, part 2740.3100, subpart 2, item B, is proposed to be amended to make more clear the reference to out-of-pocket expenses.

Minnesota Rules, part 2740.3100, subpart 2, item C, is proposed to be amended to make clear that the $250,000 maximum lifetime benefit under the qualified plan of the state plan is to be reduced only by the amount of benefits paid under another qualified plan of the state plan.

Minnesota Rule, part 2740.3100, subpart 3, is proposed to be amended to delete reference to actuarial equivalence with respect to qualified medicare supplement plans as is required by the 1981 amendment to the Act.

Minnesota Rules, part 2740.3100, subpart 3, item A, is proposed to be amended to delete reference to persons age 65 or older in connection with the qualified medicare supplement plan of the state plan since the Association issues the qualified medicare supplement plan to persons under age 65 who are covered by parts A and B of medicare.

Minnesota Rules, part 2740.3100, subpart 3, item A, subitems (1) through (5), are proposed to be added to the description of benefits of a qualified medicare supplement plan in order to make clear that the benefits of the qualified medicare supplement plan must be consistent with the requirements of Minnesota Statutes, section 62A.32. This is required by 1981 Minnesota Laws, chapter 318.

Minnesota Rules, part 2740.3100, subpart 3, item B, is also proposed to be amended to delete reference to actuarial equivalence, which is no longer permitted under the qualified medicare supplement plan of

the state plan. Further, this is proposed to be amended to reference the amendments made in the immediately preceding paragraph.

Minnesota Rules, part 2740.3100, subpart 3, item D, is proposed to be amended to change the maximium lifetime benefit provision under the Rules to make clear that the $100,000 qualified medicare supplement plan maximum lifetime benefit is separate from the $250,000 qualified plan 1 or 2 maximum lifetime benefit under the state plan, and that the maximum lifetime benefit for a person under the qualified medicare supplement plan of the state plan shall be reduced only by any amounts paid to or on behalf of the covered person under any other qualified medicare supplement plan of the state plan. Further, it is provided that this benefit shall not be subject to substitution of an actuarially equivalent benefit, which is required under 1981 Minnesota Laws, chapter 318.

Minnesota Rules, part 2740.3600, subpart 2, item A, subitem (1), is proposed to be amended to delete reference to sex in the application for state plan coverage, since this is inconsistent with the 1983 amendments to the Act.

Minnesota Rules, part 2740.3600, subpart 2, item A, subitem (3), is proposed to be amended to make clear that evidence of rejection for coverage under a qualified medicare supplement plan is required for persons age 65 and over for coverage under the qualified medicare supplement plan of the state plan. This provision is also proposed to be changed to incorporate the new statutory requirement of only one rejection, restrictive rider, rate up, or pre-existing conditions limitation and the authority for such action by authorized representatives of members, as described in connection with the amendments to Minnesota Rules, part 2740.0100, subpart 53, above.

Minnesota Rules, part 2740.3600, subpart 2, item B, is a new item intended to permit the Association to develop by operating rule a list of conditions which (upon provision of evidence by an applicant which meets the requirements of an operating rule adopted by the Association) is considered to be sufficient to allow a person to obtain coverage under the state plan without need to obtain a rejection, restrictive rider, rate up or pre-existing condition limitation as would otherwise be required for eligibility. The purpose for this provision is to streamline the application process for those persons who would clearly be able to secure the necessary rejection or other limitation on qualified plan or qualified medicare supplement plan coverage, and it appears reasonable for the efficient administration of the state plan. This change is consistent with the 1979 amendments to Minnesota Statutes, section 62E.14, subdivision 1(c).

Minnesota Rules, part 2740.3600, subpart 2, item C, contains a change in citation which is necessitated by the addition of the new item described in the previous paragraph.

Minnesota Rules, part 2740.3600, subpart 2, item D, is proposed to be amended to make clear that a person covered under a qualified plan of the state plan may become covered under the qualified medicare supplement plan without need to obtain the one rejection, restrictive rider, rate up or pre-existing conditions limitation from a member of the Association or a member's authorized representative not only by reaching age 65 but also upon becoming enrolled in medicare. This will permit those persons under age 65 who become enrolled in part A and part B of medicare to transfer automatically into the state plan qualified medicare supplement plan without the need to again obtain the necessary

rejection for eligibility under the state plan as is already permitted for persons who are covered by a qualified plan of the state plan upon becoming age 65. This change appears reasonable for the efficient administration of the state plan.

Minnesota Rules, part 2740.3600, subpart 2, item E, is proposed to be amended to add a sentence which makes clear that a person under age 65 who is otherwise eligible for state plan coverage and is enrolled in medicare may, at that person's option, be permitted to purchase either a qualified plan 1 or 2 or a qualified medicare supplement plan of the state plan. This appears reasonable since such persons would qualify for coverage under either the qualified plan 1 or 2 or the qualified medicare supplement plan, and there would appear to be no reason to require them to accept coverage under a particular plan.

Minnesota Rules, part 2740.3600, subpart 2, item F, is proposed to be amended to make clear that the maximum lifetime benefit under one or more qualified plans of the state plan is a total of $250,000.00, and a person who has exhausted that amount is not an eligible person for coverage under any other qualified plan of the state plan. Similarly, the provision relating to the maximum lifetime benefit of the qualified medicare supplement plan of the state plan is proposed to be amended to make clear that there is a separate maximium lifetime benefit of $100,000.00 for this coverage, and a person who has exhausted the $100,000.00 maximum lifetime benefit is not an eligible person for coverage under the qualified medicare supplement plan of the state plan. This is required by 1981 Minnesota Laws, chapter 318.

Minnesota Rules, part 2740.3700, subpart 1, is amended to change a citation in the Rules as a result of other amendments.

Minnesota Rules, part 2740.3700, subpart 2, item B, is amended to change a citation as a result of other amendments to the Rules.

Minnesota Rules, part 2740.3700, subpart 3, is amended to make the establishment of a review mechanism to review requests for reconsideration of rejected certificates of eligibility discretionary in the board of the Association, rather than mandatory, as it is under the current Rules. This is intended to facilitate direct appeals to the Minnesota Commerce Department in appropriate circumstances.

Minnesota Rules, part 2740.3900, subparts 1, 2 and 3, are proposed to be amended to make more clear the role of the Association in disseminating information concerning the state plan. The subpart 2 amendments clarify that the Association shall make available application forms to its members and also deletes the term "solicitors," which is obsolete. The subpart 3 amendments clarify the Association's duty to pay referral fees to agents (including the 1984 legislative increase to $50 for any certificate of eligibility accepted) and further makes clear the agent's limited role in referring applicants to the state plan for coverage, as well as the Association's lack of responsibility for their conduct.

Minnesota Rules, part 2740.4400, subpart 1, item B, subitem (4), is proposed to be amended to require the writing carrier to exercise reasonable efforts to advise covered persons within 60 business days of receipt of a properly completed and executed proof of loss, whether the submitted claim was accepted or rejected, unless sooner settled. This is consistent with 1984 Minnesota Laws, chapter 555, section 1.

Minnesota Rules, part 2740.4400, subpart 1, item B, subitem (5), is proposed to be amended to make discretionary the requirement that the

writing carrier establish an appeals procedure. This change is consistent with the proposed change to Minnesota Rules, part 2740.3700, subpart 3, above.

Minnesota Rules, part 2740.4400, subpart 3, is proposed to be amended to incorporate the statutory changes to the percentages of premium to be used for claim expenses and for the writing carrier's direct and indirect expenses, including agent referral fees. In addition, a citation to a provision in the Rule is modified.

Minnesota Rules, part 2740.4400, subpart 4, item A is proposed to be amended to reflect the changed percentage for payment of the writing carrier's direct and indirect expenses under the Act.

Minnesota Rules, part 2740.4400, subpart 5, is proposed to be amended to make clear that the provision relates to the writing carrier.

Minnesota Rules, part 2740.5200, subpart 2, is proposed to be amended to make a grammatical change.

Minnesota Rules, parts 2740.9905 through 2740.9986, relating to the Actuarial Equivalence of Qualified Plans and Qualified Medicare Supplement Plans, are proposed to be amended and superceded in their entirety to establish a test of Actuarial Equivalence which automatically adjusts for inflation. This will permit companies to more accurately value scheduled benefits whose value with respect to reasonable and customary charges declines each year due to inflation. Further, these proposed rules delete the reference to the Actuarial Equivalence of Qualified Medicare Supplement Plans as Minnesota Statutes no longer permit the option of an Actuarial Equivalent Plan for Medicare Supplement Policies. See Minnesota Statutes, sections 62A.31 through 62A.33.

Minnesota Rules, part 2740.2300, is proposed to be eliminated since the concept of a contract between the Association and its members, as originally contained in Minnesota Statutes, section 62E.10, subdivision 5, was eliminated by 1979 Minnesota Laws, chapter 272, section 7.

SMALL BUSINESS CONSIDERATION

The businesses expected to be affected by these rules are not encompassed in the definition of small businesses. Further, the intent of the rules is the protection of the consumer, and even if there were an effect on a small business, it has been determined that no changes in the rules could be made which would differentiate between large and small businesses that would not result in a reduction in the protection of the consumer. Therefore, no attempt was made or is necessary to differentiate the impact of these rules on small as opposed to large businesses.

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE

In the Matter of the Proposed Adoption of Rules Governing Comprehensive Health Insurance Association	STATEMENT OF COMPLIANCE WITH RULEMAKING PROCEDURES

I, Special Assistant Attorney General John C. Bjork, do hereby declare that I have examined the rules and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedure Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed. Any exceptions are noted below.

Dated: June 20, 1985.

John C. Bjork

JOHN C. BJORK
Special Assistant Attorney General

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE

In the Matter of the Proposed Adoption of Rules Relating to the Comprehensive Health Insurance Association

NOTICE OF SUBMISSION TO THE ATTORNEY GENERAL

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Richard G. Gomsrud, being first duly sworn, deposes and says:

That he is Department Counsel for the Department of Commerce.

That part of his duties is the promulgation and adoption of departmental rules, including those captioned above.

That to date, no person has requested notice of submission of the rules in the above-entitled matter to the Attorney General.

Richard G. Gomsrud

RICHARD G. GOMSRUD
Department Counsel, Department of Commerce

Subscribed and sworn to before me this 14th day of June, 1985.

Nancy I. Link

NANCY I. LINK
NOTARY PUBLIC-MINNESOTA
HENNEPIN COUNTY
MY COMMISSION EXPIRES DECEMBER 3, 1990