to merit systems established pursuant to sections 12.22, subdivision 3; 144.071; and ~~393.07, subdivision 5~~ 256.012, shall be removed from existing merit system coverage and placed under a personnel department established pursuant to sections 375.56 to 375.71, until that personnel department is certified ~~by the United States Civil Service Commission as meeting the operating standards of a merit system~~ in accordance with the United States office of personnel management's standards for a merit system of personnel administration. Nothing in section 387.43, shall be construed to prohibit the inclusion of sheriff's department personnel in a personnel system established pursuant to sections 375.56 to 375.69.

Sec. 4. **EFFECTIVE DATE.**

This act is effective the day following final enactment.

Approved May 29, 1981

CHAPTER 318 — S.F.No. 665

An act relating to insurance; establishing standards applicable to accident or health insurance policies which purport to supplement medicare benefits; prescribing minimum levels of coverage; providing for certain disclosures; and prescribing penalties; amending Minnesota Statutes 1980, Section 62E.02, Subdivision 5; proposing new law coded in Minnesota Statutes, Chapter 62A.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

MEDICARE SUPPLEMENT INSURANCE

Section 1. **[62A.31] MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.**

Subdivision 1. **POLICY REQUIREMENTS.** No individual or group policy, certificate, subscriber contract or other evidence of accident and health insurance issued or delivered in this state shall be sold or issued to an individual age 65 or older covered by medicare unless the following requirements are met:

(a) The policy must provide a minimum of the coverage set out in subdivision 2;

(b) The policy must cover pre-existing conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage;

(c) The policy must contain a provision that the plan will not be canceled or nonrenewed on the grounds of the deterioration of health of the insured; and

(d) An outline of coverage as provided in section 9 must be delivered at the time of application and prior to payment of any premium.

The requirements of sections 1 to 12 shall not apply to disability income protection insurance policies or group policies of accident and health insurance which do not purport to supplement medicare issued to any of the following groups:

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

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

(c) A policy issued to an association, a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 100 persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have a constitution and by-laws which provide that (1) the association or associations hold regular meetings not less frequently than annually to further purposes of the members, (2) except for credit unions, the association or associations collect dues or solicit contributions from members, and (3) the members have voting privileges and representation on the governing board and committees.

Subd. 2. **GENERAL COVERAGE.** For a policy to meet the requirements of this section it must contain (1) a designation specifying whether the policy is a medicare supplement 1+, 1, 2, or 3, (2) a caption stating that the commissioner has established four categories of medicare supplement insurance and minimum standards for each, with medicare supplement 1+ being the most comprehensive and medicare supplement 3 being the least comprehensive, and (3) the policy must provide the minimum coverage prescribed in sections 2 to 5 for the supplement specified.

Sec. 2. **[62A.32] MEDICARE SUPPLEMENT 1+; COVERAGE.**

Medicare supplement 1+ must have a level of coverage so that it will be certified as a qualified plan pursuant to chapter 62E, and will provide:

(a) 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 co-payment required under medicare for the first 60 days of any medicare benefit period;

(b) 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;

(c) 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;

(d) 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;

(e) 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;

(f) 80 percent of charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by medicare or pursuant to paragraphs (a) to (e); and

(g) Shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services. The coverage must be subject to a maximum lifetime benefit of not less than $100,000.

Sec. 3. **[62A.33] MEDICARE SUPPLEMENT 1; COVERAGE.**

Medicare supplement 1 must have a level of coverage that, at a minimum, will provide:

(a) 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 co-payment required under medicare for the first 60 days of any medicare benefit period;

(b) 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;

(c) 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;

(d) 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;

(e) Coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of the medicare calendar year part B deductible and a maximum benefit of at least $5,000 per calendar year; and

(f) 50 percent of charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by medicare or pursuant to paragraphs (a) to (e).

Sec. 4. **[62A.34] MEDICARE SUPPLEMENT 2; COVERAGE.**

Medicare supplement 2 must have a level of coverage that, at a minimum, will provide:

(a) 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;

(b) 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;

(c) 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 lifetime maximum benefit of an additional 365 days; and

(d) Coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of the medicare calendar year part B deductible and a maximum benefit of at least $5,000 per calendar year.

Sec. 5. **[62A.35] MEDICARE SUPPLEMENT 3; COVERAGE.**

Medicare supplement 3 must have a level of coverage that, at a minimum, will provide:

(a) 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;

(b) 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;

(c) 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; and

(d) Coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement and coverage of a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year.

Sec. 6. **[62A.36] LOSS RATIO STANDARDS.**

Subdivision 1. **MINIMUM LOSS RATIOS.** Notwithstanding the provisions of section 62A.02, subdivision 3, relating to loss ratios, medicare

supplement policies shall be expected to return to policyholders in the form of aggregate benefits under the policy, as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices:

(a) At least 75 percent of the aggregate amount of premiums collected in the case of group policies, and

(b) At least 65 percent of the aggregate amount of premiums collected in the case of individual policies.

Subd. 2. **SOLICITATIONS BY MAIL OR MEDIA ADVERTISEMENT.** For purposes of this section, medicare supplement policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

Sec. 7. **[62A.37] SEALS AND EMBLEM PROHIBITED.**

Subdivision 1. No graphic seal or emblem shall be displayed on any policy or promotional literature to indicate or give the impression that there is any connection, certification, approval or endorsement from medicare or any governmental body of this state or any agency thereof or of the United States of America or any agency thereof.

Subd. 2. Any false statement or representation printed on the policy or on promotional literature that indicates the policy has a connection with, is certified by, or has the approval or endorsement of any agency of this state or of the United States of America shall be unlawful.

Sec. 8. **[62A.38] NOTICE OF FREE EXAMINATION.**

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

Sec. 9. **[62A.39] DISCLOSURE.**

No individual medicare supplement plan shall be delivered or issued in this state and no certificate shall be delivered pursuant to a group medicare

supplement plan delivered or issued in this state unless an outline containing at least the following information is delivered to the applicant at the time the application is made:

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

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

(c) A statement of the renewal provisions including any reservations by the insurer of a right to change premiums;

(d) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(e) A statement of the policy's loss ratio as follows: "This policy provides an anticipated loss ratio of [..%]. This means that, on the average, policyholders may expect that [$.....] of every $100.00 in premium will be returned as benefits to policyholders over the life of the contract.".

Sec. 10. **[62A.40] REPLACEMENT.**

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

Sec. 11. **[62A.41] PENALTIES.**

Any insurer, general agent, agent, or other person who knowingly or willfully, either directly or indirectly, makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to compliance of any policy with the standards and requirements set forth in this section; falsely assumes or pretends to be acting, or misrepresents in any way, including a violation of section 7, that he is acting, under the authority or in association with medicare, or any federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value; or knowingly sells a health insurance policy to an individual entitled to benefits

under part A or part B of medicare with the knowledge that such policy substantially duplicates health benefits to which such individual is otherwise entitled under a requirement of state or federal law other than under medicare shall be guilty of a felony and subject to a civil penalty of not more than $5,000 per violation, and the commissioner may revoke or suspend the license of any company, association, society, other insurer, or agent thereof.

Sec. 12. **[62A.42] RULEMAKING AUTHORITY.**

To carry out the purposes of sections 1 to 12, the commissioner may promulgate rules pursuant to chapter 15. These rules may:

(a) Prescribe additional disclosure requirements for medicare supplement plans, designed to adequately inform the prospective insured of the need and extent of coverage offered;

(b) Prescribe uniform policy forms in order to give the insurance purchaser a reasonable opportunity to compare the cost of insuring with various insurers; and

(c) Establish other reasonable standards to further the purpose of sections 1 to 12.

Sec. 13. Minnesota Statutes 1980, Section 62E.02, Subdivision 5, is amended to read:

Subd. 5. "Qualified medicare supplement plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by section 62E.07 ~~or the actuarial equivalent of those benefits~~.

Approved May 29, 1981

CHAPTER 319 — S.F.No. 690

An act relating to retirement; providing survivor benefit coverage for certain former judges on deferred status; clarifying retirement coverage for certain members of the public employees police and fire fund; providing survivor benefits for survivors of certain deceased teachers; providing for retroactive effect of a special retirement program for the military affairs department; amending Minnesota Statutes 1980, Section 490.124, Subdivisions 9 and 12.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1980, Section 490.124, Subdivision 9, is amended to read: