SESSION LAWS

of the

STATE OF MINNESOTA

ENACTED BY THE SEVENTY-EIGHTH LEGISLATURE

AT THE 1993 REGULAR SESSION

JANUARY 5 TO MAY 17, 1993

CHAPTER 1—H.F.No. 22

An act relating to insurance; Medicare supplement; permitting phased-in compliance with community rating; amending Minnesota Statutes 1992, section 62A.31, subdivision 1.

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

Section 1. Minnesota Statutes 1992, section 62A.31, subdivision 1, is amended to read:

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

(a) The policy must provide a minimum of the coverage set out in subdivision 2 and section 62E.07.

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

(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.

(d) Before the policy is sold or issued, an offer of both categories of Medicare supplement insurance has been made to the individual, together with an explanation of both coverages.

(e) An outline of coverage as provided in section 62A.39 must be delivered at the time of application and prior to payment of any premium.

(f)(1) The policy must provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period, not to exceed 24 months, in which the policyholder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder notifies the issuer of the policy within 90 days after the date the individual becomes entitled to this assistance;

(2) if suspension occurs and if the policyholder or certificate holder loses entitlement to this medical assistance, the policy shall be automatically reinstated, effective as of the date of termination of this entitlement, if the policyholder provides notice of loss of the entitlement within 90 days after the date of the loss;

(3) the policy must provide that upon reinstatement (i) there is no additional waiting period with respect to treatment of preexisting conditions, (ii) coverage is provided which is substantially equivalent to coverage in effect before the date of the suspension, and (iii) premiums are classified on terms that are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had coverage not been suspended.

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

(h) No issuer of Medicare supplement policies, including policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., in this state may impose preexisting condition limitations or otherwise deny or condition the issuance or effectiveness of any Medicare supplement insurance policy form available for sale in this state, nor may it discriminate in the pricing of such a policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such insurance is submitted during the six-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B. This paragraph applies regardless of whether the individual has attained the age of 65 years.

(i) If a Medicare supplement policy replaces another Medicare supplement policy, the issuer of the replacing policy shall waive any time periods applicable

to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for benefits to the extent the time was spent under the original policy.

(j) The policy has been filed with and approved by the department as meeting all the requirements of sections 62A.31 to 62A.44.

(k) The policy guarantees renewability.

Only the following standards for renewability may be used in Medicare supplement insurance policy forms.

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

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

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

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

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

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

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

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

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

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

(n) Termination by an issuer of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that began while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy or certificate was in force may be conditioned on the continuous total disability of the insured, limited to the duration of the policy or certificate benefit period, if any, or payment of the maximum benefits. The extension of benefits does not apply when the termination is based on fraud, misrepresentation, or nonpayment of premium. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days before discontinuing the availability of the form of the policy or certificate. An issuer that discontinues the availability of a policy form or certificate shall not file for approval a new policy form or certificate form of the same type for the same Medicare supplement benefit plan as the discontinued form for five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section. A change in the rating structure or methodology shall be considered a discontinuance under this section unless the issuer complies with the following requirements:

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

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

(o)(1) Except as provided in clause (2), the Minnesota experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section 62A.36;

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

(p) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately

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

Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person eligible for Medicare by reason of age shall provide to such applicants a Medicare Supplement Buyer's Guide in the form developed by the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the Buyer's Guide must be made whether or not such policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this section. Except in the case of direct response issuers, delivery of the Buyer's Guide must be made to the applicant at the time of application, and acknowledgment of receipt of the Buyer's Guide must be obtained by the issuer. Direct response issuers shall deliver the Buyer's Guide to the applicant upon request, but no later than the time at which the policy is delivered.

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

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

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

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

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

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

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

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

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

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

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

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

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

(r) Each health maintenance organization, health service plan corporation, insurer, or fraternal benefit society that sells coverage that supplements Medicare coverage shall establish a separate community rate for that coverage. Beginning January 1, 1993, no coverage that supplements Medicare or that is governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., may be offered, issued, sold, or renewed to a Minnesota resident, except at the community rate required by this paragraph. The same community rate must apply to newly-issued coverage and to renewal coverage.

For coverage that supplements Medicare and for the Part A rate calculation for plans governed by section 1833 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., the community rate may take into account only the following factors:

(1) actuarially valid differences in benefit designs or provider networks;

(2) geographic variations in rates if preapproved by the commissioner of commerce; and

(3) premium reductions in recognition of healthy lifestyle behaviors, including but not limited to, refraining from the use of tobacco. Premium reductions must be actuarially valid and must relate only to those healthy lifestyle behaviors that have a proven positive impact on health. Factors used by the health carrier making this premium reduction must be filed with and approved by the commissioner of commerce.

For insureds not residing in Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, or Washington county, a health plan may, at the option of the health carrier, phase in compliance under the following timetable:

(i) a premium adjustment as of March 1, 1993, that consists of one-half of the difference between the community rate that would be applicable to the person as of March 1, 1993, and the premium rate that would be applicable to the person as of March 1, 1993, under the rate schedule permitted on December 31, 1992. A health plan may, at the option of the health carrier, implement the entire premium difference described in this clause for any person as of March 1, 1993, if the premium difference would be 15 percent or less of the premium rate that would be applicable to the person as of March 1, 1993, under the rate schedule permitted on December 31, 1992, if the health plan does so uniformly regardless of whether the premium difference causes premiums to rise or to fall. The premium difference described in this clause is in addition to any premium adjustment attributable to medical cost inflation or any other lawful factor and is intended to describe only the premium difference attributable to the transition to the community rate; and

(ii) with respect to any person whose premium adjustment was constrained under clause (i), a premium adjustment as of January 1, 1994, that consists of the remaining one-half of the premium difference attributable to the transition to the community rate, as described in clause (i).

A health plan that initially follows the phase-in timetable may at any subsequent time comply on a more rapid timetable. A health plan that is in full compliance as of January 1, 1993, may not use the phase-in timetable and must remain in full compliance. Health plans that follow the phase-in timetable must charge the same premium rate for newly-issued coverage that they charge for renewal coverage. A health plan whose premiums are constrained by clause (i) may take the constraint into account in establishing its community rate.

From January 1, 1993 to February 28, 1993, a health plan may, at the health carrier's option, charge the community rate under this paragraph or may instead charge premiums permitted as of December 31, 1992.

(s) Beginning January 1, 1993, a health maintenance organization that

issues coverage that supplements Medicare or that issues coverage governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., must offer, to each person to whom it offers any contract described in this paragraph, at least one contract that either:

(1) covers 80 percent of the reasonable and customary charge for prescription drugs or the copayment equivalency; or

(2) offers the coverage described in clause (1) as an optional rider that may be purchased separately from other optional coverages. Each contract issued without prescription drug coverage by any insurer, health service plan corporation, health maintenance organization, or fraternal benefit society must contain, displayed prominently by type or other appropriate means, on the first page of the contract, the following:

"Notice to buyer: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to you. Please ask for further details."

From January 1, 1993 to February 28, 1993, compliance with this paragraph is optional. If a health maintenance organization does not comply with this paragraph during that period, the health maintenance organization must extend any person's six-month eligibility period provided under paragraph (h) that began prior to or during that period and ends during or after that period. The length of the extension must be no less than that portion of the person's six-month eligibility period during which the health carrier did not comply with this paragraph. The extended eligibility period applies only to contracts that provide the prescription drug coverage required by this paragraph.

Sec. 2. **EFFECTIVE DATE.**

Section 1 is effective July 30, 1992.

Presented to the governor January 19, 1993

Signed by the governor January 21, 1993, 2:47 p.m.

CHAPTER 2—H.F.No. 11

An act relating to education; authorizing the Lake Benton and Pipestone school districts to direct the Lincoln county auditor to certify certain 1993 levies for the Verdi school district.

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

Section 1. **COUNTY CERTIFICATION OF CERTAIN 1993 SCHOOL DISTRICT LEVIES.**