CHAPTER 90—H.F.No. 1968

An act relating to insurance; making changes in Medicare supplemental insurance required by federal law; amending Minnesota Statutes 1998, sections 62A.31, subdivisions 1, 3, and by adding a subdivision; and 62A.43, subdivision 4.

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

Section 1. Minnesota Statutes 1998, 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 requirements in subdivisions 1a to ~~1s~~ 1u are met.

Sec. 2. Minnesota Statutes 1998, section 62A.31, is amended by adding a subdivision to read:

Subd. 1u. **GUARANTEED ISSUE FOR ELIGIBLE PERSONS.** (a)(1) Eligible persons are those individuals described in paragraph (b) who apply to enroll under the Medicare supplement policy not later than 63 days after the date of the termination of enrollment described in paragraph (b), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

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

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

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

(2) the individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Medicare part C, and any of the following circumstances apply:

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

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

the federal Social Security Act, United States Code, title 42, section 1395w–26), or the plan is terminated for all individuals within a residence area;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5)(i) the individual was enrolled under a Medicare supplement policy and terminates that enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under Medicare part C; any eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare risk or cost); any similar organization operating under demonstration project authority; an organization under an agreement under section 1833(a)(1)(A) of the federal Social Security Act, United States Code,

title 42, section 1395l(a)(1)(A) (health care prepayment plan); or a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the subsequent enrollment under paragraph (a) is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment; or

(6) the individual, upon first enrolling for benefits under Medicare part B, enrolls in a Medicare+Choice plan under Medicare part C, and disenrolls from the plan by not later than 12 months after the effective date of enrollment.

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

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

(2) paragraph (b), clause (5), is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, any policy described in clause (1) offered by any issuer;

(3) paragraph (b), clause (6), shall include any Medicare supplement policy offered by any issuer.

(d)(1) At the time of an event described in paragraph (b), because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated contemporaneously with the notification of termination.

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

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

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

Sec. 3. Minnesota Statutes 1998, section 62A.31, subdivision 3, is amended to read:

Subd. 3. **DEFINITIONS.** (a) The definitions provided in this subdivision apply to sections 62A.31 to 62A.44.

(b) "Accident," "accidental injury," or "accidental means" means to employ "result" language and does not include words that establish an accidental means test or use

words such as "external," "violent," "visible wounds," or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under a workers' compensation, employer's liability or similar law, or motor vehicle no–fault plan, unless prohibited by law.

~~(b)~~ (c) "Applicant" means:

(1) in the case of an individual Medicare supplement policy or certificate, the person who seeks to contract for insurance benefits; and

(2) in the case of a group Medicare supplement policy or certificate, the proposed certificate holder.

~~(c)~~ (d) "Bankruptcy" means a situation in which a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(e) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

~~(d)~~ (f) "Certificate" means a certificate delivered or issued for delivery in this state or offered to a resident of this state under a group Medicare supplement policy or certificate.

~~(e)~~ (g) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

~~(f)~~ (h) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

~~(g)~~ (i) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in United States Code, title 29, section 1002 (Employee Retirement Income Security Act).

(j) "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers. The expenses shall not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; and

(7) claims processing costs.

~~(h)~~ (k) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in the Medicare program.

~~(i)~~ (l) "Insolvency" means a situation in which an issuer, licensed to transact the business of insurance in this state, including the right to transact business as any type of issuer, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(m) "Issuer" includes insurance companies, fraternal benefit societies, health ~~care~~ service ~~plans~~ plan corporations, health maintenance organizations, and any other entity delivering or issuing for delivery Medicare supplement policies or certificates in this state or offering these policies or certificates to residents of this state.

~~(j)~~ (n) "Medicare" shall be defined in the policy and certificate. Medicare may be defined as the Health Insurance for the Aged Act, title XVIII of the Social Security Amendments of 1965, as amended, or title I, part I, of Public Law Number 89–97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as amended.

~~(k)~~ (o) "Medicare eligible expenses" means health care expenses covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

~~(l)~~ (p) "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare part C as defined in section 1859 of the federal Social Security Act, United States Code, title 42, section 1395w–28, and includes:

(1) coordinated care plans which provide health care services, including, but not limited to, health maintenance organization plans, with or without a point–of–service option, plans offered by provider–sponsored organizations, and preferred provider organization plans;

(2) medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

(3) Medicare+Choice private fee–for–service plans.

(q) "Medicare–related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.31 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by section 1833 (known as "cost" or "HCPP" contracts) or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

~~(m)~~ (r) "Medicare supplement policy or certificate" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, or those policies or certificates covered by section 1833 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., or an issued policy under a demonstration project specified under amendments to the federal Social Security Act, which is advertised, marketed, or de-

signed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.

~~(n)~~ (s) "Physician" shall not be defined more restrictively than as defined in the Medicare program or section 62A.04, subdivision 1, or 62A.15, subdivision 3a.

~~(o)~~ (t) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

~~(p)~~ (u) "Secretary" means the Secretary of the United States Department of Health and Human Services.

(v) "Sickness" shall not be defined more restrictively than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under a workers' compensation, occupational disease, employer's liability, or similar law.

Sec. 4. Minnesota Statutes 1998, section 62A.43, subdivision 4, is amended to read:

Subd. 4. **OTHER POLICIES NOT PROHIBITED.** The prohibition in this section or the requirements of section 62A.31, subdivision 1, against the sale of duplicate Medicare supplement coverage do not preclude the sale of ~~insurance coverage, such as travel, accident and sickness coverage, the effect or purpose of which is not to supplement Medicare coverage~~ a health insurance policy or certificate if it will pay benefits without regard to other health coverage and if prospective purchasers are provided, on or together with the application for the policy or certificate, the appropriate disclosure statement for health insurance policies sold to Medicare beneficiaries that duplicate Medicare as prescribed by the National Association of Insurance Commissioners. Notwithstanding this provision, if the commissioner determines that the coverage being sold is in fact Medicare supplement insurance, the commissioner shall notify the insurer in writing of the determination. If the insurer does not thereafter comply with sections 62A.31 to 62A.44, the commissioner may, pursuant to chapter 14, revoke or suspend the insurer's authority to sell accident and health insurance in this state or impose a civil penalty not to exceed $10,000, or both.

Sec. 5. **EFFECTIVE DATE.**

Sections 1 to 4 are effective the day following final enactment.

Presented to the governor April 20, 1999

Signed by the governor April 23, 1999, 11:16 a.m.