CHAPTER 62L

SMALL EMPLOYER INSURANCE REFORM

62L.02 DEFINITIONS.

[For text of subds 1 to 8, see M.S.1996]

Subd. 9. **Continuous coverage.** "Continuous coverage" means the maintenance of continuous and uninterrupted qualifying coverage. An individual is considered to have maintained continuous coverage if the individual requests enrollment in qualifying coverage within 63 days of termination of qualifying coverage.

[For text of subds 9a and 10, see M.S.1996]

Subd. 11. **Dependent.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 19 years, unmarried child under the age of 25 years who is a full-time student as defined in section 62A.301, dependent child of any age who is handicapped and who meets the eligibility criteria in section 62A.14, subdivision 2, or any other person whom state or federal law requires to be treated as a dependent for purposes of health plans. For the purpose of this definition, a child includes a child for whom the employee or the employee's spouse has been appointed legal guardian and an adoptive child as provided in section 62A.27.

[For text of subds 11a to 13a, see M.S.1996]

Subd. 13b. **Enrollment date.** "Enrollment date" means, with respect to a covered individual, the date of enrollment of the individual in the health benefit plan or, if earlier, the first day of the waiting period for the individual's enrollment.

[For text of subds 14 and 14a, see M.S.1996]

Subd. 15. **Health benefit plan.** "Health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a health carrier to a small employer for the coverage of medical and hospital benefits. Health benefit plan includes a small employer plan. Health benefit plan does not include coverage, including any combination of the following coverages, that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) liability insurance or supplemental to liability insurance;

(4) designed solely to provide coverage for a specified disease or illness or to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, if offered as independent, noncoordinated coverage;

(5) credit accident and health insurance as defined in section 62B.02;

(6) designed solely to provide dental or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident-only coverage;

(9) a long-term care policy as defined in section 62A.46 or a qualified long-term care insurance policy as defined in section 62S.01;

(10) Medicare-related coverage as defined in section 62Q.01, subdivision 6;

(11) workers' compensation insurance; or

(12) limited to care provided at on-site medical clinics operated by an employer for the benefit of the employer's employees and their dependents, in connection with which the employer does not transfer risk.

For the purpose of this chapter, a health benefit plan issued to eligible employees of a small employer who meets the participation requirements of section 62L.03, subdivision 3,

is considered to have been issued to a small employer. A health benefit plan issued on behalf of a health carrier is considered to be issued by the health carrier.

Subd. 16. **Health carrier.** "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan corporation licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network operating under chapter 62N; a fraternal benefit society operating under chapter 64B; a joint self–insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in United States Code, title 29, section 1002(40), as amended. Any use of this definition in another chapter by reference does not include a community integrated service network, unless otherwise specified. For the purpose of this chapter, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one health carrier, except that any insurance company or health service plan corporation that is an affiliate of a health maintenance organization located in Minnesota, or any health maintenance organization located in Minnesota that is an affiliate of an insurance company or health service plan corporation, or any health maintenance organization that is an affiliate of another health maintenance organization in Minnesota, may treat the health maintenance organization as a separate health carrier.

[For text of subds 17 and 18, see M.S.1996]

Subd. 19. **Late entrant.** "Late entrant" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period applicable to the employee or dependent under the terms of the health benefit plan, provided that the initial enrollment period must be a period of at least 30 days. However, an eligible employee or dependent must not be considered a late entrant if:

(1) the individual was covered under qualifying coverage at the time the individual was eligible to enroll in the health benefit plan, declined enrollment on that basis, and presents to the health carrier a certificate of termination of the qualifying coverage, due to loss of eligibility for that coverage, or proof of the termination of employer contributions toward that coverage, provided that the individual maintains continuous coverage and requests enrollment within 30 days of termination of qualifying coverage or termination of the employer's contribution toward that coverage. For purposes of this clause, loss of eligibility includes loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. For purposes of this clause, an individual is not a late entrant if the individual elects coverage under the health benefit plan rather than accepting continuation coverage for which the individual is eligible under state or federal law with respect to the individual's previous qualifying coverage;

(2) the individual has lost coverage under another group health plan due to the expiration of benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law Number 99–272, as amended, and any state continuation laws applicable to the employer or health carrier, provided that the individual maintains continuous coverage and requests enrollment within 30 days of the loss of coverage;

(3) the individual is a new spouse of an eligible employee, provided that enrollment is requested within 30 days of becoming legally married;

(4) the individual is a new dependent child of an eligible employee, provided that enrollment is requested within 30 days of becoming a dependent;

(5) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(6) a court has ordered that coverage be provided for a former spouse or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order.

[For text of subds 20 to 22, see M.S.1996]

Subd. 23. **Preexisting condition.** "Preexisting condition" means, with respect to coverage, a condition present before the individual's enrollment date for the coverage, for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the enrollment date.

Subd. 24. **Qualifying coverage.** "Qualifying coverage" means health benefits or health coverage provided under:

(1) a health benefit plan, as defined in this section, but without regard to whether it is issued to a small employer and including blanket accident and sickness insurance, other than accident–only coverage, as defined in section 62A.11;

(2) part A or part B of Medicare;

(3) medical assistance under chapter 256B;

(4) general assistance medical care under chapter 256D;

(5) MCHA;

(6) a self–insured health plan;

(7) the MinnesotaCare program established under section 256L.02;

(8) a plan provided under section 43A.316, 43A.317, or 471.617;

(9) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or other coverage provided under United States Code, title 10, chapter 55;

(10) coverage provided by a health care network cooperative under chapter 62R or by a health provider cooperative under section 62R.17;

(11) a medical care program of the Indian Health Service or of a tribal organization;

(12) the federal Employees Health Benefits Plan, or other coverage provided under United States Code, title 5, chapter 89;

(13) a health benefit plan under section 5(e) of the Peace Corps Act, codified as United States Code, title 22, section 2504(e); or

(14) a plan similar to any of the above plans provided in this state or in another state as determined by the commissioner.

[For text of subd 25, see M.S.1996]

Subd. 26. **Small employer.** (a) "Small employer" means, with respect to a calendar year and a plan year, a person, firm, corporation, partnership, association, or other entity actively engaged in business, including a political subdivision of the state, that employed an average of no fewer than two nor more than 50 current employees on business days during the preceding calendar year and that employs at least two current employees on the first day of the plan year. If an employer has only one eligible employee who has not waived coverage, the sale of a health plan to or for that eligible employee is not a sale to a small employer and is not subject to this chapter and may be treated as the sale of an individual health plan. A small employer plan may be offered through a domiciled association to self–employed individuals and small employers who are members of the association, even if the self–employed individual or small employer has fewer than two current employees. Entities that are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the federal Internal Revenue Code are considered a single employer for purposes of determining the number of current employees. Small employer status must be determined on an annual basis as of the renewal date of the health benefit plan. The provisions of this chapter continue to apply to an employer who no longer meets the requirements of this definition until the annual renewal date of the employer's health benefit plan. If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based upon the average number of current employees that it is reasonably expected that the employer will employ on business days in the current calendar year. For purposes of this definition, the term employer includes any predecessor of the employer. An employer that has more than 50 current employees but has 50 or fewer employees, as "employee" is defined under United States Code, title 29, section 1002(6), is a small employer under this subdivision.

(b) Where an association, as defined in section 62L.045, comprised of employers contracts with a health carrier to provide coverage to its members who are small employers, the association and health benefit plans it provides to small employers, are subject to section 62L.045, with respect to small employers in the association, even though the association also provides coverage to its members that do not qualify as small employers.

(c) If an employer has employees covered under a trust specified in a collective bargaining agreement under the federal Labor–Management Relations Act of 1947, United States

Code, title 29, section 141, et seq., as amended, or employees whose health coverage is determined by a collective bargaining agreement and, as a result of the collective bargaining agreement, is purchased separately from the health plan provided to other employees, those employees are excluded in determining whether the employer qualifies as a small employer. Those employees are considered to be a separate small employer if they constitute a group that would qualify as a small employer in the absence of the employees who are not subject to the collective bargaining agreement.

[For text of subds 27 and 28, see M.S.1996]

Subd. 29. **Waiting period.** "Waiting period" means, with respect to an individual who is a potential enrollee under a health benefit plan, the period that must pass with respect to the individual before the individual is eligible, under the employer's eligibility requirements, for coverage under the health benefit plan.

History: *1997 c 71 art 2 s 7; 1997 c 175 art 2 s 1–9; 1997 c 225 art 2 s 62*

62L.03 AVAILABILITY OF COVERAGE.

Subdivision 1. **Guaranteed issue and reissue.** (a) Every health carrier shall, as a condition of authority to transact business in this state in the small employer market, affirmatively market, offer, sell, issue, and renew any of its health benefit plans, on a guaranteed issue basis, to any small employer that meets the participation and contribution requirements of subdivision 3, as provided in this chapter.

(b) Notwithstanding paragraph (a), a health carrier may, at the time of coverage renewal, modify the health coverage for a product offered in the small employer market if the modification is consistent with state law, approved by the commissioner, and effective on a uniform basis for all small employers purchasing that product other than through a qualified association in compliance with section 62L.045, subdivision 2.

Paragraph (a) does not apply to a health benefit plan designed for a small employer to comply with a collective bargaining agreement, provided that the health benefit plan otherwise complies with this chapter and is not offered to other small employers, except for other small employers that need it for the same reason. This paragraph applies only with respect to collective bargaining agreements entered into prior to August 21, 1996, and only with respect to plan years beginning before the later of July 1, 1997, or the date upon which the last of the collective bargaining agreements relating to the plan terminates determined without regard to any extension agreed to after August 21, 1996.

(c) Every health carrier participating in the small employer market shall make available both of the plans described in section 62L.05 to small employers and shall fully comply with the underwriting and the rate restrictions specified in this chapter for all health benefit plans issued to small employers.

(d) A health carrier may cease to transact business in the small employer market as provided under section 62L.09.

Subd. 2. **Exceptions.** (a) No health maintenance organization is required to offer coverage or accept applications under subdivision 1 in the case of the following:

(1) with respect to a small employer, where the small employer does not have eligible employees who work or reside in the health maintenance organization's approved service areas; or

(2) with respect to an employee, when the employee does not work or reside within the health maintenance organization's approved service areas.

(b) A health carrier participating in the small employer market shall not be required to offer coverage or accept applications pursuant to subdivision 1 where the commissioner finds that the acceptance of an application or applications would place the health carrier participating in the small employer market in a financially impaired condition, provided, however, that a health carrier participating in the small employer market that has not offered coverage or accepted applications pursuant to this paragraph shall not offer coverage or accept applications for any health benefit plan until 180 days following a determination by the commissioner that the health carrier is not financially impaired and that offering coverage or ac-

cepting applications under subdivision 1 would not cause the health carrier to become financially impaired.

Subd. 3. **Minimum participation and contribution.** (a) A small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan and that contributes at least 50 percent toward the cost of coverage of each eligible employee must be guaranteed coverage on a guaranteed issue basis from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. A health carrier must not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdivision, waiver of coverage includes only waivers due to: (1) coverage under another group health plan; (2) coverage under Medicare Parts A and B; (3) coverage under MCHA permitted under section 62E.141; or (4) coverage under medical assistance under chapter 256B or general assistance medical care under chapter 256D.

(b) If a small employer does not satisfy the contribution or participation requirements under this subdivision, a health carrier may voluntarily issue or renew individual health plans, or a health benefit plan which must fully comply with this chapter. A health carrier that provides a health benefit plan to a small employer that does not meet the contribution or participation requirements of this subdivision must maintain this information in its files for audit by the commissioner. A health carrier may not offer an individual health plan, purchased through an arrangement between the employer and the health carrier, to any employee unless the health carrier also offers the individual health plan, on a guaranteed issue basis, to all other employees of the same employer.

(c) Nothing in this section obligates a health carrier to issue coverage to a small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer. This paragraph does not apply if the small employer will meet the required participation level with respect to the new coverage.

Subd. 4. **Underwriting restrictions.** (a) Health carriers may apply underwriting restrictions to coverage for health benefit plans for small employers, including any preexisting condition limitations, only as expressly permitted under this chapter. For purposes of this section, "underwriting restrictions" means any refusal of the health carrier to issue or renew coverage, any premium rate higher than the lowest rate charged by the health carrier for the same coverage, any preexisting condition limitation, preexisting condition exclusion, or any exclusionary rider.

(b) Health carriers may collect information relating to the case characteristics and demographic composition of small employers, as well as health status and health history information about employees, and dependents of employees, of small employers.

(c) Except as otherwise authorized for late entrants, preexisting conditions may be excluded by a health carrier for a period not to exceed 12 months from the enrollment date of an eligible employee or dependent, but exclusionary riders must not be used. Late entrants may be subject to a preexisting condition limitation not to exceed 18 months from the enrollment date of the late entrant, but must not be subject to any exclusionary rider or preexisting condition exclusion. When calculating any length of preexisting condition limitation, a health carrier shall credit the time period an eligible employee or dependent was previously covered by qualifying coverage, provided that the individual maintains continuous coverage. The credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. Section 60A.082, relating to replacement of group coverage, and the rules adopted under that section apply to this chapter, and this chapter's requirements are in addition to the requirements of that section and the rules adopted under it. A health carrier shall, at the time of first issuance or renewal of a health benefit plan on or after July 1, 1993, credit against any preexisting condition limitation or exclusion permitted under this section, the time period prior to July 1, 1993, during which an eligible employee or dependent was covered by qualifying coverage, if the person has maintained continuous coverage.

(d) Health carriers shall not use pregnancy as a preexisting condition under this chapter.

Subd. 5. **Cancellations and failures to renew.** (a) No health carrier shall cancel, decline to issue, or fail to renew a health benefit plan as a result of the claim experience or health status of the persons covered or to be covered by the health benefit plan. For purposes of this subdivision, a failure to renew does not include a uniform modification of coverage at time of renewal, as described in subdivision 1.

(b) A health carrier may cancel or fail to renew a health benefit plan:

(1) for nonpayment of the required premium;

(2) for fraud or misrepresentation by the small employer with respect to eligibility for coverage or any other material fact;

(3) if the employer fails to comply with the minimum contribution percentage required under subdivision 3; or

(4) for any other reasons or grounds expressly permitted by the respective licensing laws and regulations governing a health carrier, including, but not limited to, service area restrictions imposed on health maintenance organizations under section 62D.03, subdivision 4, paragraph (m), to the extent that these grounds are not expressly inconsistent with this chapter.

(c) A health carrier may fail to renew a health benefit plan:

(1) if eligible employee participation during the preceding calendar year declines to less than 75 percent, subject to the waiver of coverage provision in subdivision 3;

(2) if the health carrier ceases to do business in the small employer market under section 62L.09; or

(3) if a failure to renew is based upon the health carrier's decision to discontinue the health benefit plan form previously issued to the small employer, but only if the health carrier permits each small employer covered under the prior form to switch to its choice of any other health benefit plan offered by the health carrier, without any underwriting restrictions that would not have been permitted for renewal purposes.

(d) A health carrier need not renew a health benefit plan, and shall not renew a small employer plan, if an employer ceases to qualify as a small employer as defined in section 62L.02. If a health benefit plan, other than a small employer plan, provides terms of renewal that do not exclude an employer that is no longer a small employer, the health benefit plan may be renewed according to its own terms. If a health carrier issues or renews a health plan to an employer that is no longer a small employer, without interruption of coverage, the health plan is subject to section 60A.082.

[For text of subd 6, see M.S.1996]

History: *1997 c 175 art 2 s 10–14*

62L.13 REINSURANCE ASSOCIATION.

[For text of subds 1 and 2, see M.S.1996]

Subd. 3. **Exemptions.** The association, its transactions, and all property owned by it are exempt from taxation under the laws of this state or any of its subdivisions, including, but not limited to, income tax, sales tax, use tax, and property tax. The association may seek exemption from payment of all fees and taxes levied by the federal government. Except as otherwise provided in this chapter, the association is not subject to the provisions of chapters 13, 60A, 62A to 62H, and section 471.705. The association is not a public employer and is not subject to the provisions of chapters 179A and 353. The board of directors and health carriers who are members of the association are exempt from sections 325D.49 to 325D.66 in the performance of their duties as directors and members of the association.

[For text of subds 4 and 5, see M.S.1996]

History: *1997 c 187 art 3 s 17*