

**SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION**

S.F. No. 1486

(SENATE AUTHORS: BOLDON)

DATE	D-PG	OFFICIAL STATUS
02/09/2023	758	Introduction and first reading Referred to Health and Human Services
02/21/2023	993	Withdrawn and re-referred to Commerce and Consumer Protection
03/22/2023		Comm report: To pass as amended Second reading

1.1 A bill for an act

1.2 relating to insurance; health; prohibiting preexisting condition limitations in

1.3 Medicare supplement insurance policies; amending Minnesota Statutes 2022,

1.4 sections 62A.31, subdivisions 1f, 1h, 1p, 1u, 4, 8; 62A.43, subdivision 1; 62A.44,

1.5 subdivision 2; repealing Minnesota Statutes 2022, section 62A.31, subdivisions

1.6 1b, 1i.

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

1.8 Section 1. Minnesota Statutes 2022, section 62A.31, subdivision 1f, is amended to read:

1.9 Subd. 1f. **Suspension based on entitlement to medical assistance.** (a) The policy or

1.10 certificate must provide that benefits and premiums under the policy or certificate shall be

1.11 suspended for any period that may be provided by federal regulation at the request of the

1.12 policyholder or certificate holder for the period, not to exceed 24 months, in which the

1.13 policyholder or certificate holder has applied for and is determined to be entitled to medical

1.14 assistance under title XIX of the Social Security Act, but only if the policyholder or certificate

1.15 holder notifies the issuer of the policy or certificate within 90 days after the date the

1.16 individual becomes entitled to this assistance.

1.17 (b) If suspension occurs and if the policyholder or certificate holder loses entitlement

1.18 to this medical assistance, the policy or certificate shall be automatically reinstated, effective

1.19 as of the date of termination of this entitlement, if the policyholder or certificate holder

1.20 provides notice of loss of the entitlement within 90 days after the date of the loss and pays

1.21 the premium attributable to the period, effective as of the date of termination of entitlement.

1.22 (c) The policy must provide that upon reinstatement (1) there is no ~~additional~~ waiting

1.23 period with respect to treatment of preexisting conditions, (2) coverage is provided which

1.24 is substantially equivalent to coverage in effect before the date of the suspension. If the

2.1 suspended policy provided coverage for outpatient prescription drugs, reinstatement of the
2.2 policy for Medicare Part D enrollees must be without coverage for outpatient prescription
2.3 drugs and must otherwise provide coverage substantially equivalent to the coverage in effect
2.4 before the date of suspension, and (3) premiums are classified on terms that are at least as
2.5 favorable to the policyholder or certificate holder as the premium classification terms that
2.6 would have applied to the policyholder or certificate holder had coverage not been suspended.

2.7 Sec. 2. Minnesota Statutes 2022, section 62A.31, subdivision 1h, is amended to read:

2.8 Subd. 1h. **Limitations on denials, conditions, and pricing of coverage.** No health
2.9 carrier issuing Medicare-related coverage in this state may ~~impose preexisting condition~~
2.10 ~~limitations or otherwise deny or~~ condition the issuance or effectiveness of any such coverage
2.11 available for sale in this state, nor may it discriminate in the pricing of such coverage,
2.12 because of the health status, claims experience, receipt of health care, medical condition,
2.13 or age of an applicant where an application for such coverage is submitted prior to or during
2.14 the six-month period beginning with the first day of the month in which an individual first
2.15 enrolled for benefits under Medicare Part B. This subdivision applies to each
2.16 Medicare-related coverage offered by a health carrier regardless of whether the individual
2.17 has attained the age of 65 years. If an individual who is enrolled in Medicare Part B due to
2.18 disability status is involuntarily disenrolled due to loss of disability status, the individual is
2.19 eligible for another six-month enrollment period provided under this subdivision beginning
2.20 the first day of the month in which the individual later becomes eligible for and enrolls
2.21 again in Medicare Part B. An individual who is or was previously enrolled in Medicare Part
2.22 B due to disability status is eligible for another six-month enrollment period under this
2.23 subdivision beginning the first day of the month in which the individual has attained the
2.24 age of 65 years and either maintains enrollment in, or enrolls again in, Medicare Part B. If
2.25 an individual enrolled in Medicare Part B voluntarily disenrolls from Medicare Part B
2.26 because the individual becomes enrolled under an employee welfare benefit plan, the
2.27 individual is eligible for another six-month enrollment period, as provided in this subdivision,
2.28 beginning the first day of the month in which the individual later becomes eligible for and
2.29 enrolls again in Medicare Part B.

2.30 Sec. 3. Minnesota Statutes 2022, section 62A.31, subdivision 1p, is amended to read:

2.31 Subd. 1p. **Renewal or continuation provisions.** Medicare supplement policies and
2.32 certificates shall include a renewal or continuation provision. The language or specifications
2.33 of the provision shall be consistent with the type of contract issued. The provision shall be
2.34 appropriately captioned and shall appear on the first page of the policy or certificate, and

3.1 shall include any reservation by the issuer of the right to change premiums. Except for riders
3.2 or endorsements by which the issuer effectuates a request made in writing by the insured,
3.3 exercises a specifically reserved right under a Medicare supplement policy or certificate,
3.4 or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all
3.5 riders or endorsements added to a Medicare supplement policy or certificate after the date
3.6 of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the
3.7 policy or certificate shall require a signed acceptance by the insured. After the date of policy
3.8 or certificate issue, a rider or endorsement that increases benefits or coverage with a
3.9 concomitant increase in premium during the policy or certificate term shall be agreed to in
3.10 writing and signed by the insured, unless the benefits are required by the minimum standards
3.11 for Medicare supplement policies or if the increased benefits or coverage is required by
3.12 law. Where a separate additional premium is charged for benefits provided in connection
3.13 with riders or endorsements, the premium charge shall be set forth in the policy, declaration
3.14 page, or certificate. ~~If a Medicare supplement policy or certificate contains limitations with~~
3.15 ~~respect to preexisting conditions, the limitations shall appear as a separate paragraph of the~~
3.16 ~~policy or certificate and be labeled as "preexisting condition limitations."~~

3.17 Issuers of accident and sickness policies or certificates that provide hospital or medical
3.18 expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare
3.19 shall provide to those applicants a "Guide to Health Insurance for People with Medicare"
3.20 in the form developed by the Centers for Medicare and Medicaid Services and in a type
3.21 size no smaller than 12-point type. Delivery of the guide must be made whether or not such
3.22 policies or certificates are advertised, solicited, or issued as Medicare supplement policies
3.23 or certificates as defined in this section and section 62A.3099. Except in the case of direct
3.24 response issuers, delivery of the guide must be made to the applicant at the time of
3.25 application, and acknowledgment of receipt of the guide must be obtained by the issuer.
3.26 Direct response issuers shall deliver the guide to the applicant upon request, but no later
3.27 than the time at which the policy is delivered.

3.28 Sec. 4. Minnesota Statutes 2022, section 62A.31, subdivision 1u, is amended to read:

3.29 Subd. 1u. **Guaranteed issue for eligible persons.** (a)(1) Eligible persons are those
3.30 individuals described in paragraph (b) who seek to enroll under the policy during the period
3.31 specified in paragraph (c) and who submit evidence of the date of termination or
3.32 disenrollment described in paragraph (b), or of the date of Medicare Part D enrollment, with
3.33 the application for a Medicare supplement policy.

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

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

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

4.11 (2) the individual is enrolled with a Medicare Advantage organization under a Medicare
4.12 Advantage plan under Medicare Part C, and any of the following circumstances apply, or
4.13 the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive
4.14 Care for the Elderly (PACE) provider under section 1894 of the federal Social Security Act,
4.15 and there are circumstances similar to those described in this clause that would permit
4.16 discontinuance of the individual's enrollment with the provider if the individual were enrolled
4.17 in a Medicare Advantage plan:

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

4.21 (ii) the individual is no longer eligible to elect the plan because of a change in the
4.22 individual's place of residence or other change in circumstances specified by the secretary,
4.23 but not including termination of the individual's enrollment on the basis described in section
4.24 1851(g)(3)(B) of the federal Social Security Act, United States Code, title 42, section
4.25 1395w-21(g)(3)(b) (where the individual has not paid premiums on a timely basis or has
4.26 engaged in disruptive behavior as specified in standards under section 1856 of the federal
4.27 Social Security Act, United States Code, title 42, section 1395w-26), or the plan is terminated
4.28 for all individuals within a residence area;

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

4.31 (A) the organization offering the plan substantially violated a material provision of the
4.32 organization's contract in relation to the individual, including the failure to provide an
4.33 enrollee on a timely basis medically necessary care for which benefits are available under

5.1 the plan or the failure to provide such covered care in accordance with applicable quality
5.2 standards; or

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

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

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

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

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

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

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

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

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

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

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

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

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

5.25 (5)(i) the individual was enrolled under a Medicare supplement policy and terminates
5.26 that enrollment and subsequently enrolls, for the first time, with any Medicare Advantage
5.27 organization under a Medicare Advantage plan under Medicare Part C; any eligible
5.28 organization under a contract under section 1876 of the federal Social Security Act, United
5.29 States Code, title 42, section 1395mm (Medicare cost); any similar organization operating
5.30 under demonstration project authority; any PACE provider under section 1894 of the federal

6.1 Social Security Act, or a Medicare Select policy under section 62A.318 or the similar law
6.2 of another state; and

6.3 (ii) the subsequent enrollment under item (i) is terminated by the enrollee during any
6.4 period within the first 12 months of the subsequent enrollment during which the enrollee
6.5 is permitted to terminate the subsequent enrollment under section 1851(e) of the federal
6.6 Social Security Act;

6.7 (6) the individual, upon first enrolling for benefits under Medicare Part B, enrolls in a
6.8 Medicare Advantage plan under Medicare Part C, or with a PACE provider under section
6.9 1894 of the federal Social Security Act, and disenrolls from the plan by not later than 12
6.10 months after the effective date of enrollment; or

6.11 (7) the individual enrolls in a Medicare Part D plan during the initial Part D enrollment
6.12 period, as defined under United States Code, title 42, section 1395ss(v)(6)(D), and, at the
6.13 time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers
6.14 outpatient prescription drugs and the individual terminates enrollment in the Medicare
6.15 supplement policy and submits evidence of enrollment in Medicare Part D along with the
6.16 application for a policy described in paragraph (e), clause (4).

6.17 (c)(1) In the case of an individual described in paragraph (b), clause (1), the guaranteed
6.18 issue period begins on the later of: (i) the date the individual receives a notice of termination
6.19 or cessation of all supplemental health benefits or, if a notice is not received, notice that a
6.20 claim has been denied because of a termination or cessation; or (ii) the date that the applicable
6.21 coverage terminates or ceases; and ends 63 days after the later of those two dates.

6.22 (2) In the case of an individual described in paragraph (b), clause (2), (3), (5), or (6),
6.23 whose enrollment is terminated involuntarily, the guaranteed issue period begins on the
6.24 date that the individual receives a notice of termination and ends 63 days after the date the
6.25 applicable coverage is terminated.

6.26 (3) In the case of an individual described in paragraph (b), clause (4), item (i), the
6.27 guaranteed issue period begins on the earlier of: (i) the date that the individual receives a
6.28 notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar
6.29 notice if any; and (ii) the date that the applicable coverage is terminated, and ends on the
6.30 date that is 63 days after the date the coverage is terminated.

6.31 (4) In the case of an individual described in paragraph (b), clause (2), (4), (5), or (6),
6.32 who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days
6.33 before the effective date of the disenrollment and ends on the date that is 63 days after the
6.34 effective date.

7.1 (5) In the case of an individual described in paragraph (b), clause (7), the guaranteed
7.2 issue period begins on the date the individual receives notice pursuant to section
7.3 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the
7.4 60-day period immediately preceding the initial Part D enrollment period and ends on the
7.5 date that is 63 days after the effective date of the individual's coverage under Medicare Part
7.6 D.

7.7 (6) In the case of an individual described in paragraph (b) but not described in this
7.8 paragraph, the guaranteed issue period begins on the effective date of disenrollment and
7.9 ends on the date that is 63 days after the effective date.

7.10 (d)(1) In the case of an individual described in paragraph (b), clause (5), or deemed to
7.11 be so described, pursuant to this paragraph, whose enrollment with an organization or
7.12 provider described in paragraph (b), clause (5), item (i), is involuntarily terminated within
7.13 the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with
7.14 another such organization or provider, the subsequent enrollment is deemed to be an initial
7.15 enrollment described in paragraph (b), clause (5).

7.16 (2) In the case of an individual described in paragraph (b), clause (6), or deemed to be
7.17 so described, pursuant to this paragraph, whose enrollment with a plan or in a program
7.18 described in paragraph (b), clause (6), is involuntarily terminated within the first 12 months
7.19 of enrollment, and who, without an intervening enrollment, enrolls in another such plan or
7.20 program, the subsequent enrollment is deemed to be an initial enrollment described in
7.21 paragraph (b), clause (6).

7.22 (3) For purposes of paragraph (b), clauses (5) and (6), no enrollment of an individual
7.23 with an organization or provider described in paragraph (b), clause (5), item (i), or with a
7.24 plan or in a program described in paragraph (b), clause (6), may be deemed to be an initial
7.25 enrollment under this paragraph after the two-year period beginning on the date on which
7.26 the individual first enrolled with the organization, provider, plan, or program.

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

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

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

8.1 December 31, 2005, if the individual was most recently enrolled in a Medicare supplement
8.2 policy with an outpatient prescription drug benefit, a Medicare supplement policy to which
8.3 the individual is entitled under paragraph (b), clause (5), is:

8.4 (i) the policy available from the same issuer but modified to remove outpatient
8.5 prescription drug coverage; or

8.6 (ii) at the election of the policyholder, a policy described in clause (4), except that the
8.7 policy may be one that is offered and available for issuance to new enrollees that is offered
8.8 by any issuer;

8.9 (3) paragraph (b), clause (6), is any Medicare supplement policy offered by any issuer;

8.10 (4) paragraph (b), clause (7), is a Medicare supplement policy that has a benefit package
8.11 classified as a basic plan under section 62A.316 if the enrollee's existing Medicare
8.12 supplement policy is a basic plan or, if the enrollee's existing Medicare supplement policy
8.13 is an extended basic plan under section 62A.315, a basic or extended basic plan at the option
8.14 of the enrollee, provided that the policy is offered and is available for issuance to new
8.15 enrollees by the same issuer that issued the individual's Medicare supplement policy with
8.16 outpatient prescription drug coverage. The issuer must permit the enrollee to retain all
8.17 optional benefits contained in the enrollee's existing coverage, other than outpatient
8.18 prescription drugs, subject to the provision that the coverage be offered and available for
8.19 issuance to new enrollees by the same issuer.

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

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

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

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

9.6 Sec. 5. Minnesota Statutes 2022, section 62A.31, subdivision 4, is amended to read:

9.7 Subd. 4. **Prohibited policy provisions.** (a) A Medicare supplement policy or certificate
 9.8 in force in the state shall not contain benefits that duplicate benefits provided by Medicare
 9.9 or contain exclusions on coverage that are more restrictive than those of Medicare.
 9.10 Duplication of benefits is permitted to the extent permitted under subdivision 1s, paragraph
 9.11 (a), for benefits provided by Medicare Part D.

9.12 (b) No Medicare supplement policy or certificate may use waivers to exclude, limit, or
 9.13 reduce coverage or benefits for specifically named or described preexisting diseases or
 9.14 physical conditions, ~~except as permitted under subdivision 1b.~~

9.15 Sec. 6. Minnesota Statutes 2022, section 62A.31, subdivision 8, is amended to read:

9.16 Subd. 8. **Prohibition against use of genetic information and requests for genetic**
 9.17 **information.** This subdivision applies to all policies with policy years beginning on or after
 9.18 May 21, 2009.

9.19 (a) An issuer of a Medicare supplement policy or certificate:

9.20 (1) shall not deny or condition the issuance or effectiveness of the policy or certificate,
 9.21 ~~including the imposition of any exclusion of benefits under the policy based on a preexisting~~
 9.22 ~~condition,~~ on the basis of the genetic information with respect to such individual; and

9.23 (2) shall not discriminate in the pricing of the policy or certificate, including the
 9.24 adjustment of premium rates, of an individual on the basis of the genetic information with
 9.25 respect to such individual.

9.26 (b) Nothing in paragraph (a) shall be construed to limit the ability of an issuer, to the
 9.27 extent otherwise permitted by law, from:

9.28 (1) denying or conditioning the issuance or effectiveness of the policy or certificate or
 9.29 increasing the premium for a group based on the manifestation of a disease or disorder of
 9.30 an insured or applicant; or

10.1 (2) increasing the premium for any policy issued to an individual based on the
10.2 manifestation of a disease or disorder of an individual who is covered under the policy. In
10.3 such case, the manifestation of a disease or disorder in one individual cannot also be used
10.4 as genetic information about other group members and to further increase the premium for
10.5 the group.

10.6 (c) An issuer of a Medicare supplement policy or certificate shall not request or require
10.7 an individual or a family member of such individual to undergo a genetic test.

10.8 (d) Paragraph (c) shall not be construed to preclude an issuer of a Medicare supplement
10.9 policy or certificate from obtaining and using the results of a genetic test in making a
10.10 determination regarding payment, as defined for the purposes of applying the regulations
10.11 promulgated under Part C of title XI and section 264 of the Health Insurance Portability
10.12 and Accountability Act of 1996 as they may be revised from time to time, and consistent
10.13 with paragraph (a).

10.14 (e) For purposes of carrying out paragraph (d), an issuer of a Medicare supplement policy
10.15 or certificate may request only the minimum amount of information necessary to accomplish
10.16 the intended purpose.

10.17 (f) Notwithstanding paragraph (c), an issuer of a Medicare supplement policy may
10.18 request, but not require, that an individual or a family member of such individual undergo
10.19 a genetic test if each of the following conditions are met:

10.20 (1) the request is made pursuant to research that complies with Code of Federal
10.21 Regulations, title 45, part 46, or equivalent federal regulations, and any applicable state or
10.22 local law or regulations for the protection of human subjects in research;

10.23 (2) the issuer clearly indicates to each individual, or in the case of a minor child, to the
10.24 legal guardian of such child, to whom the request is made that:

10.25 (i) compliance with the request is voluntary; and

10.26 (ii) noncompliance will have no effect on enrollment status or premium or contribution
10.27 amounts;

10.28 (3) no genetic information collected or acquired under this paragraph shall be used for
10.29 underwriting, determination of eligibility to enroll or maintain enrollment status, premium
10.30 rates, or the issuance, renewal, or replacement of a policy or certificate;

10.31 (4) the issuer notifies the secretary in writing that the issuer is conducting activities
10.32 pursuant to the exception provided for under this paragraph, including a description of the
10.33 activities conducted; and

11.1 (5) the issuer complies with such other conditions as the secretary may by regulation
11.2 require for activities under this paragraph.

11.3 (g) An issuer of a Medicare supplement policy or certificate shall not request, require,
11.4 or purchase genetic information for underwriting purposes.

11.5 (h) An issuer of a Medicare supplement policy or certificate shall not request, require,
11.6 or purchase genetic information with respect to any individual prior to such individual's
11.7 enrollment under the policy in connection with such enrollment.

11.8 (i) An issuer of a Medicare supplement policy or certificate that obtains genetic
11.9 information incidental to the requesting, requiring, or purchasing of other information
11.10 concerning any individual, such request, requirement, or purchase shall not be considered
11.11 a violation of paragraph (h) if such request, requirement, or purchase is not in violation of
11.12 paragraph (g).

11.13 (j) For purposes of this subdivision only:

11.14 (1) "family member" means, with respect to an individual, any other individual who is
11.15 a first-degree, second-degree, third-degree, or fourth-degree relative of such individual;

11.16 (2) "genetic information" means, with respect to any individual, information about such
11.17 individual's genetic tests, the genetic test of family members of such individual, and the
11.18 manifestation of a disease or disorder in family members of such individual. Such terms
11.19 include, with respect to any individual, any request for, or receipt of, genetic services, or
11.20 participation in clinical research that includes genetic services, by such individual or any
11.21 family member of such individual. Any reference to genetic information concerning an
11.22 individual or family member of an individual who is a pregnant woman, includes genetic
11.23 information of any fetus carried by such pregnant woman, or with respect to an individual
11.24 or family member utilizing reproductive technology, includes genetic information of any
11.25 embryo legally held by an individual or family member. The term genetic information does
11.26 not include information about the sex or age of any individual;

11.27 (3) "genetic services" means a genetic test or genetic counseling, including obtaining,
11.28 interpreting, or assessing genetic information or genetic education;

11.29 (4) "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or
11.30 metabolites, that detect genotypes, mutations, or chromosomal changes. The term genetic
11.31 test does not mean an analysis of proteins or metabolites that does not detect genotypes,
11.32 mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly
11.33 related to a manifested disease, disorder, or pathological condition that could reasonably

12.1 be detected by a health care professional with appropriate training and expertise in the field
12.2 of medicine involved;

12.3 (5) "issuer of a Medicare supplement policy or certificate" includes a third-party
12.4 administrator or other person acting for or on behalf of such issuer; and

12.5 (6) "underwriting purposes" means:

12.6 (i) rules for, or determination of, eligibility including enrollment and continued eligibility,
12.7 for benefits under the policy;

12.8 (ii) the computation of premium or contribution amounts under the policy; and

12.9 (iii) ~~the application of any preexisting condition exclusion under the policy; and~~

12.10 ~~(iv)~~ other activities related to the creation, renewal, or replacement of a contract of health
12.11 insurance or health benefits.

12.12 Sec. 7. Minnesota Statutes 2022, section 62A.43, subdivision 1, is amended to read:

12.13 Subdivision 1. **Duplicate coverage prohibited.** No agent shall sell a Medicare
12.14 supplement plan, as defined in section 62A.3099, to a person who currently has one plan
12.15 in effect; however, an agent may sell a replacement plan in accordance with section 62A.40,
12.16 ~~provided that the second plan is not made effective any sooner than necessary to provide~~
12.17 ~~continuous benefits for preexisting conditions.~~ Every application for Medicare supplement
12.18 insurance shall require a written statement signed by the applicant listing all health and
12.19 accident insurance maintained by the applicant as of the date the application is taken and
12.20 stating whether the applicant is entitled to any medical assistance. The written statement
12.21 must be accompanied by a written acknowledgment, signed by the seller of the policy, of
12.22 the request for and receipt of the statement.

12.23 Sec. 8. Minnesota Statutes 2022, section 62A.44, subdivision 2, is amended to read:

12.24 Subd. 2. **Questions.** (a) Application forms shall include the following questions designed
12.25 to elicit information as to whether, as of the date of the application, the applicant has another
12.26 Medicare supplement or other health insurance policy or certificate in force or whether a
12.27 Medicare supplement policy or certificate is intended to replace any other accident and
12.28 sickness policy or certificate presently in force. A supplementary application or other form
12.29 to be signed by the applicant and agent containing the questions and statements may be
12.30 used.

12.31 "(1) You do not need more than one Medicare supplement policy or certificate.

13.1 (2) If you purchase this policy, you may want to evaluate your existing health coverage
13.2 and decide if you need multiple coverages.

13.3 (3) You may be eligible for benefits under Medicaid and may not need a Medicare
13.4 supplement policy or certificate.

13.5 (4) The benefits and premiums under your Medicare supplement policy or certificate
13.6 can be suspended, if requested, during your entitlement to benefits under Medicaid for
13.7 24 months. You must request this suspension within 90 days of becoming eligible for
13.8 Medicaid. If you are no longer entitled to Medicaid, your policy or certificate will be
13.9 reinstated if requested within 90 days of losing Medicaid eligibility.

13.10 (5) Counseling services may be available in Minnesota to provide advice concerning
13.11 medical assistance through state Medicaid, Qualified Medicare Beneficiaries (QMBs),
13.12 and Specified Low-Income Medicare Beneficiaries (SLMBs).

13.13 To the best of your knowledge:

13.14 (1) Do you have another Medicare supplement policy or certificate in force?

13.15 (a) If so, with which company?

13.16 (b) If so, do you intend to replace your current Medicare supplement policy with this
13.17 policy or certificate?

13.18 (2) Do you have any other health insurance policies that provide benefits which this
13.19 Medicare supplement policy or certificate would duplicate?

13.20 (a) If so, please name the company.

13.21 (b) What kind of policy?

13.22 (3) Are you covered for medical assistance through the state Medicaid program? If so,
13.23 which of the following programs provides coverage for you?

13.24 (a) Specified Low-Income Medicare Beneficiary (SLMB),

13.25 (b) Qualified Medicare Beneficiary (QMB), or

13.26 (c) full Medicaid Beneficiary?"

13.27 (b) Agents shall list any other health insurance policies they have sold to the applicant.

13.28 (1) List policies sold that are still in force.

13.29 (2) List policies sold in the past five years that are no longer in force.

14.1 (c) In the case of a direct response issuer, a copy of the application or supplemental
 14.2 form, signed by the applicant, and acknowledged by the insurer, shall be returned to the
 14.3 applicant by the insurer on delivery of the policy or certificate.

14.4 (d) Upon determining that a sale will involve replacement of Medicare supplement
 14.5 coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the
 14.6 applicant, before issuance or delivery of the Medicare supplement policy or certificate, a
 14.7 notice regarding replacement of Medicare supplement coverage. One copy of the notice
 14.8 signed by the applicant and the agent, except where the coverage is sold without an agent,
 14.9 shall be provided to the applicant and an additional signed copy shall be retained by the
 14.10 issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of
 14.11 the policy or certificate the notice regarding replacement of Medicare supplement coverage.

14.12 (e) The notice required by paragraph (d) for an issuer shall be provided in substantially
 14.13 the following form in no less than 12-point type:

14.14 "NOTICE TO APPLICANT REGARDING REPLACEMENT
 14.15 OF MEDICARE SUPPLEMENT INSURANCE

14.16 (Insurance company's name and address)

14.17 SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

14.18 According to (your application) (information you have furnished), you intend to terminate
 14.19 existing Medicare supplement insurance and replace it with a policy or certificate to be
 14.20 issued by (Company Name) Insurance Company. Your new policy or certificate will provide
 14.21 30 days within which you may decide without cost whether you desire to keep the policy
 14.22 or certificate.

14.23 You should review this new coverage carefully. Compare it with all accident and sickness
 14.24 coverage you now have. If, after due consideration, you find that purchase of this Medicare
 14.25 supplement coverage is a wise decision you should terminate your present Medicare
 14.26 supplement policy. You should evaluate the need for other accident and sickness coverage
 14.27 you have that may duplicate this policy.

14.28 STATEMENT TO APPLICANT BY ISSUER, AGENT, (BROKER OR OTHER
 14.29 REPRESENTATIVE): I have reviewed your current medical or health insurance
 14.30 coverage. To the best of my knowledge this Medicare supplement policy will not duplicate
 14.31 your existing Medicare supplement policy because you intend to terminate the existing
 14.32 Medicare supplement policy. The replacement policy or certificate is being purchased
 14.33 for the following reason(s) (check one):

- 15.1 Additional benefits
- 15.2 No change in benefits, but lower premiums
- 15.3 Fewer benefits and lower premiums
- 15.4 Other (please specify)
- 15.5
- 15.6
- 15.7

15.8 ~~(1) Health conditions which you may presently have (preexisting conditions) may not~~
 15.9 ~~be immediately or fully covered under the new policy or certificate. This could result~~
 15.10 ~~in denial or delay of a claim for benefits under the new policy or certificate, whereas a~~
 15.11 ~~similar claim might have been payable under your present policy or certificate.~~

15.12 ~~(2) State law provides that your replacement policy or certificate may not contain new~~
 15.13 ~~preexisting conditions, waiting periods, elimination periods, or probationary periods.~~
 15.14 ~~The insurer will waive any time periods applicable to preexisting conditions, waiting~~
 15.15 ~~periods, elimination periods, or probationary periods in the new policy (or coverage)~~
 15.16 ~~for similar benefits to the extent the time was spent (depleted) under the original policy~~
 15.17 ~~or certificate.~~

15.18 ~~(3) If you still wish to terminate your present policy or certificate and replace it with~~
 15.19 ~~new coverage, be certain to truthfully and completely answer all questions on the~~
 15.20 ~~application concerning your medical and health history. Failure to include all material~~
 15.21 ~~medical information on an application may provide a basis for the company to deny any~~
 15.22 ~~future claims and to refund your premium as though your policy or certificate had never~~
 15.23 ~~been in force. After the application has been completed and before you sign it, review~~
 15.24 ~~it carefully to be certain that all information has been properly recorded. (If the policy~~
 15.25 ~~or certificate is guaranteed issue, this paragraph need not appear.)~~

15.26 Do not cancel your present policy or certificate until you have received your new policy
 15.27 or certificate and you are sure that you want to keep it.

15.28
 15.29 (Signature of Agent, Broker, or Other Representative)*

15.30
 15.31 (Typed Name and Address of Issuer, Agent, or Broker)

15.32
 15.33 (Date)

15.34
 15.35 (Applicant's Signature)

16.1

16.2 (Date)

16.3 *Signature not required for direct response sales."

16.4 ~~(f) Paragraph (e), clauses (1) and (2), of the replacement notice (applicable to preexisting~~
16.5 ~~conditions) may be deleted by an issuer if the replacement does not involve application of~~
16.6 ~~a new preexisting condition limitation.~~

16.7 Sec. 9. **REPEALER.**

16.8 Minnesota Statutes 2022, section 62A.31, subdivisions 1b and 1i, are repealed.

16.9 Sec. 10. **EFFECTIVE DATE.**

16.10 Sections 1 to 9 are effective January 1, 2024, and apply to policies offered, issued, or
16.11 renewed on or after that date.

62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.

Subd. 1b. **Preexisting condition coverage.** 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.

Subd. 1i. **Replacement coverage.** If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the issuer of the replacing policy or certificate shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate for benefits to the extent the time was spent under the original policy or certificate. For purposes of this subdivision, "Medicare supplement policy or certificate" means all coverage described in section 62A.011, subdivision 3, clause (10).