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State of Minnesota
HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 4030

03/02/2020 Authored by Gruenhagen, Schultz, Liebling, Cantrell and McDonald
The bill was read for the first time and referred to the Committee on Commerce

A bill for an act

relating to health insurance; modifying Medicare supplement plans; amending Minnesota Statutes 2018, section 62A.31, subdivisions 1e, 1h; Minnesota Statutes 2019 Supplement, sections 62A.315; 62A.316; repealing Minnesota Statutes 2018, section 62A.31, subdivision 1u.

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

Section 1. Minnesota Statutes 2018, section 62A.31, subdivision 1e, is amended to read:

Subd. 1e. **Delivery of outline of coverage; policy.** An outline of coverage as provided in section 62A.39 and a copy of the policy must be delivered at the time of application and prior to payment of any premium and, except for direct response policies, an acknowledgment of receipt of this outline must be obtained from the applicant.

Sec. 2. Minnesota Statutes 2018, section 62A.31, subdivision 1h, is amended to read:

Subd. 1h. **Limitations on denials, conditions, and pricing of coverage.** No health carrier issuing Medicare-related coverage in this state may impose preexisting condition limitations or otherwise deny or condition the issuance or effectiveness of any such coverage available for sale in this state, nor may it discriminate in the pricing of such coverage, because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant ~~where an application for such coverage is submitted prior to or during the six-month period beginning with the first day of the month in which an individual first enrolled for benefits under Medicare Part B. This subdivision applies to each Medicare-related coverage offered by a health carrier regardless of whether the individual has attained the age of 65 years. If an individual who is enrolled in Medicare Part B due to disability status is involuntarily disenrolled due to loss of disability status, the individual is~~

~~eligible for another six-month enrollment period provided under this subdivision beginning the first day of the month in which the individual later becomes eligible for and enrolls again in Medicare Part B. An individual who is or was previously enrolled in Medicare Part B due to disability status is eligible for another six-month enrollment period under this subdivision beginning the first day of the month in which the individual has attained the age of 65 years and either maintains enrollment in, or enrolls again in, Medicare Part B. If an individual enrolled in Medicare Part B voluntarily disenrolls from Medicare Part B because the individual becomes enrolled under an employee welfare benefit plan, the individual is eligible for another six-month enrollment period, as provided in this subdivision, beginning the first day of the month in which the individual later becomes eligible for and enrolls again in Medicare Part B~~. Applicants must be accepted at all times throughout the year for any Medicare-related coverage offered in Minnesota. This subdivision applies to applicants enrolled in Medicare whether by reason of age or disability.

Sec. 3. Minnesota Statutes 2019 Supplement, section 62A.315, is amended to read:

62A.315 EXTENDED BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.

(a) The extended basic Medicare supplement plan must have a level of coverage so that it will be certified as a qualified plan pursuant to section 62E.07, and will provide:

(1) coverage for all of the Medicare Part A inpatient hospital deductible and coinsurance amounts, and 100 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, plus coverage for 365 days after Medicare benefits end;

(2) coverage for the daily co-payment amount of Medicare Part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, and the Medicare Part B deductible amount;

(4) 80 percent of the usual and customary hospital and medical expenses and supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation established by the Medicare program or state law, the usual and customary hospital and medical expenses and supplies, described in section 62E.06, subdivision 1, while in a foreign country; and prescription drug expenses, not covered by Medicare. An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare supplement policy or certificate issued on or after January 1, 2006;

3.1 (5) coverage for the reasonable cost of the first three pints of blood, or equivalent
3.2 quantities of packed red blood cells as defined under federal regulations under Medicare
3.3 Parts A and B, unless replaced in accordance with federal regulations;

3.4 (6) 100 percent of the cost of immunizations not otherwise covered under Part D of the
3.5 Medicare program and routine screening procedures for cancer, including mammograms
3.6 and pap smears;

3.7 (7) preventive medical care benefit: coverage for the following preventive health services
3.8 not covered by Medicare:

3.9 (i) an annual clinical preventive medical history and physical examination that may
3.10 include tests and services from clause (ii) and patient education to address preventive health
3.11 care measures;

3.12 (ii) preventive screening tests or preventive services, the selection and frequency of
3.13 which is determined to be medically appropriate by the attending physician.

3.14 Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved
3.15 amount for each service as if Medicare were to cover the service as identified in American
3.16 Medical Association current procedural terminology (AMA CPT) codes to a maximum of
3.17 $120 annually under this benefit. This benefit shall not include payment for any procedure
3.18 covered by Medicare;

3.19 (8) coverage of cost sharing for all Medicare Part A eligible hospice care and respite
3.20 care expenses; and

3.21 (9) coverage for cost sharing for Medicare Part A or B home health care services and
3.22 medical supplies.

3.23 (b) An extended basic Medicare supplement plan must provide the benefits contained
3.24 in this section, but must not provide coverage for 100 percent or any portion of the Medicare
3.25 Part B deductible to a newly eligible individual.

3.26 Sec. 4. Minnesota Statutes 2019 Supplement, section 62A.316, is amended to read:

3.27 **62A.316 BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.**

3.28 (a) The basic Medicare supplement plan must have a level of coverage that will provide:

3.29 (1) coverage for all of the Medicare Part A inpatient hospital coinsurance amounts, and
3.30 100 percent of all Medicare part A eligible expenses for hospitalization not covered by
3.31 Medicare, <u>plus coverage for 365 days after Medicare benefits end,</u> after satisfying the
3.32 Medicare Part A deductible;

4.1 (2) coverage for the daily co-payment amount of Medicare Part A eligible expenses for
4.2 the calendar year incurred for skilled nursing facility care;

4.3 (3) coverage for the coinsurance amount, or in the case of outpatient department services
4.4 paid under a prospective payment system, the co-payment amount, of Medicare eligible
4.5 expenses under Medicare Part B regardless of hospital confinement, subject to the Medicare
4.6 Part B deductible amount;

4.7 (4) 80 percent of the hospital and medical expenses and supplies incurred during travel
4.8 outside the United States as a result of a medical emergency;

4.9 (5) coverage for the reasonable cost of the first three pints of blood, or equivalent
4.10 quantities of packed red blood cells as defined under federal regulations under Medicare
4.11 Parts A and B, unless replaced in accordance with federal regulations;

4.12 (6) 100 percent of the cost of immunizations not otherwise covered under Part D of the
4.13 Medicare program and routine screening procedures for cancer screening including
4.14 mammograms and pap smears;

4.15 (7) 80 percent of coverage for all physician prescribed medically appropriate and
4.16 necessary equipment and supplies used in the management and treatment of diabetes not
4.17 otherwise covered under Part D of the Medicare program. Coverage must include persons
4.18 with gestational, type I, or type II diabetes. Coverage under this clause is subject to section
4.19 62A.3093, subdivision 2;

4.20 (8) coverage of cost sharing for all Medicare Part A eligible hospice care and respite
4.21 care expenses; and

4.22 (9) coverage for cost sharing for Medicare Part A or B home health care services and
4.23 medical supplies subject to the Medicare Part B deductible amount.

4.24 (b) The following benefit riders must be offered with this plan:

4.25 (1) coverage for all of the Medicare Part A inpatient hospital deductible amount;

4.26 (2) 100 percent of the Medicare Part B excess charges coverage for all of the difference
4.27 between the actual Medicare Part B charges as billed, not to exceed any charge limitation
4.28 established by the Medicare program or state law, and the Medicare-approved Part B charge;

4.29 (3) coverage for all of the Medicare Part B annual deductible; and

4.30 (4) preventive medical care benefit coverage for the following preventative health services
4.31 not covered by Medicare:

5.1 (i) an annual clinical preventive medical history and physical examination that may
5.2 include tests and services from item (ii) and patient education to address preventive health
5.3 care measures;

5.4 (ii) preventive screening tests or preventive services, the selection and frequency of
5.5 which is determined to be medically appropriate by the attending physician.

5.6 Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved
5.7 amount for each service, as if Medicare were to cover the service as identified in American
5.8 Medical Association current procedural terminology (AMA CPT) codes, to a maximum of
5.9 $120 annually under this benefit. This benefit shall not include payment for a procedure
5.10 covered by Medicare.

5.11 (c) A basic Medicare supplement plan must provide the benefits contained in this section,
5.12 but must not provide coverage for 100 percent or any portion of the Medicare Part B
5.13 deductible to a newly eligible individual.

5.14 Sec. 5. **REPEALER.**

5.15 Minnesota Statutes 2018, section 62A.31, subdivision 1u, is repealed.

5.16 Sec. 6. **EFFECTIVE DATE.**

5.17 Sections 1 to 5 are effective August 1, 2020, and apply to Medicare supplement plans
5.18 offered, renewed, or issued on or after that date.

62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.

Subd. 1u. **Guaranteed issue for eligible persons.** (a)(1) Eligible persons are those individuals described in paragraph (b) who seek to enroll under the policy during the period specified in paragraph (c) and who submit evidence of the date of termination or disenrollment described in paragraph (b), or of the date of Medicare Part D enrollment, 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 Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the federal Social Security Act, and there are circumstances similar to those described in this clause that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan:

(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 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 Advantage organization under a Medicare Advantage 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 cost); any similar organization operating under demonstration project authority; any PACE provider under section 1894 of the federal Social Security Act, or a Medicare Select policy under section 62A.318 or the similar law of another state; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f)(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.

(g) 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.

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