Senator ..... moves to amend the delete-everything amendment (A19-0201) to S.F. No. 2313 as follows:

Page 5, line 4, delete "section" and insert "subdivision"

Page 5, line 33, delete everything after the period

Page 6, delete lines 1 and 2

Page 6, after line 25, insert:

"(c) If an insurer or group of insurers that is exempt from the subdivision 15a requirements no longer qualifies for that exemption, it shall have one year after the year the threshold is exceeded to comply with the requirements."

Page 11, delete lines 1 and 2

Page 11, line 3, delete "(i)" and insert "(h)"

Page 17, delete subdivision 5

Renumber the subdivisions in sequence

Page 20, after line 14, insert:

"ARTICLE 5

MEDICARE SUPPLEMENT INSURANCE

Section 1. Minnesota Statutes 2018, section 62A.3099, is amended by adding a subdivision to read:

Subd. 18a. **Newly eligible individual.** "Newly eligible individual" means an individual who is eligible for Medicare on or after January 1, 2020, because the individual:

(1) has attained age 65 on or after January 2020; or

(2) although under age 65, is entitled to or deemed eligible for benefits under Medicare Part A by reason of disability or otherwise.

Sec. 2. Minnesota Statutes 2018, 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, including to supplement coverage under Medicare Advantage plans established under Medicare Part C, 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 ~~1u~~ 1v are met.

Sec. 3. Minnesota Statutes 2018, section 62A.31, is amended by adding a subdivision to read:

Subd. 1v. **Medicare Part B deductible.** A Medicare supplemental policy or certificate must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

Sec. 4. Minnesota Statutes 2018, 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;

(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;

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

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

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2018, section 62A.316, is amended to read:

62A.316 BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.

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

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

(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 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, subject to the Medicare Part B deductible amount;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 6. Minnesota Statutes 2018, section 62A.3161, is amended to read:

62A.3161 MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT COVERAGE.

(a) The Medicare supplement plan with 50 percent coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (8);

(3) coverage for 50 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (8);

(4) coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (8);

(5) coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations, until the out-of-pocket limitation is met as described in clause (8);

(6) except for coverage provided in this clause, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B, after the policyholder pays the Medicare Part B deductible, until the out-of-pocket limitation is met as described in clause (8);

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible; and

(8) coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment by the secretary of the United States Department of Health and Human Services.

(b) A Medicare supplement plan with 50 percent coverage must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

Sec. 7. Minnesota Statutes 2018, section 62A.3162, is amended to read:

62A.3162 MEDICARE SUPPLEMENT PLAN WITH 75 PERCENT COVERAGE.

(a) The basic Medicare supplement plan with 75 percent coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 75 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (8);

(3) coverage for 75 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (8);

(4) coverage for 75 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (8);

(5) coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations until the out-of-pocket limitation is met as described in clause (8);

(6) except for coverage provided in this clause, coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in clause (8);

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible; and

(8) coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2,000 in 2006, indexed each year by the appropriate inflation adjustment by the Secretary of the United States Department of Health and Human Services.

(b) A Medicare supplement plan with 75 percent coverage must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

Sec. 8. Minnesota Statutes 2018, section 62A.3163, is amended to read:

62A.3163 MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT PART A DEDUCTIBLE COVERAGE.

(a) The Medicare supplement plan with 50 percent Medicare Part A deductible coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A;

(4) coverage for cost sharing for all Medicare Part A eligible hospice and respite care expenses;

(5) coverage under Medicare Part A or B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations;

(6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B, after the policyholder pays the Medicare Part B deductible;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

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

(9) coverage for 100 percent of the Medicare Part A or B home health care services and medical supplies after the policyholder pays the Medicare Part B deductible.

(b) A Medicare supplement plan with 50 percent Part A deductible coverage must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

Sec. 9. Minnesota Statutes 2018, section 62A.3164, is amended to read:

62A.3164 MEDICARE SUPPLEMENT PLAN WITH $20 AND $50 CO-PAYMENT MEDICARE PART B COVERAGE.

(a) The Medicare supplement plan with $20 and $50 co-payment Medicare Part B coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A;

(4) coverage for the cost sharing for all Medicare Part A eligible hospice and respite care expenses;

(5) coverage for Medicare Part A or B of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations;

(6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B except for the lesser of $20 or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit and the lesser of $50 or the Medicare Part B coinsurance or co-payment for each covered emergency room visit; however, this co-payment

shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

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

(9) coverage for Medicare Part A or B home health care services and medical supplies after the policyholder pays the Medicare Part B deductible.

(b) A Medicare supplement plan with $20 and $50 co-payment Medicare Part B coverage must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual. No portion of the co-payment referenced in this paragraph may be applied to a Medicare Part B deductible.

Sec. 10. Minnesota Statutes 2018, section 62A.3165, is amended to read:

62A.3165 MEDICARE SUPPLEMENT PLAN WITH HIGH DEDUCTIBLE COVERAGE.

(a) The Medicare supplement plan will pay 100 percent coverage upon payment of the annual high deductible. The annual deductible shall consist of out-of-pocket expenses, other than premiums, for services covered. This plan must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for 100 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A;

(4) coverage for 100 percent of cost sharing for all Medicare Part A eligible expenses and respite care;

(5) coverage for 100 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations;

(6) except for coverage provided in this clause, coverage for 100 percent of the cost sharing otherwise applicable under Medicare Part B;

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible;

(8) coverage of 100 percent of the hospital and medical expenses and supplies incurred during travel outside of the United States as a result of a medical emergency;

(9) coverage for 100 percent of Medicare Part A and B home health care services and medical supplies; and

(10) the basis for the deductible shall be $1,860 and shall be adjusted annually from 2010 by the secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

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

Sec. 11. Minnesota Statutes 2018, section 62A.318, subdivision 17, is amended to read:

Subd. 17. **Types of plans.** (a) Medicare select policies and certificates offered by the issuer must provide the coverages specified in sections 62A.315 to 62A.3165. Before a Medicare select policy or certificate is sold or issued in this state, the applicant must be provided with an explanation of coverage for each of the coverages specified in sections 62A.315 to 62A.3165 and must be provided with the opportunity of purchasing such coverage if offered by the issuer. The basic plan may also include any of the optional benefit riders authorized by section 62A.316. Preventive care provided by Medicare select policies or certificates must be provided as set forth in section 62A.315 or 62A.316, except that the benefits are as defined in chapter 62D.

(b) Medicare select policies and certificates must provide the benefits contained in this section, but must not provide coverage for 100 percent or any portion of the Medicare Part B deductible to a newly eligible individual.

Sec. 12. Minnesota Statutes 2018, section 62E.07, is amended to read:

62E.07 QUALIFIED MEDICARE SUPPLEMENT PLAN.

(a) Any plan which provides benefits may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 100 percent of the deductibles required under Medicare, with exclusion under paragraph (b) for any part of the Medicare Part B deductible, and 80 percent of the charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by Medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services.

(b) Any plan sold or issued to a newly eligible individual, as defined in section 62A.3099, subdivision 18a, that provides benefits may be certified as a qualified Medicare supplemental plan if the plan is designed to supplement Medicare and provides coverage of 100 percent of the deductibles, with the exception of coverage of:

(1) 100 percent or any portion of the Medicare Part B deductible; and

(2) 80 percent of the charges for covered services, as provided under section 62E.06, subdivision 6, that are charges not paid by Medicare.

The coverage must include a $1,000 per person limitation on total annual out-of-pocket expenses for the covered services.

Sec. 13. **EFFECTIVE DATE.**

Sections 1 to 12 are effective the day following final enactment. The coverage requirements provided by this act in sections 1 to 12 apply to Medicare supplemental policies or certificates sold or issued on or after January 1, 2020, to a newly eligible individual."

Amend the title accordingly