Sec. 2. **EFFECTIVE DATE.**

Section 1 is effective on the day following final enactment.

Presented to the governor March 16, 1998

Signed by the governor March 18, 1998, 10:09 a.m.

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## CHAPTER 292—S.F.No. 2574

*An act relating to regional development commissions; authorizing the headwaters regional development commission to establish a nonprofit housing corporation; proposing coding for new law in Minnesota Statutes, chapter 462.*

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

Section 1. **[462.3912] REGIONAL HOUSING DEVELOPMENT.**

The headwaters regional development commission may establish a not–for–profit corporation for the purposes of increasing the supply of affordable housing and improving opportunities for home ownership in development region two. The not–for–profit corporation may, among other things, acquire land, accept grant and loan funds from the state and federal governments, construct and rehabilitate housing units, and sell or manage housing in the region.

Presented to the governor March 16, 1998

Signed by the governor March 18, 1998, 11:10 a.m.

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## CHAPTER 293—S.F.No. 2608

*An act relating to insurance; providing basic Medicare supplement plan coverage for diabetes equipment and supplies; increasing the maximum lifetime benefit for policies of the comprehensive health insurance plan; amending Minnesota Statutes 1996, section 62E.12; and Minnesota Statutes 1997 Supplement, section 62A.316.*

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

Section 1. Minnesota Statutes 1997 Supplement, 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 copayment amount of Medicare part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the copayment 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; ~~and~~

(6) 100 percent of the cost of immunizations and routine screening procedures for cancer screening including mammograms and pap smears; and

(7) 80 percent of coverage for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes. Coverage must include persons with gestational, type I, or type II diabetes.

(b) Only the following optional benefit riders may be added to this plan:

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

(2) a minimum of 80 percent of eligible medical expenses and supplies not covered by Medicare part B, not to exceed any charge limitation established by the Medicare program or state law;

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

(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses;

(5) coverage for the following preventive health services:

(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) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) fecal occult blood test and/or digital rectal examination;

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(C) pure tone (air only) hearing screening test, administered or ordered by a physician;

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

(iii) any other tests or preventive measures determined 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;

(6) coverage for services to provide short–term at–home assistance with activities of daily living for those recovering from an illness, injury, or surgery:

(i) For purposes of this benefit, the following definitions apply:

(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self–administered, and changing bandages or other dressings;

(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aid, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "at–home recovery visit" means the period of a visit required to provide at–home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24–hour period of services provided by a care provider is one visit;

(ii) Coverage requirements and limitations:

(A) at–home recovery services provided must be primarily services that assist in activities of daily living;

(B) the insured's attending physician must certify that the specific type and frequency of at–home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) coverage is limited to:

(I) no more than the number and type of at–home recovery visits certified as necessary by the insured's attending physician. The total number of at–home recovery visits shall not exceed the number of Medicare–approved home care visits under a Medicare–approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at–home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit;

(iii) Coverage is excluded for:

(A) home care visits paid for by Medicare or other government programs; and

(B) care provided by family members, unpaid volunteers, or providers who are not care providers;

(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses to a maximum of $1,200 paid by the issuer annually under this benefit. An issuer of Medicare supplement insurance policies that elects to offer this benefit rider shall also make available coverage that contains the rider specified in clause (4).

Sec. 2. Minnesota Statutes 1996, section 62E.12, is amended to read:

62E.12 **MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLAN.**

The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan and a number two qualified plan, except that the maximum lifetime benefit on these plans shall be ~~$1,500,000~~ $2,000,000, and an extended basic plan and a basic Medicare plan as described in sections 62A.31 to 62A.44 and 62E.07. The requirement that a policy issued by the association must be a qualified plan is satisfied if the association contracts with a preferred provider network and the level of benefits for services provided within the network satisfies the requirements of a qualified plan. If the association uses a preferred provider network, payments to nonparticipating providers must meet the minimum requirements of section 72A.20, subdivision 15. They shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier. Notwithstanding the provisions of section 62E.06 and unless those charges are billed by a provider that is part of the association's preferred provider network, the state plan shall exclude coverage of services of a private duty nurse other than on an inpatient basis and any charges for treatment in a hospital located outside of the state of Minnesota in which the covered person is receiving treatment for a mental or nervous disorder, unless similar treatment for the mental or nervous disorder is medically necessary, unavailable in Minnesota and provided upon referral by a licensed Minnesota medical practitioner.

Sec. 3. **EFFECTIVE DATE.**

Section 1 is effective for policies issued or renewed after January 1, 1999. Section 2 is effective the day following final enactment.

Presented to the governor March 16, 1998

Signed by the governor March 18, 1998, 11:12 a.m.

**New language is indicated by underline, deletions by ~~strikeout.~~**