

This Document can be made available in alternative formats upon request

State of Minnesota

Printed Page No. 125

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 2051

- 03/04/2019 Authored by Elkins and Halverson
The bill was read for the first time and referred to the Committee on Commerce
- 03/20/2019 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time
- 03/28/2019 By motion, re-referred to Judiciary Finance and Civil Law Division
- 04/04/2019 Adoption of Report: Placed on the General Register as Amended
Pursuant to Joint Rule 2.03, re-referred to the Committee on Rules and Legislative Administration
- 04/10/2019 Adoption of Report: Placed on the General Register
Read for the Second Time
- 05/09/2019 Referred to the Chief Clerk for Comparison with S. F. No. 2313
- 05/10/2019 Postponed Indefinitely

1.1 A bill for an act

1.2 relating to insurance; making changes to conform with certain model regulations;

1.3 making federally conforming changes to supplemental Medicare coverage;

1.4 amending Minnesota Statutes 2018, sections 60A.1291, subdivisions 1, 15, by

1.5 adding a subdivision; 60A.51, by adding a subdivision; 60A.52, subdivision 1;

1.6 60D.15, by adding subdivisions; 62A.3099, by adding a subdivision; 62A.31,

1.7 subdivision 1, by adding a subdivision; 62A.315; 62A.316; 62A.3161; 62A.3162;

1.8 62A.3163; 62A.3164; 62A.3165; 62A.318, subdivision 17; 62E.07; proposing

1.9 coding for new law in Minnesota Statutes, chapters 60A; 60D.

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

1.11 ARTICLE 1

1.12 ANNUAL FINANCIAL REPORTING AND AUDIT

1.13 Section 1. Minnesota Statutes 2018, section 60A.1291, subdivision 1, is amended to read:

1.14 Subdivision 1. **Definitions.** The definitions in this subdivision apply to this section.

1.15 (a) "Accountant" and "independent public accountant" mean an independent certified

1.16 public accountant or accounting firm in good standing with the American Institute of Certified

1.17 Public Accountants and in all states in which the accountant or firm is licensed or is required

1.18 to be licensed to practice. For Canadian and British companies, the term means a

1.19 Canadian-chartered or British-chartered accountant.

1.20 (b) "Affiliate" or "affiliated" means a person that directly or indirectly through one or

1.21 more intermediaries controls, is controlled by, or is under common control with a person.

1.22 ~~(b)~~ (c) "Audit committee" means a committee or equivalent body established by the

1.23 board of directors of an entity for the purpose of overseeing the accounting and financial

1.24 reporting processes of an insurer or group of insurers, ~~and~~ the internal audit function of an

2.1 insurer or group of insurers, if applicable, and external audits of financial statements of the
2.2 insurer or group of insurers. The audit committee of any entity that controls a group of
2.3 insurers may be deemed to be the audit committee for one or more of these controlled
2.4 insurers solely for the purposes of this section at the election of the controlling person under
2.5 subdivision 15, paragraph (e). If an audit committee is not designated by the insurer, the
2.6 insurer's entire board of directors constitutes the audit committee.

2.7 (d) "Audited financial report" means the report described in subdivision 4.

2.8 ~~(e)~~ (e) "Indemnification" means an agreement of indemnity or a release from liability
2.9 where the intent or effect is to shift or limit in any manner the potential liability of the person
2.10 or firm for failure to adhere to applicable auditing or professional standards, whether or not
2.11 resulting in part from knowing of other misrepresentations made by the insurer or its
2.12 representatives.

2.13 ~~(d)~~ (f) "Independent board member" has the same meaning as described in subdivision
2.14 15, paragraph (c).

2.15 (g) "Internal audit function" means a person or persons that provide independent, objective
2.16 and reasonable assurance designed to add value and improve an organization's operations
2.17 and accomplish its objectives by bringing a systematic, disciplined approach to evaluate
2.18 and improve the effectiveness of risk management, control, and governance processes.

2.19 ~~(e)~~ (h) "Internal control over financial reporting" means a process effected by an entity's
2.20 board of directors, management, and other personnel designed to provide reasonable
2.21 assurance regarding the reliability of the financial statements, for example, those items
2.22 specified in subdivision 4, paragraphs (a), clauses (2) to (6), (b), and (c), and includes those
2.23 policies and procedures that:

2.24 (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly
2.25 reflect the transactions and dispositions of assets;

2.26 (2) provide reasonable assurance that transactions are recorded as necessary to permit
2.27 preparation of the financial statements, for example, those items specified in subdivision 4,
2.28 paragraphs (a), clauses (2) to (6), (b), and (c), and that receipts and expenditures are being
2.29 made only in accordance with authorizations of management and directors; and

2.30 (3) provide reasonable assurance regarding prevention or timely detection of unauthorized
2.31 acquisition, use, or disposition of assets that could have a material effect on the financial
2.32 statements, for example, those items specified in subdivision 4, paragraphs (a), clauses (2)
2.33 to (6), (b), and (c).

3.1 ~~(f)~~ (i) "SEC" means the United States Securities and Exchange Commission.

3.2 ~~(g)~~ (j) "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the
3.3 SEC's rules and regulations promulgated under it.

3.4 ~~(h)~~ (k) "Section 404 report" means management's report on "internal control over financial
3.5 reporting" as defined by the SEC and the related attestation report of the independent certified
3.6 public accountant as described in paragraph (a).

3.7 ~~(i)~~ (l) "SOX compliant entity" means an entity that either is required to be compliant
3.8 with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley
3.9 Act of 2002: (i) the preapproval requirements of Section 201 (section 10A(i) of the Securities
3.10 Exchange Act of 1934); (ii) the audit committee independence requirements of Section 301
3.11 (section 10A(m)(3) of the Securities Exchange Act of 1934); and (iii) the internal control
3.12 over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

3.13 Sec. 2. Minnesota Statutes 2018, section 60A.1291, subdivision 15, is amended to read:

3.14 Subd. 15. **Requirements for audit committee.** (a) The audit committee must be directly
3.15 responsible for the appointment, compensation, and oversight of the work of any accountant
3.16 including resolution of disagreements between management and the accountant regarding
3.17 financial reporting for the purpose of preparing or issuing the audited financial report or
3.18 related work pursuant to this section. Each accountant shall report directly to the audit
3.19 committee.

3.20 (b) The audit committee of an insurer or group of insurers is responsible for overseeing
3.21 the insurer's internal audit function and granting the person or persons performing the
3.22 function suitable authority and resources to fulfill their responsibilities if required by
3.23 subdivision 15a.

3.24 ~~(b)~~ (c) Each member of the audit committee must be a member of the board of directors
3.25 of the insurer or a member of the board of directors of an entity elected pursuant to paragraph
3.26 ~~(e)~~ (f) and subdivision 1, paragraph ~~(b)~~ (c).

3.27 ~~(e)~~ (d) In order to be considered independent for purposes of this section, a member of
3.28 the audit committee may not, other than in his or her capacity as a member of the audit
3.29 committee, the board of directors, or any other board committee, accept any consulting,
3.30 advisory, or other compensatory fee from the entity or be an affiliated person of the entity
3.31 or any subsidiary of the entity. However, if law requires board participation by otherwise
3.32 nonindependent members, that law shall prevail and such members may participate in the

4.1 audit committee and be designated as independent for audit committee purposes, unless
4.2 they are an officer or employee of the insurer or one of its affiliates.

4.3 ~~(d)~~ (e) If a member of the audit committee ceases to be independent for reasons outside
4.4 the member's reasonable control, that person, with notice by the responsible entity to the
4.5 state, may remain an audit committee member of the responsible entity until the earlier of
4.6 the next annual meeting of the responsible entity or one year from the occurrence of the
4.7 event that caused the member to be no longer independent.

4.8 ~~(e)~~ (f) To exercise the election of the controlling person to designate the audit committee
4.9 for purposes of this section, the ultimate controlling person shall provide written notice to
4.10 the commissioners of the affected insurers. Notification must be made timely before the
4.11 issuance of the statutory audit report and include a description of the basis for the election.
4.12 The election can be changed through notice to the commissioner by the insurer, which shall
4.13 include a description of the basis for the change. The election remains in effect for perpetuity,
4.14 until rescinded.

4.15 ~~(f)~~ (g) The audit committee shall require the accountant that performs for an insurer any
4.16 audit required by this section to timely report to the audit committee in accordance with the
4.17 requirements of SAS No. 114, The Auditor's Communication with Those Charged with
4.18 Governance, or its replacement, including:

4.19 (1) all significant accounting policies and material permitted practices;

4.20 (2) all material alternative treatments of financial information within statutory accounting
4.21 principles that have been discussed with management officials of the insurer, ramifications
4.22 of the use of the alternative disclosures and treatments, and the treatment preferred by the
4.23 accountant; and

4.24 (3) other material written communications between the accountant and the management
4.25 of the insurer, such as any management letter or schedule of unadjusted differences.

4.26 ~~(g)~~ (h) If an insurer is a member of an insurance holding company system, the reports
4.27 required by paragraph ~~(f)~~ (g) may be provided to the audit committee on an aggregate basis
4.28 for insurers in the holding company system, provided that any substantial differences among
4.29 insurers in the system are identified to the audit committee.

4.30 ~~(h)~~ (i) The proportion of independent audit committee members shall meet or exceed
4.31 the following criteria:

4.32 (1) for companies with prior calendar year direct written and assumed premiums \$0 to
4.33 \$300,000,000, no minimum requirements;

5.1 (2) for companies with prior calendar year direct written and assumed premiums over
5.2 \$300,000,000 to \$500,000,000, majority of members must be independent; and

5.3 (3) for companies with prior calendar year direct written and assumed premiums over
5.4 \$500,000,000, 75 percent or more must be independent.

5.5 ~~(h)~~ (j) An insurer with direct written and assumed premium, excluding premiums reinsured
5.6 with the Federal Crop Insurance Corporation and Federal Flood Program, less than
5.7 \$500,000,000 may make application to the commissioner for a waiver from the requirements
5.8 of this subdivision based upon hardship. The insurer shall file, with its annual statement
5.9 filing, the approval for relief from this subdivision with the states that it is licensed in or
5.10 doing business in and the NAIC. If the nondomestic state accepts electronic filing with the
5.11 NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

5.12 This subdivision does not apply to foreign or alien insurers licensed in this state or an
5.13 insurer that is a SOX compliant entity or a direct or indirect wholly owned subsidiary of a
5.14 SOX compliant entity.

5.15 Sec. 3. Minnesota Statutes 2018, section 60A.1291, is amended by adding a subdivision
5.16 to read:

5.17 Subd. 15a. **Internal audit function requirements.** (a) An insurer is exempt from the
5.18 requirements of this section if:

5.19 (1) the insurer has annual direct written and unaffiliated assumed premium, including
5.20 international direct and assumed premium but excluding premiums reinsured with the Federal
5.21 Crop Insurance Corporation and Federal Flood Program, less than \$500,000,000; and

5.22 (2) if the insurer is a member of a group of insurers, the group has annual direct written
5.23 and unaffiliated assumed premium including international direct and assumed premium,
5.24 but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal
5.25 Flood Program, less than \$1,000,000,000.

5.26 (b) The insurer or group of insurers shall establish an internal audit function providing
5.27 independent, objective, and reasonable assurance to the audit committee and insurer
5.28 management regarding the insurer's governance, risk management, and internal controls.
5.29 This assurance shall be provided by performing general and specific audits, reviews, and
5.30 tests and by employing other techniques deemed necessary to protect assets, evaluate control
5.31 effectiveness and efficiency, and evaluate compliance with policies and regulations.

5.32 (c) In order to ensure that internal auditors remain objective, the internal audit function
5.33 must be organizationally independent. Specifically, the internal audit function will not defer

6.1 ultimate judgment on audit matters to others, and shall appoint an individual to head the
6.2 internal audit function who will have direct and unrestricted access to the board of directors.
6.3 Organizational independence does not preclude dual-reporting relationships.

6.4 (d) The head of the internal audit function shall report to the audit committee regularly,
6.5 but no less than annually, on the periodic audit plan, factors that may adversely impact the
6.6 internal audit function's independence or effectiveness, material findings from completed
6.7 audits and the appropriateness of corrective actions implemented by management as a result
6.8 of audit findings.

6.9 (e) If an insurer is a member of an insurance holding company system or included in a
6.10 group of insurers, the insurer may satisfy the internal audit function requirements set forth
6.11 in this section at the ultimate controlling parent level, an intermediate holding company
6.12 level or the individual legal entity level.

6.13 **EFFECTIVE DATE.** The requirements of this subdivision are effective January 1,
6.14 2020. If an insurer or group of insurers that is exempt from this subdivision no longer
6.15 qualifies for that exemption, it shall have one year after the year the threshold is exceeded
6.16 to comply with the requirements of this subdivision.

6.17 **ARTICLE 2**

6.18 **INSURANCE HOLDING COMPANY SYSTEMS**

6.19 Section 1. Minnesota Statutes 2018, section 60D.15, is amended by adding a subdivision
6.20 to read:

6.21 Subd. 4b. **Groupwide supervisor.** "Groupwide supervisor" means the regulatory official
6.22 authorized to engage in conducting and coordinating groupwide supervision activities who
6.23 is determined or acknowledged by the commissioner under section 60D.217 to have sufficient
6.24 significant contacts with the internationally active insurance group.

6.25 Sec. 2. Minnesota Statutes 2018, section 60D.15, is amended by adding a subdivision to
6.26 read:

6.27 Subd. 6a. **Internationally active insurance group.** "Internationally active insurance
6.28 group" means an insurance holding company system that (1) includes an insurer registered
6.29 under section 60D.19; and (2) meets the following criteria: (i) premiums written in at least
6.30 three countries, (ii) the percentage of gross premiums written outside the United States is
6.31 at least ten percent of the insurance holding company system's total gross written premiums,
6.32 and (iii) based on a three-year rolling average, the total assets of the insurance holding

7.1 company system are at least \$50,000,000,000 or the total gross written premiums of the
7.2 insurance holding company system are at least \$10,000,000,000.

7.3 **Sec. 3. [60D.217] GROUPWIDE SUPERVISION OF INTERNATIONALLY ACTIVE**
7.4 **INSURANCE GROUPS.**

7.5 (a) The commissioner is authorized to act as the groupwide supervisor for any
7.6 internationally active insurance group in accordance with the provisions of this section.
7.7 However, the commissioner may otherwise acknowledge another regulatory official as the
7.8 groupwide supervisor where the internationally active insurance group:

7.9 (1) does not have substantial insurance operations in the United States;

7.10 (2) has substantial insurance operations in the United States, but not in this state; or

7.11 (3) has substantial insurance operations in the United States and this state, but the
7.12 commissioner has determined pursuant to the factors set forth in subsections (b) and (f) that
7.13 the other regulatory official is the appropriate groupwide supervisor.

7.14 An insurance holding company system that does not otherwise qualify as an internationally
7.15 active insurance group may request that the commissioner make a determination or
7.16 acknowledgment as to a groupwide supervisor pursuant to this section.

7.17 (b) In cooperation with other state, federal, and international regulatory agencies, the
7.18 commissioner will identify a single groupwide supervisor for an internationally active
7.19 insurance group. The commissioner may determine that the commissioner is the appropriate
7.20 groupwide supervisor for an internationally active insurance group that conducts substantial
7.21 insurance operations concentrated in this state. However, the commissioner may acknowledge
7.22 that a regulatory official from another jurisdiction is the appropriate groupwide supervisor
7.23 for the internationally active insurance group. The commissioner shall consider the following
7.24 factors when making a determination or acknowledgment under this subsection:

7.25 (1) the place of domicile of the insurers within the internationally active insurance group
7.26 that hold the largest share of the group's written premiums, assets, or liabilities;

7.27 (2) the place of domicile of the top-tiered insurer(s) in the insurance holding company
7.28 system of the internationally active insurance group;

7.29 (3) the location of the executive offices or largest operational offices of the internationally
7.30 active insurance group;

7.31 (4) whether another regulatory official is acting or is seeking to act as the groupwide
7.32 supervisor under a regulatory system that the commissioner determines to be:

8.1 (i) substantially similar to the system of regulation provided under the laws of this state;

8.2 or

8.3 (ii) otherwise sufficient in terms of providing for groupwide supervision, enterprise risk
8.4 analysis, and cooperation with other regulatory officials; and

8.5 (5) whether another regulatory official acting or seeking to act as the groupwide
8.6 supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

8.7 However, a commissioner identified under this section as the groupwide supervisor may
8.8 determine that it is appropriate to acknowledge another supervisor to serve as the groupwide
8.9 supervisor. The acknowledgment of the groupwide supervisor shall be made after
8.10 consideration of the factors listed in clauses (1) to (5), and shall be made in cooperation
8.11 with and subject to the acknowledgment of other regulatory officials involved with
8.12 supervision of members of the internationally active insurance group, and in consultation
8.13 with the internationally active insurance group.

8.14 (c) Notwithstanding any other provision of law, when another regulatory official is acting
8.15 as the groupwide supervisor of an internationally active insurance group, the commissioner
8.16 shall acknowledge that regulatory official as the groupwide supervisor. However, in the
8.17 event of a material change in the internationally active insurance group that results in:

8.18 (1) the internationally active insurance group's insurers domiciled in this state holding
8.19 the largest share of the group's premiums, assets, or liabilities; or

8.20 (2) this state being the place of domicile of the top-tiered insurer(s) in the insurance
8.21 holding company system of the internationally active insurance group,
8.22 the commissioner shall make a determination or acknowledgment as to the appropriate
8.23 groupwide supervisor for such an internationally active insurance group pursuant to
8.24 subsection (b).

8.25 (d) Pursuant to section 60D.21, the commissioner is authorized to collect from any
8.26 insurer registered pursuant to section 60D.19 all information necessary to determine whether
8.27 the commissioner may act as the groupwide supervisor of an internationally active insurance
8.28 group or if the commissioner may acknowledge another regulatory official to act as the
8.29 groupwide supervisor. Prior to issuing a determination that an internationally active insurance
8.30 group is subject to groupwide supervision by the commissioner, the commissioner shall
8.31 notify the insurer registered pursuant to section 60D.19 and the ultimate controlling person
8.32 within the internationally active insurance group. The internationally active insurance group
8.33 shall have not less than 30 days to provide the commissioner with additional information

9.1 pertinent to the pending determination. The commissioner shall publish in the State Register
9.2 and on the department's website the identity of internationally active insurance groups that
9.3 the commissioner has determined are subject to groupwide supervision by the commissioner.

9.4 (e) If the commissioner is the groupwide supervisor for an internationally active insurance
9.5 group, the commissioner is authorized to engage in any of the following groupwide
9.6 supervision activities:

9.7 (1) assess the enterprise risks within the internationally active insurance group to ensure
9.8 that:

9.9 (i) the material financial condition and liquidity risks to the members of the internationally
9.10 active insurance group that are engaged in the business of insurance are identified by
9.11 management; and

9.12 (ii) reasonable and effective mitigation measures are in place; or

9.13 (2) request, from any member of an internationally active insurance group subject to the
9.14 commissioner's supervision, information necessary and appropriate to assess enterprise risk,
9.15 including but not limited to information about the members of the internationally active
9.16 insurance group regarding:

9.17 (i) governance, risk assessment, and management;

9.18 (ii) capital adequacy; and

9.19 (iii) material intercompany transactions;

9.20 (3) coordinate and, through the authority of the regulatory officials of the jurisdictions
9.21 where members of the internationally active insurance group are domiciled, compel
9.22 development and implementation of reasonable measures designed to ensure that the
9.23 internationally active insurance group is able to timely recognize and mitigate enterprise
9.24 risks to members of such internationally active insurance group that are engaged in the
9.25 business of insurance;

9.26 (4) communicate with other state, federal and international regulatory agencies for
9.27 members within the internationally active insurance group and share relevant information
9.28 subject to the confidentiality provisions of section 60D.22, through supervisory colleges as
9.29 set forth in section 60D.215 or otherwise;

9.30 (5) enter into agreements with or obtain documentation from any insurer registered under
9.31 section 60D.19, any member of the internationally active insurance group, and any other
9.32 state, federal, and international regulatory agencies for members of the internationally active

10.1 insurance group, providing the basis for or otherwise clarifying the commissioner's role as
10.2 groupwide supervisor, including provisions for resolving disputes with other regulatory
10.3 officials. Such agreements or documentation shall not serve as evidence in any proceeding
10.4 that any insurer or person within an insurance holding company system not domiciled or
10.5 incorporated in this state is doing business in this state or is otherwise subject to jurisdiction
10.6 in this state; and

10.7 (6) other groupwide supervision activities, consistent with the authorities and purposes
10.8 enumerated above, as considered necessary by the commissioner.

10.9 (f) If the commissioner acknowledges that another regulatory official from a jurisdiction
10.10 that is not accredited by the NAIC is the groupwide supervisor, the commissioner is
10.11 authorized to reasonably cooperate, through supervisory colleges or otherwise, with
10.12 groupwide supervision undertaken by the groupwide supervisor, provided that:

10.13 (1) the commissioner's cooperation is in compliance with the laws of this state; and

10.14 (2) the regulatory official acknowledged as the groupwide supervisor also recognizes
10.15 and cooperates with the commissioner's activities as a groupwide supervisor for other
10.16 internationally active insurance groups where applicable. Where such recognition and
10.17 cooperation is not reasonably reciprocal, the commissioner is authorized to refuse recognition
10.18 and cooperation.

10.19 (g) The commissioner is authorized to enter into agreements with or obtain documentation
10.20 from any insurer registered under section 60D.19, any affiliate of the insurer, and other
10.21 state, federal, and international regulatory agencies for members of the internationally active
10.22 insurance group, that provide the basis for or otherwise clarify a regulatory official's role
10.23 as groupwide supervisor.

10.24 (h) A registered insurer subject to this section shall be liable for and shall pay the
10.25 reasonable expenses of the commissioner's participation in the administration of this section,
10.26 including the engagement of attorneys, actuaries, and any other professionals and all
10.27 reasonable travel expenses.

ARTICLE 3**RISK-BASED CAPITAL TREND TEST FOR HEALTH ORGANIZATIONS**

Section 1. Minnesota Statutes 2018, section 60A.51, is amended by adding a subdivision to read:

Subd. 2a. **Excess of capital.** An excess of capital (net worth) over the amount produced by the risk-based capital requirements contained in sections 60A.50 to 60A.592 and the formulas, schedules, and instructions referenced in sections 60A.50 to 60A.592 is desirable in the business of health insurance. Health organizations should seek to maintain capital above the RBC levels required by sections 60A.50 to 60A.592. Additional capital is useful in the insurance business and helps to secure a health organization against various risk inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in sections 60A.50 to 60A.592.

Sec. 2. Minnesota Statutes 2018, section 60A.52, subdivision 1, is amended to read:

Subdivision 1. **Definition.** "Company action level event" means the following events:

(1) the filing of an RBC report by a health organization that indicates that the health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC. If a health organization has total adjusted capital greater than or equal to its company action level RBC but less than the product of its authorized control level RBC multiplied by three, and triggers the trend test determined in accordance with the trend test calculation included in the health RBC instructions;

(2) notification by the commissioner to the health organization of an adjusted RBC report that indicates an event in clause (1), provided the health organization does not challenge the adjusted RBC report under section 60A.56; or

(3) if, pursuant to section 60A.56, a health organization challenges an adjusted RBC report that indicates the event in clause (1), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

ARTICLE 4**CORPORATE GOVERNANCE ANNUAL DISCLOSURE**

Section 1. [60A.1391] CORPORATE GOVERNANCE ANNUAL DISCLOSURE.

Subdivision 1. **Purpose and scope.** (a) The purpose of sections 60A.142 to 60A.149 is to:

12.1 (1) provide the commissioner a summary of an insurer or insurance group's corporate
12.2 governance structure, policies, and practices to permit the commissioner to gain and maintain
12.3 an understanding of the insurer's corporate governance framework; and

12.4 (2) outline the requirements for completing a corporate governance annual disclosure
12.5 with the commissioner.

12.6 (b) Nothing in this section shall be construed to limit the commissioner's authority, or
12.7 the rights or obligations of third parties.

12.8 (c) The requirements of this section apply to all insurers domiciled in this state.

12.9 Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision
12.10 have the meanings given them.

12.11 (b) "Commissioner" means the commissioner of commerce.

12.12 (c) "Corporate Governance Annual Disclosure (CGAD)" means a confidential report
12.13 filed by the insurer or insurance group according to this section.

12.14 (d) "Insurance group" means those insurers and affiliates included within an insurance
12.15 holding company system as defined in section 60D.15, subdivision 5.

12.16 (e) "Insurer" has the meaning given in section 60A.705, subdivision 4, except that it
12.17 does not include agencies, authorities, or instrumentalities of the United States, its possessions
12.18 and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or
12.19 political subdivision of a state.

12.20 (f) "ORSA summary report" means the report filed under section 60D.54.

12.21 (g) "Senior management" means any corporate officer responsible for reporting
12.22 information to the board of directors at regular intervals or providing this information to
12.23 shareholders or regulators and shall include, for example and without limitation, the Chief
12.24 Executive Officer (CEO), Chief Financial Officer (CFO), Chief Operations Officer (COO),
12.25 Chief Procurement Officer (CPO), Chief Legal Officer (CLO), Chief Information Officer
12.26 (CIO), Chief Technology Officer (CTO), Chief Revenue Officer (CRO), Chief Visionary
12.27 Officer (CVO), or any other "C" level executive.

12.28 Subd. 3. **Disclosure and filing requirements.** (a) An insurer, or the insurance group of
12.29 which the insurer is a member, shall, no later than June 1 of each calendar year, submit to
12.30 the commissioner a Corporate Governance Annual Disclosure (CGAD) that contains the
12.31 information described in subdivision 4. Notwithstanding any request from the commissioner
12.32 made pursuant to paragraph (c), if the insurer is a member of an insurance group, the insurer

13.1 shall submit the report required by this section to the commissioner of the lead state for the
13.2 insurance group, in accordance with the laws of the lead state, as determined by the
13.3 procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC.

13.4 (b) The CGAD must include a signature of the insurer or insurance group's chief executive
13.5 officer or corporate secretary attesting to the best of that individual's belief and knowledge
13.6 that the insurer has implemented the corporate governance practices and that a copy of the
13.7 disclosure has been provided to the insurer's or the insurance group's board of directors or
13.8 the appropriate committee thereof.

13.9 (c) An insurer not required to submit a CGAD under this section shall do so upon the
13.10 commissioner's request.

13.11 (d) For purposes of completing the CGAD, the insurer or insurance group may provide
13.12 information regarding corporate governance at the ultimate controlling parent level, an
13.13 intermediate holding company level, or the individual legal entity level, depending upon
13.14 how the insurer or insurance group has structured its system of corporate governance. The
13.15 insurer or insurance group is encouraged to make the CGAD disclosures at the level at
13.16 which the insurer's or insurance group's risk appetite is determined, or at which the earnings,
13.17 capital, liquidity, operations, and reputation of the insurer are overseen collectively and at
13.18 which the supervision of those factors are coordinated and exercised, or the level at which
13.19 legal liability for failure of general corporate governance duties would be placed. If the
13.20 insurer or insurance group determines the level of reporting based on these criteria, it shall
13.21 indicate which of the three criteria was used to determine the level of reporting and explain
13.22 any subsequent changes in level of reporting.

13.23 (e) The review of the CGAD and any additional requests for information shall be made
13.24 through the lead state as determined by the procedures within the most recent Financial
13.25 Analysis Handbook referenced in paragraph (a). If the CGAD is completed at the insurance
13.26 group level, then it must be filed with the lead state of the group as determined by the
13.27 procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC.
13.28 In these instances, a copy of the CGAD must also be provided to the chief regulatory official
13.29 of any state in which the insurance group has a domestic insurer, upon request.

13.30 (f) Insurers providing information substantially similar to the information required under
13.31 this section in other documents provided to the commissioner, including proxy statements
13.32 filed in conjunction with Form B requirements, or other state or federal filings provided to
13.33 this department shall not be required to duplicate that information in the CGAD, but shall
13.34 be required to clearly cross-reference the location of the relevant information within the

14.1 CGAD and attach the referenced document in which the information is included if not
14.2 already filed with or available to the regulator.

14.3 (g) Each year following the initial filing of the CGAD, the insurer or insurance group
14.4 shall file an amended version of the previously filed CGAD indicating where changes have
14.5 been made. If no changes were made in the information or activities reported by the insurer
14.6 or insurance group, the filing should so state.

14.7 Subd. 4. **Contents of Corporate Governance Annual Disclosure.** (a) The insurer or
14.8 insurance group shall have discretion regarding the appropriate format for providing the
14.9 information required by this section, provided the CGAD shall contain the material
14.10 information necessary to permit the commissioner to gain an understanding of the insurer's
14.11 or group's corporate governance structure, policies, and practices. The commissioner may
14.12 request additional information deemed material and necessary to provide the commissioner
14.13 with a clear understanding of the corporate governance policies, the reporting or information
14.14 system, or controls implementing those policies. Documentation and supporting information
14.15 shall be maintained and made available upon examination or upon request of the
14.16 commissioner.

14.17 (b) The insurer or insurance group shall be as descriptive as possible in completing the
14.18 CGAD, with inclusion of attachments or example documents that are used in the governance
14.19 process, as these may provide a means to demonstrate the strengths of their governance
14.20 framework and practices.

14.21 (c) The CGAD shall describe the insurer's or insurance group's corporate governance
14.22 framework and structure including consideration of the following:

14.23 (1) the board and various committees thereof ultimately responsible for overseeing the
14.24 insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate
14.25 control level, intermediate holding company, legal entity, etc.). The insurer or insurance
14.26 group shall describe and discuss the rationale for the current board size and structure; and

14.27 (2) the duties of the board and each of its significant committees and how they are
14.28 governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the board's
14.29 leadership is structured, including a discussion of the roles of Chief Executive Officer and
14.30 Chairman of the Board within the organization.

14.31 (d) The insurer or insurance group shall describe the policies and practices of the most
14.32 senior governing entity and significant committees thereof, including a discussion of the
14.33 following factors:

- 15.1 (1) how the qualifications, expertise, and experience of each board member meet the
15.2 needs of the insurer or insurance group;
- 15.3 (2) how an appropriate amount of independence is maintained on the board and its
15.4 significant committees;
- 15.5 (3) the number of meetings held by the board and its significant committees over the
15.6 past year as well as the information on director attendance;
- 15.7 (4) how the insurer or insurance group identifies, nominates, and elects members to the
15.8 board and its committees. The discussion should include, for example:
- 15.9 (i) whether the nomination committee is in place to identify and select individuals for
15.10 consideration;
- 15.11 (ii) whether term limits are placed on directors;
- 15.12 (iii) how the election and reelection processes function; and
- 15.13 (iv) whether a board diversity policy is in place and if so, how it functions; and
- 15.14 (5) the processes in place for the board to evaluate its performance and the performance
15.15 of its committees, as well as any recent measures taken to improve performance, including
15.16 any board or committee training programs that have been put in place.
- 15.17 (e) The insurer or insurance group shall describe the policies and practices for directing
15.18 senior management, including a description of the following factors:
- 15.19 (1) any processes or practices (i.e., sustainability standards) to determine whether officers
15.20 and key persons in control functions have the appropriate background, experience, and
15.21 integrity to fulfill their prospective roles, including:
- 15.22 (i) identification of the specific positions for which suitability standards have been
15.23 developed and a description of the standards employed; and
- 15.24 (ii) any changes in an officer's or key person's suitability as outlined by the insurer's or
15.25 insurance group's standards and procedures to monitor and evaluate such changes;
- 15.26 (2) the insurer's or insurance group's code of business conduct and ethics, the discussion
15.27 of which considers, for example:
- 15.28 (i) compliance with laws, rules, and regulations; and
- 15.29 (ii) proactive reporting of any illegal or unethical behavior;
- 15.30 (3) the insurer's or insurance group's processes for performance evaluation, compensation,
15.31 and corrective action to ensure effective senior management throughout the organization,

16.1 including a description of the general objectives of significant compensation programs and
16.2 what the programs are designed to reward. The description shall include sufficient detail to
16.3 allow the commissioner to understand how the organization ensures that compensation
16.4 programs do not encourage or reward excessive risk taking. Elements to be discussed may
16.5 include, for example:

16.6 (i) the board's role in overseeing management compensation programs and practices;

16.7 (ii) the various elements of compensation awarded in the insurer's or insurance group's
16.8 compensation programs and how the insurer or insurance group determines and calculates
16.9 the amount of each element of compensation paid;

16.10 (iii) how compensation programs are related to both company and individual performance
16.11 over time;

16.12 (iv) whether compensation programs include risk adjustments and how those adjustments
16.13 are incorporated into the programs for employees at different levels;

16.14 (v) any clawback provisions built into the programs to recover awards or payments if
16.15 the performance measures upon which they are based are restated or otherwise adjusted;
16.16 and

16.17 (vi) any other factors relevant in understanding how the insurer or insurance group
16.18 monitors its compensation policies to determine whether its risk management objectives
16.19 are met by incentivizing its employees; and

16.20 (4) the insurer's or insurance group's plans for CEO and senior management succession.

16.21 (f) The insurer or insurance group shall describe the processes by which the board, its
16.22 committees, and senior management ensure an appropriate amount of oversight to the critical
16.23 risk areas impacting the insurer's business activities, including a discussion of:

16.24 (1) how oversight and management responsibilities are delegated between the board, its
16.25 committees, and senior management;

16.26 (2) how the board is kept informed of the insurer's strategic plans, the associated risks,
16.27 and steps that senior management is taking to monitor and manage those risks; and

16.28 (3) how reporting responsibilities are organized for each critical risk area. The description
16.29 should allow the commissioner to understand the frequency at which information on each
16.30 critical risk area is reported to and reviewed by senior management and the board. This
16.31 description may include, for example, the following critical risk areas of the insurer:

17.1 (i) risk management processes (an ORSA Summary Report filer may refer to its ORSA
17.2 Summary Report pursuant to the Risk Management and Own Risk and Solvency Assessment
17.3 Model Act);

17.4 (ii) actuarial function;

17.5 (iii) investment decision-making processes;

17.6 (iv) reinsurance decision-making processes;

17.7 (v) business strategy and finance decision-making processes;

17.8 (vi) compliance function;

17.9 (vii) financial reporting and internal auditing; and

17.10 (viii) market conduct decision-making processes.

17.11 Subd. 5. **Confidentiality.** (a) Documents, materials, or other information, including the
17.12 CGAD, in the possession or control of the department that are obtained by, created by, or
17.13 disclosed to the commissioner or any other person under this section are recognized by this
17.14 state as being confidential, protected nonpublic, and containing trade secrets. Those
17.15 documents, materials, or other information are classified as confidential, protected nonpublic,
17.16 or both, are not subject to subpoena, and are not subject to discovery or admissible in
17.17 evidence in any private civil action. However, the commissioner may use the documents,
17.18 materials, or other information in the furtherance of a regulatory or legal action brought as
17.19 a part of the commissioner's official duties. The commissioner shall not otherwise make the
17.20 documents, materials, or other information public without the prior written consent of the
17.21 insurer. Nothing in this section shall be construed to require written consent of the insurer
17.22 before the commissioner may share or receive confidential documents, materials, or other
17.23 CGAD-related information pursuant to paragraph (c) below to assist in the performance of
17.24 the commissioner's regular duties.

17.25 (b) Neither the commissioner nor any person who received documents, materials, or
17.26 other CGAD-related information, through examination or otherwise, while acting under the
17.27 authority of the commissioner, or with whom the documents, materials, or other information
17.28 are shared pursuant to this section are permitted or required to testify in any private civil
17.29 action concerning documents, materials, or information subject to this subdivision that are
17.30 classified as confidential, protected nonpublic, or both.

17.31 (c) In order to assist in the performance of the commissioner's regulatory duties, the
17.32 commissioner:

18.1 (1) may, upon request, share documents, materials, or other CGAD-related information,
18.2 including the confidential, protected nonpublic, and privileged documents, materials, or
18.3 information subject to this subdivision, with other state, federal, and international financial
18.4 regulatory agencies, including members of any supervisory college as defined in section
18.5 60D.215, with the NAIC, and with third-party consultants pursuant to subdivision 7, provided
18.6 that the recipient agrees in writing to maintain the confidentiality and privileged status of
18.7 the CGAD-related documents, material, or other information and has verified in writing the
18.8 legal authority to maintain confidentiality; and

18.9 (2) may receive documents, materials, or other CGAD-related information, including
18.10 otherwise confidential, protected nonpublic, and privileged documents, materials, or
18.11 information, from regulatory officials of other state, federal, and international financial
18.12 regulatory agencies, including members of any supervisory college as defined in section
18.13 60D.215 and from the NAIC, and shall maintain as confidential, protected nonpublic, or
18.14 privileged any documents, materials, or information received with notice or the understanding
18.15 that it is confidential, protected nonpublic, or privileged under the laws of the jurisdiction
18.16 that is the source of the document, material, or information.

18.17 (d) The sharing of information and documents by the commissioner pursuant to this
18.18 section shall not constitute a delegation of regulatory authority or rulemaking, and the
18.19 commissioner is solely responsible for the administration, execution, and enforcement of
18.20 the provisions of this section.

18.21 (e) No waiver of any applicable privilege or claim of confidentiality in the documents,
18.22 trade-secret materials, or other CGAD-related information shall occur as a result of disclosure
18.23 of such CGAD-related information or documents to the commissioner under this subdivision
18.24 or as a result of sharing as authorized under this section.

18.25 Subd. 6. **NAIC and third-party consultants.** (a) The commissioner may retain, at the
18.26 insurer's expense, third-party consultants, including attorneys, actuaries, accountants, and
18.27 other experts not otherwise a part of the commissioner's staff as may be reasonably necessary
18.28 to assist the commissioner in reviewing the CGAD and related information or the insurer's
18.29 compliance with this section.

18.30 (b) Any person retained under paragraph (a) shall be under the direction and control of
18.31 the commissioner and shall act in a purely advisory capacity.

18.32 (c) The NAIC and third-party consultants shall be subject to the same confidentiality
18.33 standards and requirements as the commissioner.

19.1 (d) As part of the retention process, a third-party consultant shall verify to the
19.2 commissioner, with notice to the insurer, that it is free of a conflict of interest and that it
19.3 has internal procedures in place to monitor compliance with a conflict and to comply with
19.4 the confidentiality standards and requirements of this section.

19.5 (e) A written agreement with the NAIC or a third-party consultant governing sharing
19.6 and use of information provided pursuant to this section shall contain the following provisions
19.7 and expressly require the written consent of the insurer prior to making public information
19.8 provided under this section:

19.9 (1) specific procedures and protocols for maintaining the confidentiality and security of
19.10 CGAD-related information shared with the NAIC or a third-party consultant pursuant to
19.11 this section;

19.12 (2) procedures and protocols for sharing by the NAIC only with other state regulators
19.13 from states in which the insurance group has domiciled insurers. The agreement shall provide
19.14 that the recipient agrees in writing to maintain the confidentiality and privileged status of
19.15 the CGAD-related documents, materials, or other information and has verified in writing
19.16 the legal authority to maintain confidentiality;

19.17 (3) a provision specifying that ownership of the CGAD-related information shared with
19.18 the NAIC or a third-party consultant remains with the department and the NAIC's or
19.19 third-party consultant's use of the information is subject to the direction of the commissioner;

19.20 (4) a provision that prohibits the NAIC or a third-party consultant from storing the
19.21 information shared pursuant to this section in a permanent database after the underlying
19.22 analysis is completed;

19.23 (5) a provision requiring the NAIC or third-party consultant to provide prompt notice
19.24 to the commissioner and to the insurer or insurance group regarding any subpoena, request
19.25 for disclosure, or request for production of the insurer's CGAD-related information; and

19.26 (6) a requirement that the NAIC or a third-party consultant to consent to intervention
19.27 by an insurer in any judicial or administrative action in which the NAIC or a third-party
19.28 consultant may be required to disclose confidential information about the insurer shared
19.29 with the NAIC or a third-party consultant pursuant to this section.

19.30 Subd. 7. **Sanctions.** Any insurer failing, without just cause, to timely file the CGAD as
19.31 required in this section shall be required to pay a penalty of \$1,000 for each day's delay, to
19.32 be recovered by the commissioner and to be paid into the general fund of this state. The

20.1 commissioner may reduce the penalty if the insurer demonstrates to the commissioner that
20.2 the imposition of the penalty would constitute a financial hardship to the insurer.

20.3 **EFFECTIVE DATE.** This section is effective on January 1, 2020. The first filing of
20.4 the CGAD shall be in 2020.

20.5 **ARTICLE 5**

20.6 **MEDICARE SUPPLEMENT INSURANCE**

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

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

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

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

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

20.15 Subdivision 1. **Policy requirements.** No individual or group policy, certificate, subscriber
20.16 contract issued by a health service plan corporation regulated under chapter 62C, or other
20.17 evidence of accident and health insurance the effect or purpose of which is to supplement
20.18 Medicare coverage, including to supplement coverage under Medicare Advantage plans
20.19 established under Medicare Part C, issued or delivered in this state or offered to a resident
20.20 of this state shall be sold or issued to an individual covered by Medicare unless the
20.21 requirements in subdivisions 1a to ~~1u~~ 1v are met.

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

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

20.27 Sec. 4. Minnesota Statutes 2018, section 62A.315, is amended to read:

20.28 **62A.315 EXTENDED BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.**

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

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

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

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

21.10 (4) 80 percent of the usual and customary hospital and medical expenses and supplies
21.11 described in section 62E.06, subdivision 1, not to exceed any charge limitation established
21.12 by the Medicare program or state law, the usual and customary hospital and medical expenses
21.13 and supplies, described in section 62E.06, subdivision 1, while in a foreign country; and
21.14 prescription drug expenses, not covered by Medicare. An outpatient prescription drug benefit
21.15 must not be included for sale or issuance in a Medicare supplement policy or certificate
21.16 issued on or after January 1, 2006;

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

21.20 (6) 100 percent of the cost of immunizations not otherwise covered under Part D of the
21.21 Medicare program and routine screening procedures for cancer, including mammograms
21.22 and pap smears;

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

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

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

21.30 Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved
21.31 amount for each service as if Medicare were to cover the service as identified in American
21.32 Medical Association current procedural terminology (AMA CPT) codes to a maximum of

22.1 \$120 annually under this benefit. This benefit shall not include payment for any procedure
22.2 covered by Medicare;

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

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

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

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

22.11 **62A.316 BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.**

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

22.13 (1) coverage for all of the Medicare Part A inpatient hospital coinsurance amounts, and
22.14 100 percent of all Medicare part A eligible expenses for hospitalization not covered by
22.15 Medicare, after satisfying the Medicare Part A deductible;

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

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

22.22 (4) 80 percent of the hospital and medical expenses and supplies incurred during travel
22.23 outside the United States as a result of a medical emergency;

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

22.27 (6) 100 percent of the cost of immunizations not otherwise covered under Part D of the
22.28 Medicare program and routine screening procedures for cancer screening including
22.29 mammograms and pap smears;

22.30 (7) 80 percent of coverage for all physician prescribed medically appropriate and
22.31 necessary equipment and supplies used in the management and treatment of diabetes not

23.1 otherwise covered under Part D of the Medicare program. Coverage must include persons
23.2 with gestational, type I, or type II diabetes. Coverage under this clause is subject to section
23.3 62A.3093, subdivision 2;

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

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

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

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

23.10 (2) 100 percent of the Medicare Part B excess charges coverage for all of the difference
23.11 between the actual Medicare Part B charges as billed, not to exceed any charge limitation
23.12 established by the Medicare program or state law, and the Medicare-approved Part B charge;

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

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

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

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

23.21 Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved
23.22 amount for each service, as if Medicare were to cover the service as identified in American
23.23 Medical Association current procedural terminology (AMA CPT) codes, to a maximum of
23.24 \$120 annually under this benefit. This benefit shall not include payment for a procedure
23.25 covered by Medicare.

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

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

24.2 **62A.3161 MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT COVERAGE.**

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

24.5 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365
24.6 days after Medicare benefits end;

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

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

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

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

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

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

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

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

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

25.2 **62A.3162 MEDICARE SUPPLEMENT PLAN WITH 75 PERCENT COVERAGE.**

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

25.5 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365
25.6 days after Medicare benefits end;

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

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

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

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

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

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

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

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

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

26.2 **62A.3163 MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT PART A**
26.3 **DEDUCTIBLE COVERAGE.**

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

26.6 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365
26.7 days after Medicare benefits end;

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

26.10 (3) coverage for the coinsurance amount for each day used from the 21st through the
26.11 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under
26.12 Medicare Part A;

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

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

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

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

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

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

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

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

27.2 **62A.3164 MEDICARE SUPPLEMENT PLAN WITH \$20 AND \$50 CO-PAYMENT**
27.3 **MEDICARE PART B COVERAGE.**

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

27.6 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365
27.7 days after Medicare benefits end;

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

27.10 (3) coverage for the coinsurance amount for each day used from the 21st through the
27.11 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under
27.12 Medicare Part A;

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

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

27.18 (6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare
27.19 Part B except for the lesser of \$20 or the Medicare Part B coinsurance or co-payment for
27.20 each covered health care provider office visit and the lesser of \$50 or the Medicare Part B
27.21 coinsurance or co-payment for each covered emergency room visit; however, this co-payment
27.22 shall be waived if the insured is admitted to any hospital and the emergency visit is
27.23 subsequently covered as a Medicare Part A expense;

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

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

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

27.31 (b) A Medicare supplement plan with \$20 and \$50 co-payment Medicare Part B coverage
27.32 must provide the benefits contained in this section, but must not provide coverage for 100

28.1 percent or any portion of the Medicare Part B deductible to a newly eligible individual. No
28.2 portion of the co-payment referenced in this paragraph may be applied to a Medicare Part
28.3 B deductible.

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

28.5 **62A.3165 MEDICARE SUPPLEMENT PLAN WITH HIGH DEDUCTIBLE**
28.6 **COVERAGE.**

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

28.11 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365
28.12 days after Medicare benefits end;

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

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

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

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

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

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

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

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

29.1 (10) the basis for the deductible shall be \$1,860 and shall be adjusted annually from
29.2 2010 by the secretary of the United States Department of Health and Human Services to
29.3 reflect the change in the Consumer Price Index for all urban consumers for the 12-month
29.4 period ending with August of the preceding year, and rounded to the nearest multiple of
29.5 \$10.

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

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

29.10 Subd. 17. **Types of plans.** (a) Medicare select policies and certificates offered by the
29.11 issuer must provide the coverages specified in sections 62A.315 to 62A.3165. Before a
29.12 Medicare select policy or certificate is sold or issued in this state, the applicant must be
29.13 provided with an explanation of coverage for each of the coverages specified in sections
29.14 62A.315 to 62A.3165 and must be provided with the opportunity of purchasing such coverage
29.15 if offered by the issuer. The basic plan may also include any of the optional benefit riders
29.16 authorized by section 62A.316. Preventive care provided by Medicare select policies or
29.17 certificates must be provided as set forth in section 62A.315 or 62A.316, except that the
29.18 benefits are as defined in chapter 62D.

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

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

29.23 **62E.07 QUALIFIED MEDICARE SUPPLEMENT PLAN.**

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

29.31 (b) Any plan sold or issued to a newly eligible individual, as defined in section 62A.3099,
29.32 subdivision 18a, that provides benefits may be certified as a qualified Medicare supplemental

30.1 plan if the plan is designed to supplement Medicare and provides coverage of 100 percent
30.2 of the deductibles, with the exception of coverage of:

30.3 (1) 100 percent or any portion of the Medicare Part B deductible; and

30.4 (2) 80 percent of the charges for covered services, as provided under section 62E.06,
30.5 subdivision 6, that are charges not paid by Medicare.

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

30.8 Sec. 13. **EFFECTIVE DATE.**

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