CHAPTER 26--S.F.No. 2313

An act relating to insurance; making changes to conform with certain model regulations; authorizing rulemaking; amending Minnesota Statutes 2018, sections 60A.1291, subdivisions 1, 15, 18, by adding a subdivision; 60A.51, by adding a subdivision; 60A.52, subdivision 1; 60D.15, by adding subdivisions; 62A.3099, by adding a subdivision; 62A.31, subdivision 1, by adding a subdivision; 62A.315; 62A.316; 62A.3161; 62A.3162; 62A.3163; 62A.3164; 62A.3165; 62A.318, subdivision 17; 62E.07; proposing coding for new law in Minnesota Statutes, chapters 60A; 60D.

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

ARTICLE 1

ANNUAL FINANCIAL REPORTING AND AUDIT

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

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

(a) "Accountant" and "independent public accountant" mean an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants and in all states in which the accountant or firm is licensed or is required to be licensed to practice. For Canadian and British companies, the term means a Canadian-chartered or British-chartered accountant.

(b) "Affiliate" or "affiliated" means a person that directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with a person.

~~(b)~~ (c) "Audit committee" means a committee or equivalent body established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, ~~and~~ the internal audit function of an insurer or group of insurers, if applicable, and external audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers solely for the purposes of this section at the election of the controlling person under subdivision 15, paragraph (e). If an audit committee is not designated by the insurer, the insurer's entire board of directors constitutes the audit committee.

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

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

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

(g) "Internal audit function" means a person or persons that provide independent, objective and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by

bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

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

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

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

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

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

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

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

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

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

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

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

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

~~(c)~~ (d) In order to be considered independent for purposes of this section, a member of the audit committee may not, other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary of the entity. However, if law requires board participation by otherwise nonindependent members, that law shall prevail and such members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

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

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

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

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

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

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

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

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

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

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

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

~~(i)~~ (j) An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000 may make application

to the commissioner for a waiver from the requirements of this subdivision based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from this subdivision with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

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

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

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

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

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

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

(c) In order to ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function will not defer ultimate judgment on audit matters to others, and shall appoint an individual to head the internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

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

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

EFFECTIVE DATE. The requirements of this subdivision are effective January 1, 2020.

Sec. 4. Minnesota Statutes 2018, section 60A.1291, subdivision 18, is amended to read:

Subd. 18. **Exemptions.** (a) Upon written application of any insurer, the commissioner may grant an exemption from compliance with the provisions of this section. In order to receive an exemption, an insurer must demonstrate to the satisfaction of the commissioner that compliance would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for specified periods. Within ten days from the denial of an insurer's written request for an exemption, the

insurer may request in writing a hearing on its application for an exemption. This hearing must be held in accordance with chapter 14. Upon written application of any insurer, the commissioner may permit an insurer to file annual audited financial reports on some basis other than a calendar year basis for a specified period. An exemption may not be granted until the insurer presents an alternative method satisfying the purposes of this section. Within ten days from a denial of a written request for an exemption, the insurer may request in writing a hearing on its application. The hearing must be held in accordance with chapter 14.

(b) This section applies to all insurers, unless otherwise indicated, required to file an annual audit by subdivision 2, except insurers having less than $1,000,000 of direct written premiums in this state in any calendar year and fewer than 1,000 policyholders or certificate holders of directly written policies nationwide at the end of the calendar year, are exempt from this section for that year, unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities, except that insurers having assumed premiums from reinsurance contracts or treaties of $1,000,000 or more are not exempt.

(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.

ARTICLE 2

INSURANCE HOLDING COMPANY SYSTEMS

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

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

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

Subd. 6a. **Internationally active insurance group.** "Internationally active insurance group" means an insurance holding company system that (1) includes an insurer registered under section 60D.19; and (2) meets the following criteria: (i) premiums written in at least three countries, (ii) the percentage of gross premiums written outside the United States is at least ten percent of the insurance holding company system's total gross written premiums, and (iii) based on a three-year rolling average, the total assets of the insurance holding company system are at least $50,000,000,000 or the total gross written premiums of the insurance holding company system are at least $10,000,000,000.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) this state being the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group,

the commissioner shall make a determination or acknowledgment as to the appropriate groupwide supervisor for such an internationally active insurance group pursuant to subsection (b).

(d) Pursuant to section 60D.21, the commissioner is authorized to collect from any insurer registered pursuant to section 60D.19 all information necessary to determine whether the commissioner may act as the groupwide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the groupwide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to groupwide supervision by the commissioner, the commissioner shall notify the insurer registered pursuant to section 60D.19 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than 30 days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish in the State Register and on the department's website the identity of internationally active insurance groups that the commissioner has determined are subject to groupwide supervision by the commissioner.

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

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

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

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

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

(i) governance, risk assessment, and management;

(ii) capital adequacy; and

(iii) material intercompany transactions;

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

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

(5) enter into agreements with or obtain documentation from any insurer registered under section 60D.19, any member of the internationally active insurance group, and any other state, federal, and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as groupwide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in

any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

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

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

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

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

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

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

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. **Scope.** (a) Nothing in this section shall be construed to prescribe or impose corporate governance standards and internal procedure beyond that which is required under applicable state corporate law. Nothing in this section shall be construed to limit the commissioner's authority, or the rights or obligations of third parties.

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

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

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

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

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

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

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

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

Subd. 3. **Disclosure and filing requirements.** (a) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the commissioner a Corporate Governance Annual Disclosure (CGAD) that contains the information described in subdivision 4. Notwithstanding any request from the commissioner made pursuant to paragraph (c), if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to the commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC.

(b) The CGAD must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has

implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's or the insurance group's board of directors or the appropriate committee thereof.

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

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

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

(f) Insurers providing information substantially similar to the information required under this section in other documents provided to the commissioner, including proxy statements filed in conjunction with Form B requirements, or other state or federal filings provided to this department shall not be required to duplicate that information in the CGAD, but shall be required to clearly cross-reference the location of the relevant information within the CGAD and attach the referenced document in which the information is included if not already filed with or available to the regulator.

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

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

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

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

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

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

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

(1) how the qualifications, expertise, and experience of each board member meet the needs of the insurer or insurance group;

(2) how an appropriate amount of independence is maintained on the board and its significant committees;

(3) the number of meetings held by the board and its significant committees over the past year as well as the information on director attendance;

(4) how the insurer or insurance group identifies, nominates, and elects members to the board and its committees. The discussion should include, for example:

(i) whether the nomination committee is in place to identify and select individuals for consideration;

(ii) whether term limits are placed on directors;

(iii) how the election and reelection processes function; and

(iv) whether a board diversity policy is in place and if so, how it functions; and

(5) the processes in place for the board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance, including any board or committee training programs that have been put in place.

(e) The insurer or insurance group shall describe the policies and practices for directing senior management, including a description of the following factors:

(1) any processes or practices (i.e., sustainability standards) to determine whether officers and key persons in control functions have the appropriate background, experience, and integrity to fulfill their prospective roles, including:

(i) identification of the specific positions for which suitability standards have been developed and a description of the standards employed; and

(ii) any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes;

(2) the insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

(i) compliance with laws, rules, and regulations; and

(ii) proactive reporting of any illegal or unethical behavior;

(3) the insurer's or insurance group's processes for performance evaluation, compensation, and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the commissioner to understand how the organization ensures that compensation programs do not encourage or reward excessive risk taking. Elements to be discussed may include, for example:

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

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

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

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

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

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

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

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

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

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

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

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

(ii) actuarial function;

(iii) investment decision-making processes;

(iv) reinsurance decision-making processes;

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

(vi) compliance function;

(vii) financial reporting and internal auditing; and

(viii) market conduct decision-making processes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 7. **Sanctions.** Any insurer failing, without just cause, to timely file the CGAD as required in this section shall be required to pay a penalty of $1,000 for each day's delay, to be recovered by the commissioner and to be paid into the general fund of this state. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

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

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.

Presented to the governor May 17, 2019

Signed by the governor May 17, 2019, 5:49 p.m.