human services to contract with the attorney general for purposes of educating and training prosecutors and law enforcement officers on enforcement of laws relating to child support, visitation, and custody, to be available until June 30, 1997.

Subd. 15. **CHILDREN'S VISITATION CENTERS.** $192,000 is appropriated from the state government special revenue fund to the commissioner of human services for supervised visitation facilities under Minnesota Statutes, section 256F.09; $96,000 is available for the fiscal year beginning July 1, 1995; and $96,000 is available for the fiscal year beginning July 1, 1996.

Any unencumbered balance remaining in the first year does not cancel and is available for the second year of the biennium.

Presented to the governor May 30, 1995

Signed by the governor June 1, 1995, 11:18 a.m.

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## CHAPTER 258—S.F.No. 440

*An act relating to insurance; regulating coverages, notice provisions, enforcement provisions, and licensees; the comprehensive health association; increasing the lifetime benefit limit; making technical changes; providing for certain breast cancer coverage; prohibiting certain rate differentials within the same town or city; amending Minnesota Statutes 1994, sections 60A.06, subdivision 3; 60A.085; 60A.111, subdivision 2; 60A.124; 60A.23, subdivision 8; 60A.26; 60A.951, subdivisions 2 and 5; 60A.954, subdivision 1; 60A.955; 60K.03, subdivision 7; 60K.14, subdivision 1; 61A.03, subdivision 1; 61A.071; 61A.092, subdivisions 3 and 6; 61B.28, subdivisions 8 and 9; 62A.042; 62A.10; 62A.135; 62A.136; 62A.14; 62A.141; 62A.31, subdivisions 1h and 1i; 62A.46, subdivision 2, and by adding a subdivision; 62A.48, subdivisions 1 and 2; 62A.50, subdivision 3; 62C.14, subdivisions 5 and 14; 62D.02, subdivision 8; 62E.02, subdivision 7; 62E.12; 62F.02, subdivision 2; 62I.09, subdivision 2; 62L.02, subdivision 16; 62L.03, subdivision 5; 65A.01, by adding a subdivision; 65B.06, subdivision 3; 65B.08, subdivision 1; 65B.09, subdivision 1; 65B.10, subdivision 3; 65B.61, subdivision 1; 72A.20, subdivision 13, and by adding a subdivision; 72B.05; 79.251, subdivision 5, and by adding a subdivision; 79.34, subdivision 2; 79.35; 79A.01, by adding a subdivision; 79A.02, subdivision 4; 79A.03, by adding a subdivision; 176.181, subdivision 2; 299F.053, subdivision 2; 515A.3-112; and 515B.3-113; proposing coding for new law in Minnesota Statutes, chapters 60A; and 62A; repealing Minnesota Statutes 1994, sections 61A.072, subdivision 3; and 65B.07, subdivision 5.*

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

Section 1. Minnesota Statutes 1994, section 60A.06, subdivision 3, is amended to read:

Subd. 3. **LIMITATION ON COMBINATION POLICIES.** (a) Unless spe-

cifically authorized by subdivision 1, clause (4), it is unlawful to combine in one policy coverage permitted by subdivision 1, clauses (4) and (5)(a). This subdivision does not prohibit the simultaneous sale of these products, but the sale must involve two separate and distinct policies.

(b) This subdivision does not apply to group policies.

(c) This subdivision does not apply to policies permitted by subdivision 1, clause (4), that contain benefits providing acceleration of life, endowment, or annuity benefits in advance of the time they would otherwise be payable, or to long-term care policies as defined in section 62A.46, subdivision 2.

Sec. 2. Minnesota Statutes 1994, section 60A.085, is amended to read:

60A.085 **CANCELLATION OF GROUP COVERAGE; NOTIFICATION TO COVERED PERSONS.**

(a) No cancellation of any group life, group accidental death and dismemberment, group disability income, or group medical expense policy, plan, or contract regulated under chapter 62A or 62C is effective unless the insurer has made a good faith effort to notify all covered persons of the cancellation at least 30 days before the effective cancellation date. For purposes of this section, an insurer has made a good faith effort to notify all covered persons if the insurer has notified all the persons included on the list required by paragraph (b) at the home address given and only if the list has been updated within the last 12 months.

(b) At the time of the application for coverage subject to paragraph (a), the insurer shall obtain an accurate list of the names and home addresses of all persons to be covered.

(c) Paragraph (a) does not apply if the group policy, plan, or contract is replaced, or if the insurer has reasonable evidence to indicate that it will be replaced, by a substantially similar policy, plan, or contract.

(d) In no event shall this section extend coverage under a group policy, plan, or contract more than 120 days beyond the date coverage would otherwise cancel based on the terms of the group policy, plan, or contract.

(e) If coverage under the group policy, plan, or contract is extended by this section, then the time period during which affected members may exercise any conversion privilege provided for in the group policy, plan, or contract is extended for the same length of time, plus 30 days.

Sec. 3. Minnesota Statutes 1994, section 60A.111, subdivision 2, is amended to read:

Subd. 2. **PLAN.** If the commissioner determines that the required liabilities of any company are greater than its qualified assets and that the combined financial resources of the insurance company members of any insurance holding

company system of which the company is a member are not adequate to counterbalance that fact, the commissioner may require the company to submit to the commissioner for approval a plan by which the company undertakes to bring the ratio of its ~~required liabilities to its~~ qualified assets to its required liabilities, expressed as a percentage, up to at least 110 percent within a reasonable period, usually not exceeding five years.

Sec. 4. Minnesota Statutes 1994, section 60A.124, is amended to read:

60A.124 **INDEPENDENT AUDIT.**

The audit report of the independent certified public accountant that performs the audit of an insurer's annual statement as required under section ~~60A.13~~ 60A.129, subdivision ~~3a~~ 3, paragraph (a), should contain a statement as to whether anything, in connection with their audit, came to their attention that caused them to believe that the insurer failed to adopt and consistently apply the valuation procedure as required by sections 60A.122 and 60A.123.

Sec. 5. Minnesota Statutes 1994, section 60A.23, subdivision 8, is amended to read:

Subd. 8. **SELF-INSURANCE OR INSURANCE PLAN ADMINISTRATORS WHO ARE VENDORS OF RISK MANAGEMENT SERVICES.** (1) **SCOPE.** This subdivision applies to any vendor of risk management services and to any entity which administers, for compensation, a self-insurance or insurance plan. This subdivision does not apply (a) to an insurance company authorized to transact insurance in this state, as defined by section 60A.06, subdivision 1, clauses (4) and (5); (b) to a service plan corporation, as defined by section 62C.02, subdivision 6; (c) to a health maintenance organization, as defined by section 62D.02, subdivision 4; (d) to an employer directly operating a self-insurance plan for its employees' benefits; ~~or~~ (e) to an entity which administers a program of health benefits established pursuant to a collective bargaining agreement between an employer, or group or association of employers, and a union or unions; or (f) to an entity which administers a self-insurance or insurance plan if a licensed Minnesota insurer is providing insurance to the plan and if the licensed insurer has appointed the entity administering the plan as one of its licensed agents within this state.

(2) **DEFINITIONS.** For purposes of this subdivision the following terms have the meanings given them.

(a) "Administering a self-insurance or insurance plan" means (i) processing, reviewing or paying claims, (ii) establishing or operating funds and accounts, or (iii) otherwise providing necessary administrative services in connection with the operation of a self-insurance or insurance plan.

(b) "Employer" means an employer, as defined by section 62E.02, subdivision 2.

(c) "Entity" means any association, corporation, partnership, sole proprietorship, trust, or other business entity engaged in or transacting business in this state.

(d) "Self-insurance or insurance plan" means a plan providing life, medical or hospital care, accident, sickness or disability insurance~~, as an employee fringe benefit~~ for the benefit of employees or members of an association, or a plan providing liability coverage for any other risk or hazard, which is or is not directly insured or provided by a licensed insurer, service plan corporation, or health maintenance organization.

(e) "Vendor of risk management services" means an entity providing for compensation actuarial, financial management, accounting, legal or other services for the purpose of designing and establishing a self-insurance or insurance plan for an employer.

(3) **LICENSE.** No vendor of risk management services or entity administering a self-insurance or insurance plan may transact this business in this state unless it is licensed to do so by the commissioner. An applicant for a license shall state in writing the type of activities it seeks authorization to engage in and the type of services it seeks authorization to provide. The license may be granted only when the commissioner is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. The commissioner may issue a license subject to restrictions or limitations upon the authorization, including the type of services which may be supplied or the activities which may be engaged in. The license fee is $100. All licenses are for a period of two years.

(4) **REGULATORY RESTRICTIONS; POWERS OF THE COMMISSIONER.** To assure that self-insurance or insurance plans are financially solvent, are administered in a fair and equitable fashion, and are processing claims and paying benefits in a prompt, fair, and honest manner, vendors of risk management services and entities administering insurance or self-insurance plans are subject to the supervision and examination by the commissioner. Vendors of risk management services, entities administering insurance or self-insurance plans, and insurance or self-insurance plans established or operated by them are subject to the trade practice requirements of sections 72A.19 to 72A.30. In lieu of an unlimited guarantee from a parent corporation for a vendor of risk management services or an entity administering insurance or self-insurance plans, the commissioner may accept a ~~fidelity~~ surety bond in a form satisfactory to the commissioner in an amount equal to 120 percent of the total amount of claims handled by the applicant in the prior year. If at any time the total amount of claims handled during a year exceeds the amount upon which the bond was calculated, the administrator shall immediately notify the commissioner. The commissioner may require that the bond be increased accordingly.

(5) **RULEMAKING AUTHORITY.** To carry out the purposes of this subdivision, the commissioner may adopt rules, including emergency rules, pursuant to sections 14.001 to 14.69. These rules may:

(a) establish reporting requirements for administrators of insurance or self-insurance plans;

(b) establish standards and guidelines to assure the adequacy of financing, reinsuring, and administration of insurance or self-insurance plans;

(c) establish bonding requirements or other provisions assuring the financial integrity of entities administering insurance or self-insurance plans; or

(d) establish other reasonable requirements to further the purposes of this subdivision.

Sec. 6. **[60A.235] STANDARDS FOR DETERMINING WHETHER CONTRACTS ARE HEALTH PLAN CONTRACTS OR STOP LOSS CONTRACTS.**

Subdivision 1. **FINDINGS AND PURPOSE.** The purpose of this section is to establish a standard for the determination of whether an insurance policy or other evidence or coverage should be treated as a policy of accident and sickness insurance or a stop loss policy for the purpose of the regulation of the business of insurance. The laws regulating the business of insurance in Minnesota impose distinctly different requirements upon accident and sickness insurance policies and stop loss policies. In particular, the regulation of accident and sickness insurance in Minnesota includes measures designed to reform the health insurance market, to minimize or prohibit selective rating or rejection of employee groups or individual group members based upon health conditions, and to provide access to affordable health insurance coverage regardless of preexisting health conditions. The health care reform provisions enacted in Minnesota will only be effective if they are applied to all insurers and health carriers who in substance, regardless of purported form, engage in the business of issuing health insurance coverage to employees of an employee group. This section applies to insurance companies and health carriers and the policies or other evidence of coverage that they issue. This section does not apply to employers or the benefit plans they establish for their employees.

Subd. 2. **DEFINITIONS.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Attachment point" means the claims amount beyond which the insurance company or health carrier incurs a liability for payment.

(b) "Direct coverage" means coverage under which an insurance company or health carrier assumes a direct obligation to an individual, under the policy or evidence of coverage, with respect to health care expenses incurred by the individual or a member of the individual's family.

(c) "Expected claims" means the amount of claims that, in the absence of a stop loss policy or other insurance or evidence of coverage, are projected to be incurred under an employer-sponsored plan covering health care expenses.

(d) "Expected plan claims" means the expected claims less the projected claims in excess of the specific attachment point, adjusted to be consistent with the employer's aggregate contract period.

(e) "Health plan" means a health plan as defined in section 62A.011 and includes group coverage regardless of the size of the group.

(f) "Health carrier" means a health carrier as defined in section 62A.011.

Subd. 3. **HEALTH PLAN POLICIES ISSUED AS STOP LOSS COVERAGE.** (a) An insurance company or health carrier issuing or renewing an insurance policy or other evidence of coverage, that provides coverage to an employer for health care expenses incurred under an employer-sponsored plan provided to the employer's employees, retired employees, or their dependents, shall issue the policy or evidence of coverage as a health plan if the policy or evidence of coverage:

(1) has a specific attachment point for claims incurred per individual that is lower than $10,000; or

(2) has an aggregate attachment point that is lower than the sum of:

(i) 140 percent of the first $50,000 of expected plan claims;

(ii) 120 percent of the next $450,000 of expected plan claims; and

(iii) 110 percent of the remaining expected plan claims.

(b) Where the insurance policy or evidence of coverage applies to a contract period of more than one year, the dollar amounts set forth in paragraph (a), clauses (1) and (2), must be multiplied by the length of the contract period expressed in years.

(c) The commissioner may adjust the constant dollar amounts provided in paragraph (a), clauses (1) and (2), on January 1 of any year, based upon changes in the medical component of the Consumer Price Index (CPI). Adjustments must be in increments of $100 and must not be made unless at least that amount of adjustment is required. The commissioner shall publish any change in these dollar amounts at least three months before their effective date.

(d) A policy or evidence of coverage issued by an insurance company or health carrier that provides direct coverage of health care expenses of an individual including a policy or evidence of coverage administered on a group basis is a health plan regardless of whether the policy or evidence of coverage is denominated as stop loss coverage.

Subd. 4. **COMPLIANCE.** (a) An insurance company or health carrier that is required to issue a policy or evidence of coverage as a health plan under this section shall, even if the policy or evidence of coverage is denominated as stop loss coverage, comply with all the laws of this state that apply to the health plan, including, but not limited to, chapters 62A, 62C, 62D, 62E, 62L, and 62Q.

(b) With respect to an employer who had been issued a policy or evidence of coverage denominated as stop loss coverage before the effective date of this section, compliance with this section is required as of the first renewal date occurring on or after the effective date of this section.

Sec. 7. **[60A.236] STOP LOSS REGULATION.**

A contract providing stop loss coverage, issued or renewed to a small employer, as defined in section 62L.02, subdivision 26, or to a plan sponsored by a small employer, must include a claim settlement period no less favorable to the small employer or plan than coverage of all claims incurred during the contract period regardless of when the claims are paid.

Sec. 8. Minnesota Statutes 1994, section 60A.26, is amended to read:

60A.26 **SUSPENSION OF INSURERS~~, NOTICE TO OTHER STATES~~; NOTIFICATIONS AND REPORTS.**

Subdivision 1. **OTHER STATES.** The commissioner of commerce shall notify the insurance departments of all other states whenever, under any law then in effect, the commissioner suspends the right of a foreign or domestic insurer to transact business in this state.

Subd. 2. **NAIC.** The commissioner of commerce shall report public regulatory actions, investigative information, and complaints to the appropriate reporting system or database of the National Association of Insurance Commissioners.

Sec. 9. Minnesota Statutes 1994, section 60A.951, subdivision 2, is amended to read:

Subd. 2. **AUTHORIZED PERSON.** "Authorized person" means the county attorney, sheriff, or chief of police responsible for investigations in the county where the suspected insurance fraud occurred; the superintendent of the bureau of criminal apprehension; the commissioner of commerce; the commissioner of labor and industry; the attorney general; or any duly constituted criminal investigative department or agency of the United States.

Sec. 10. Minnesota Statutes 1994, section 60A.951, subdivision 5, is amended to read:

Subd. 5. **INSURER.** "Insurer" means insurance company, risk retention group as defined in section 60E.02, service plan corporation as defined in section 62C.02, health maintenance organization as defined in section 62D.02, integrated service network as defined in section 62N.02, fraternal benefit society regulated under chapter 64B, township mutual company regulated under chapter 67A, joint self-insurance plan or multiple employer trust regulated under chapter 60F, 62H, or section 471.617, subdivision 2, and persons administering a self-insurance plan as defined in section 60A.23, subdivision 8, clause (2), paragraphs (a) and (d), and the workers' compensation reinsurance association established in section 79.34.

Sec. 11. Minnesota Statutes 1994, section 60A.954, subdivision 1, is amended to read:

Subdivision 1. **ESTABLISHMENT.** An insurer shall institute, implement, and maintain an antifraud plan. For the purpose of this section, the term insurer does not include reinsurers, the workers' compensation reinsurance association, self-insurers, and excess insurers. Within 30 days after instituting or modifying an antifraud plan, the insurer shall notify the commissioner in writing. The notice must include the name of the person responsible for administering the plan. An antifraud plan shall establish procedures to:

(1) prevent insurance fraud, including: internal fraud involving the insurer's officers, employees, or agents; fraud resulting from misrepresentations on applications for insurance; and claims fraud;

(2) report insurance fraud to appropriate law enforcement authorities; and

(3) cooperate with the prosecution of insurance fraud cases.

Sec. 12. Minnesota Statutes 1994, section 60A.955, is amended to read:

60A.955 CLAIM **FORMS TO CONTAIN FRAUD WARNING.**

All insurance claim forms issued by an insurer for use in submitting a claim for payment or a claim for any other benefit pursuant to a policy shall clearly contain a warning substantially as follows: "A person who ~~submits an application or~~ files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime." An insurer may comply with this section by including the warning on an addendum attached to the ~~application or~~ claim form. The absence of the required warning does not constitute a defense in a prosecution for a violation of chapter 609 or any other chapter of Minnesota Statutes.

Sec. 13. Minnesota Statutes 1994, section 60K.03, subdivision 7, is amended to read:

Subd. 7. **EXCEPTIONS.** The following are exempt from the general licensing requirements prescribed by this section:

(1) agents of township mutuals who are exempted pursuant to section 60K.04;

(2) fraternal benefit society representatives exempted pursuant to section 60K.05;

(3) any regular salaried officer or employee of a licensed insurer, without license or other qualification, may act on behalf of that licensed insurer in the negotiation of insurance for that insurer, provided that a licensed agent must participate in the sale of the insurance;

(4) employers and their officers or employees, and the trustees or employees

of any trust plan, to the extent that the employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits for the employees of the employers or employees of their subsidiaries or affiliates involving the use of insurance issued by a licensed insurance company; provided that the activities of the officers, employees and trustees are incidental to clerical or administrative duties and their compensation does not vary with the volume of insurance or applications for insurance;

(5) employees of a creditor who enroll debtors for credit life, credit accident and health, or credit involuntary unemployment insurance; provided the employees receive no commission or fee for it;

(6) clerical or administrative employees of an insurance agent who take insurance applications or receive premiums in the office of their employer, if the activities are incidental to clerical or administrative duties and the employee's compensation does not vary with the volume of the applications or premiums; ~~and~~

(7) rental vehicle companies and their employees in connection with the offer of rental vehicle personal accident insurance under section 72A.125; and

(8) employees of a retailer who enroll purchasers for credit insurance associated with a retail purchase; provided the employees receive no commission, fee, bonus, or other form of compensation for it.

Sec. 14. Minnesota Statutes 1994, section 60K.14, subdivision 1, is amended to read:

Subdivision 1. **PERSONAL SOLICITATION OF INSURANCE SALES.** (a) **DEFINITIONS.** For the purposes of this section, the following terms have the meanings given them:

(1) "agent" means a person, copartnership, or corporation required to be licensed pursuant to section 60K.02; and

(2) "personal solicitation" means any contact by an agent, or any person acting on behalf of an agent, made for the purpose of selling or attempting to sell insurance, when either the agent or a person acting for the agent contacts the buyer by telephone or in person, except: (i) an attempted sale in which the buyer personally knows the identity of the agent, the name of the general agency, if any, which the agent represents, and the fact that the agent is an insurance agent; (ii) an attempted sale in which the prospective purchaser of insurance initiated the contact; or (iii) a personal contact which takes place at the agent's place of business.

(b) **DISCLOSURE REQUIREMENT.** Before a personal solicitation, the agent or person acting for an agent shall, at the time of initial personal contact ~~or communication~~ with the potential buyer, clearly and expressly disclose in writing:

(1) the name and state insurance agent license number of the person making the contact ~~or communication~~;

(2) the name of the agent, general agency, or insurer that person represents; and

(3) the fact that the agent, agency, or insurer is in the business of selling insurance.

If the initial personal contact is made by telephone, the disclosures required by this subdivision need not be made in writing.

(c) **FALSE REPRESENTATION OF GOVERNMENT AFFILIATION.** No agent or person acting for an agent shall make any communication to a potential buyer that indicates or gives the impression that the agent is acting on behalf of a government agency.

Sec. 15. Minnesota Statutes 1994, section 61A.03, subdivision 1, is amended to read:

Subdivision 1. **GENERALLY.** No policy of life insurance may be issued in this state or by a life insurance company organized under the laws of this state unless it contains the following provisions:

(a) **PREMIUM.** A provision that all premiums are payable in advance either at the home office of the company, or to an agent of the company, upon delivery of a receipt signed by one or more officers named in the policy and countersigned by the agent, but a policy may contain a provision that the policy itself is a receipt for the first premium;

(b) **GRACE PERIOD.** A provision for a one month grace period for the payment of every premium after the first, during which the insurance will continue in force. The provision may subject the late payment to a finance charge and contain a stipulation that if the insured dies during the grace period, the overdue premium will be deducted in any settlement under the policy;

(c) **ENTIRE CONTRACT.** A provision that the policy constitutes the entire contract between the parties and is incontestable after it has been in force during the lifetime of the insured for two years from its date, except for nonpayment of premiums and except for violations of the conditions of the policy relating to naval and military services in time of war; that at the option of the company, provisions relative to benefits in the event of total and permanent disability and provisions which grant additional insurance specifically against death by accident, may be excepted; and that a special form of policy may be issued on the life of a person employed in an occupation classified by the company as extra hazardous or as leading to hazardous employment, which provides that service in certain designated occupations may reduce the company's liability under the policy to a certain designated amount not less than the full policy reserve;

(d) **REPRESENTATIONS AND WARRANTIES.** A provision that, in the

absence of fraud, all statements made by the insured are representations and not warranties, and that no statement voids the policy unless it is contained in a written application and a copy of the application is endorsed upon or attached to the policy when issued;

(e) **MISSTATEMENT OF AGE.** A provision that if the age of the insured is understated the amount payable under the policy will be the amount the premium would have purchased at the correct age;

(f) **DIVIDENDS ON PARTICIPATING POLICIES.** A provision that the policy will participate in the surplus of the company and that, beginning not later than the end of the third policy year, the company will annually determine and account for the portion of the divisible surplus accruing on the policy, and that the owner of the policy has the right, each year after the fifth, to have the current dividend arising from the participation paid in cash. If the policy provides other dividend options, it must specify which option is effective if the owner of the policy does not elect an option. The provision may condition any dividends payable during the first five years of the policy upon the payment of the next ensuing annual premium. This provision is not required in nonparticipating policies, in policies issued on under-average lives, or in insurance in exchange for lapsed or surrendered policies;

(g) **POLICY LOANS.** A provision (1) that after three full years' premiums have been paid, the company at any time while the policy is in force, will advance, on proper assignment of the policy, and on the sole security thereof, at a specified rate of interest, not to exceed eight percent per annum, or at an adjustable rate of interest as otherwise provided for in this section, a sum equal to, or, at the option of the owner of the policy, less than the loan value thereof; (2) that the loan value is the cash surrender value thereof at the end of the current policy year; (3) that the loan, unless made to pay premiums, may be deferred for not more than six months after the application for it is made; (4) that the company will deduct from the loan value any existing indebtedness on the policy and any unpaid balance of the premium for current policy year, and may collect interest in advance on the loan to the end of the current policy year; (5) that the failure to repay an advance or to pay interest does not void the policy unless the total indebtedness thereon to the company equals or exceeds the loan value at the time of the failure, nor until one month after notice has been mailed by the company to the last known address of the insured and of the assignee of record at the home office of the company; and (6) that no condition other than those provided in this section will be exacted as a prerequisite to an advance. This provision is not required in term insurance;

(h) **REINSTATEMENT.** A provision that if, in event of default in premium payments, the nonforfeiture value of the policy is applied to the purchase of other insurance, and if that insurance is in force and the original policy has not been surrendered to the company and canceled, the policy may be reinstated within three years after the default upon evidence of insurability satisfactory to the company and payment of arrears of premiums with interest;

(i) **PAYMENT OF CLAIMS.** A provision that, when a policy becomes a claim by the death of the insured, settlement will be made within two months after receipt of due proof of death;

(j) **SETTLEMENT OPTION.** A table showing the amount of installments in which the policy may provide its proceeds may be payable;

(k) **DESCRIPTION OF POLICY.** A title on the face and on the back of the policy briefly and correctly describing the policy in bold letters stating its general character, dividend periods, and other particulars, so that the holder will not be able to mistake the nature and scope of the contract;

(l) **FORM NUMBER.** A form number in the lower left-hand corner of the first page of each form, including riders and endorsements.

Any of the foregoing provisions or portions thereof relating to premiums not applicable to single premium policies must not be incorporated therein.

Sec. 16. Minnesota Statutes 1994, section 61A.071, is amended to read:

61A.071 **APPLICATIONS.**

No individual life insurance policy~~, except life insurance marketed on a direct response basis,~~ shall be issued or delivered in this state to a person age 65 or older unless a signed and completed copy of the application for insurance is left with the applicant at the time application is made. This requirement will not apply to life insurers who mail a copy of the signed, completed application to the applicant within 24 hours of receiving the application. However, where an individual life policy is marketed on a direct response basis, a copy of any application signed by the applicant shall be delivered to the insured along with, or as part of, the policy.

Sec. 17. Minnesota Statutes 1994, section 61A.092, subdivision 3, is amended to read:

Subd. 3. **NOTICE OF OPTIONS.** Upon termination of or layoff from employment of a covered employee, the employer shall inform the employee of:

(1) the employee's right to elect to continue the coverage;

(2) the amount the employee must pay monthly to the employer to retain the coverage;

(3) the manner in which and the office of the employer to which the payment to the employer must be made; and

(4) the time by which the payments to the employer must be made to retain coverage.

The employee has 60 days within which to elect coverage. The 60-day period shall begin to run on the date coverage would otherwise terminate or on

the date upon which notice of the right to coverage is received, whichever is later.

If the covered employee or covered dependent dies during the 60-day election period and before the covered employee makes an election to continue or reject continuation, then the covered employee will be considered to have elected continuation of coverage. The estate of the former employee or covered dependent would then be entitled to a death benefit equal to the amount of insurance that could have been continued less any unpaid premium owing as of the date of death.

Notice must be in writing and sent by first class mail to the employee's last known address which the employee has provided to the employer.

A notice in substantially the following form is sufficient: "As a terminated or laid off employee, the law authorizes you to maintain your group insurance benefits, in an amount equal to the amount of insurance in effect on the date you terminated or were laid off from employment, for a period of up to 18 months. To do so, you must notify your former employer within 60 days of your receipt of this notice that you intend to retain this coverage and must make a monthly payment of $..... at ..... by the ..... of each month."

Sec. 18. Minnesota Statutes 1994, section 61A.092, subdivision 6, is amended to read:

Subd. 6. **APPLICATION.** This section applies to a policy, certificate of insurance, or similar evidence of coverage issued to a Minnesota resident or issued to provide coverage to a Minnesota resident. This section does not apply to: (1) a certificate of insurance or similar evidence of coverage that meets the conditions of section 61A.093, subdivision 2; or (2) a group life insurance policy that contains a provision permitting the certificate holder, upon termination or layoff from employment, to retain the coverage provided under the group policy by paying premiums directly to the insurer, provided that the employer shall give the employee notice of the employee's and each related certificate holder's right to continue the insurance by paying premiums directly to the insurer. A related certificate holder is an insured spouse of the employee.

Sec. 19. Minnesota Statutes 1994, section 61B.28, subdivision 8, is amended to read:

Subd. 8. **FORM.** The form of notice referred to in subdivision 7, paragraph (a), is as follows:

".....
.....
.....
(insert name, current address, and
telephone number of insurer)
NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

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

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
(insert current address and telephone number)

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $300,000. Subject to this $300,000 limit, the guaranty association will pay up to $300,000 in life insurance death benefits, $100,000 in net cash surrender and net cash withdrawal values for life insurance, $300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $100,000 in annuity net cash surrender and net cash withdrawal values, $300,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $300,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $100,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $7,500,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $7,500,000, the $7,500,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE."

Additional language may be added to the notice if approved by the commissioner prior to its use in the form. This section does not apply to fraternal benefit societies regulated under chapter 64B.

Sec. 20. Minnesota Statutes 1994, section 61B.28, subdivision 9, is amended to read:

Subd. 9. **COMBINATION FIXED-VARIABLE POLICY.** The notice required in subdivision 8 must clearly describe what portions of a combination fixed-variable policy are not covered by the Minnesota life and health insurance guaranty association. The notice requirements specified in subdivision ~~8~~ 7, paragraph (c), do not apply to a combination fixed-variable policy.

Sec. 21. **[62A.023] NOTICE OF RATE CHANGE.**

A health insurer or service plan corporation must send written notice to its policyholders and contract holders at their last known address at least 30 days in advance of the effective date of a proposed rate change. This notice requirement does not apply to individual certificate holders covered by group insurance policies or group subscriber contracts.

Sec. 22. Minnesota Statutes 1994, section 62A.042, is amended to read:

62A.042 **FAMILY COVERAGE; COVERAGE OF NEWBORN INFANTS.**

Subdivision 1. **INDIVIDUAL FAMILY POLICIES; RENEWALS.** (a) No policy of individual accident and sickness insurance which provides for insurance for more than one person under section 62A.03, subdivision 1, clause (3), and no individual health maintenance contract which provides for coverage for more than one person under chapter 62D, shall be renewed to insure or cover any person in this state or be delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered members of the family any newborn infants, including dependent grandchildren who reside with a covered grandparent, immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth.

(b) The coverage under paragraph (a) includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. If orthodontic services are eligible for

coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision.

Subd. 2. **GROUP POLICIES; RENEWALS.** (a) No group accident and sickness insurance policy and no group health maintenance contract which provide for coverage of family members or other dependents of an employee or other member of the covered group shall be renewed to cover members of a group located in this state or delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered family members or dependents any newborn infants, including dependent grandchildren who reside with a covered grandparent, immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth.

(b) The coverage under paragraph (a) includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision.

Sec. 23. Minnesota Statutes 1994, section 62A.10, is amended to read:

62A.10 **GROUP INSURANCE.**

Subdivision 1. **REQUIREMENTS.** Group accident and health insurance ~~is hereby declared to be that form of accident and health insurance covering~~ may be issued to cover groups of not less than two employees nor less than ten members, and which may include the employee's or member's dependents, consisting of husband, wife, children, and actual dependents residing in the household, ~~written under a.~~ The master policy may be issued to any governmental corporation, unit, agency, or department thereof, or to any corporation, copartnership, individual, employer, or to any association as defined by section 60A.02, subdivision 1a, where officers, members, employees, or classes or divisions thereof, may be insured for their individual benefit.

Subd. 2. **GROUP ACCIDENTAL DEATH AND GROUP DISABILITY INCOME POLICIES.** Group accidental death insurance and group disability income insurance policies may be issued in connection with first real estate mortgage loans to cover groups of not less than ten debtors of a creditor written under a master policy issued to a creditor to insure its debtors in connection with first real estate mortgage loans, in amounts not to exceed the actual or scheduled amount of their indebtedness. No other accident and health coverages

may be issued in connection with first real estate mortgage loans on a group basis to a debtor-creditor group.

Subd. 3. **AUTHORITY TO ISSUE.** Any insurer authorized to write accident and health insurance in this state shall have power to issue group accident and health policies.

Subd. ~~2~~ 4. **POLICY FORMS.** No policy of group accident and health insurance may be issued or delivered in this state unless the same has been approved by the commissioner in accordance with section 62A.02, subdivisions 1 to 6. These forms shall contain the standard provisions relating and applicable to health and accident insurance and shall conform with the other requirements of law relating to the contents and terms of policies of accident and sickness insurance in so far as they may be applicable to group accident and health insurance, and also the following provisions:

(1) **ENTIRE CONTRACT.** A provision that the policy and the application of the creditor, employer, or executive officer or trustee of any association, and the individual applications, if any, of the debtors, employees, or members, insured, shall constitute the entire contract between the parties, and that all statements made by the creditor, employer, or any executive officer or trustee ~~in~~ on behalf of the group to be insured, shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in the written application;

(2) **MASTER POLICY-CERTIFICATES.** A provision that the insurer will issue a master policy to the creditor, employer, or to the executive officer or trustee of the association; and the insurer shall also issue to the creditor, the employer, or to the executive officer or trustee of the association, for delivery to the debtor, employee, or member, who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which the debtor, employee, or member is entitled and to whom payable, together with a statement as to when and where the master policy, or a copy thereof, may be seen for inspection by the individual insured~~;~~ ~~this~~. The individual certificate may contain the names of, and insure the dependents of, the employee, or member, as provided for herein;

(3) **NEW INSUREDS.** A provision that to the group or class thereof originally insured may be added, from time to time, all new employees of the employer ~~or~~, members of the association, or debtors of the creditor eligible to and applying for insurance in that group or class and covered or to be covered by the master policy.

(4) **CONVERSION PRIVILEGE.** In the case of accidental death insurance and disability income insurance issued to debtors of a creditor, the policy must contain a conversion privilege permitting an insured debtor to convert, without evidence of insurability, to an individual policy within 30 days of the date the insured debtor's group coverage is terminated, and not replaced with other

group coverage, for any reason other than nonpayment of premiums. The individual policy must provide the same amount of insurance and be subject to the same terms and conditions as the group policy and the initial premium for the individual policy must be the same premium the insured debtor was paying under the group policy. This provision does not apply to a group policy which provides that the certificate holder may, upon termination of coverage under the group policy for any reason other than nonpayment of premium, retain coverage provided under the group policy by paying premiums directly to the insurer.

Sec. 24. Minnesota Statutes 1994, section 62A.135, is amended to read:

**62A.135 ~~NONCOMPREHENSIVE~~ FIXED INDEMNITY POLICIES; MINIMUM LOSS RATIOS.**

~~(a) This section applies to individual or group policies, certificates, or other evidence of coverage designed primarily to provide coverage for hospital or medical expenses on a per diem, fixed indemnity, or nonexpense incurred basis offered, issued, or renewed, to provide coverage to a Minnesota resident.~~

~~(b) Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, policies must return to Minnesota policyholders in the form of aggregate benefits under the policy, for each year, on the basis of incurred claims experience and earned premiums in Minnesota and in accordance with accepted actuarial principles and practices:~~

~~(1) at least 75 percent of the aggregate amount of premiums earned in the case of group policies; and~~

~~(2) at least 65 percent of the aggregate amount of premiums earned in the case of individual policies.~~

~~(c) An insurer may only issue or renew an individual policy on a guaranteed renewable or noncancelable basis.~~

~~(d) Noncomprehensive policies, certificates, or other evidence of coverage subject to the provisions of this section are also subject to the requirements, penalties, and remedies applicable to medicare supplement policies, as set forth in section 62A.36, subdivisions 1a, 1b, and 2.~~

~~The first supplement to the annual statement required to be filed pursuant to this paragraph must be for the annual statement required to be submitted on or after January 1, 1993.~~

Subdivision 1. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given them:

(a) "fixed indemnity policy" is a policy form, other than a long-term care policy as defined in section 62A.46, subdivision 2, that pays a predetermined, specified, fixed benefit for services provided. Claim costs under these forms are generally not subject to inflation, although they may be subject to changes in the

utilization of health care services. For policy forms providing both expense-incurred and fixed benefits, the policy form is a fixed indemnity policy if 50 percent or more of the total claims are for predetermined, specified, fixed benefits;

(b) "guaranteed renewable" means that, during the renewal period (to a specified age) renewal cannot be declined nor coverage changed by the insurer for any reason other than nonpayment of premiums, fraud, or misrepresentation, but the insurer can revise rates on a class basis upon approval by the commissioner;

(c) "noncancelable" means that, during the renewal period (to a specified age) renewal cannot be declined nor coverage changed by the insurer for any reason other than nonpayment of premiums, fraud, or misrepresentation and that rates cannot be revised by the insurer. This includes policies that are guaranteed renewable to a specified age, such as 60 or 65, at guaranteed rates; and

(d) "average annualized premium" means the average of the estimated annualized premium per covered person based on the anticipated distribution of business using all significant criteria having a price difference, such as age, sex, amount, dependent status, mode of payment, and rider frequency. For filing of rate revisions, the amount is the anticipated average assuming the revised rates have fully taken effect.

Subd. 2. **APPLICABILITY.** This section applies to individual or group policies, certificates, or other evidence of coverage meeting the definition of a fixed indemnity policy, offered, issued, or renewed, to provide coverage to a Minnesota resident.

Subd. 3. **MINIMUM LOSS RATIO STANDARDS.** Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, the minimum loss ratios for fixed indemnity policies are:

(1) as shown in the following table:

| Type of Coverage | Renewal Provision | |
|---|---|---|
| | Guaranteed Renewable | Noncancelable |
| Group | 75% | 70% |
| Individual | 65% | 60% |

or

(2) for policies or certificates where the average annualized premium is less than $1,000, the average annualized premium less $30, multiplied by the required loss ratio in clause (1), divided by the average annualized premium. However, in no event may the minimum loss ratio be less than the required loss ratio from clause (1) minus ten percent.

The commissioner of commerce may adjust the constant dollar amounts provided in clause (2) on January 1 of any year, based upon changes in the CPI-U, the consumer price index for all urban consumers, published by the

United States Department of Labor, Bureau of Labor Statistics. Adjustments must be in increments of $5 and must not be made unless at least that amount of adjustment is required to each amount.

All rate filings must include a demonstration that the rates are not excessive. Rates are not excessive if the anticipated loss ratio and the lifetime anticipated loss ratio meet or exceed the minimum loss ratio standard in this subdivision.

Subd. 4. **RENEWAL PROVISION.** An insurer may only issue or renew an individual policy on a guaranteed renewable or noncancelable basis.

Subd. 5. **SUPPLEMENT TO ANNUAL STATEMENTS.** Each insurer that has fixed indemnity policies in force in this state shall, as a supplement to the annual statement required by section 60A.13, submit, in a form prescribed by the commissioner, the experience data for the calendar year showing its incurred claims, earned premiums, incurred to earned loss ratio, and the ratio of the actual loss ratio to the expected loss ratio for each fixed indemnity policy form in force in Minnesota. The experience data must be provided on both a Minnesota only and a national basis. If in the opinion of the company's actuary, the deviation of the actual loss ratio from the expected loss ratio for a policy form is due to unusual reserve fluctuations, economic conditions, or other non-recurring conditions, the insurer should also file that opinion with appropriate justification.

If the data submitted does not confirm that the insurer has satisfied the loss ratio requirements of this section, the commissioner shall notify the insurer in writing of the deficiency. The insurer shall have 30 days from the date of receipt of the commissioner's notice to file amended rates that comply with this section or a request for an exemption with appropriate justification. If the insurer fails to file amended rates within the prescribed time and the commissioner does not exempt the policy form from the need for a rate revision, the commissioner shall order that the insurer's filed rates for the nonconforming policy be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The insurer's failure to file amended rates within the specified time of the issuance of the commissioner's order amending the rates does not preclude the insurer from filing an amendment of its rates at a later time.

Subd. 6. **PENALTIES.** Each sale of a policy that does not comply with the loss ratio requirements of this section is subject to the penalties in sections 72A.17 to 72A.32.

Subd. 7. **SOLICITATIONS BY MAIL OR MEDIA ADVERTISEMENT.** For purposes of this section, fixed indemnity policies issued without the use of an agent as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, must be treated as group policies.

Sec. 25. Minnesota Statutes 1994, section 62A.136, is amended to read:

62A.136 **DENTAL AND VISION ~~PLANS~~ PLAN COVERAGE.**

The following provisions do not apply to health plans providing dental or vision coverage only: sections 62A.041~~,~~; 62A.047~~,~~; 62A.149~~,~~; 62A.151~~,~~; 62A.152~~,~~; 62A.154~~,~~; 62A.155~~,~~; 62A.21, subdivision 2b; 62A.26~~,~~; 62A.28~~,~~; and 62A.30.

Sec. 26. Minnesota Statutes 1994, section 62A.14, is amended to read:

62A.14 **HANDICAPPED CHILDREN.**

Subdivision 1. **INDIVIDUAL FAMILY POLICIES.** An individual hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, or an individual health maintenance contract delivered or issued for delivery in this state after August 1, 1984, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap and (b) chiefly dependent upon the policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or health maintenance organization by the policyholder or enrollee within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Subd. 2. **GROUP POLICIES.** A group hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, or a group health maintenance contract delivered or issued for delivery in this state after August 1, 1984, which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap and (b) chiefly dependent upon the employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or organization by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Sec. 27. Minnesota Statutes 1994, section 62A.141, is amended to read:

62A.141 **COVERAGE FOR HANDICAPPED DEPENDENTS.**

No group policy or group plan of health and accident insurance regulated

under this chapter, chapter 62C, or 62D, which provides for dependent coverage may be issued or renewed in this state after August 1, 1983, unless it covers the handicapped dependents of the insured, subscriber, or enrollee of the policy or plan. For purposes of this section, a handicapped dependent is a person that is and continues to be both: (1) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap; and (2) chiefly dependent upon the policyholder for support and maintenance. Consequently, the policy or plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning handicapped dependents.

If ordered by the commissioner of commerce, the insurer of a Minnesota-domiciled nonprofit association which is composed solely of agricultural members may restrict coverage under this section to apply only to Minnesota residents.

Sec. 28. **[62A.309] BREAST CANCER COVERAGE.**

Subdivision 1. **SCOPE OF COVERAGE.** This section applies to all health plans as defined in section 62A.011.

Subd. 2. **REQUIRED COVERAGE.** Every health plan included in subdivision 1 must provide to each covered person who is a resident of Minnesota coverage for the treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation and for expenses arising from the treatment.

Subd. 3. **GREATER COINSURANCE OR COPAYMENT PROHIBITED.** Coverage under this section shall not be subject to any greater coinsurance or copayment than that applicable to any other coverage provided by the health plan.

Subd. 4. **GREATER DEDUCTIBLE PROHIBITED.** Coverage under this section shall not be subject to any greater deductible than that applicable to any other coverage provided by the health plan.

Sec. 29. Minnesota Statutes 1994, section 62A.31, subdivision 1h, is amended to read:

Subd. 1h. **LIMITATIONS ON DENIALS, CONDITIONS, AND PRICING OF COVERAGE.** No issuer of Medicare supplement policies, including policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., in this state may impose preexisting condition limitations or otherwise deny or condition the issuance or effectiveness of any Medicare supplement insurance policy form available for sale in this state, nor may it discriminate in the pricing of such a policy, because of the health status, claims experience, receipt of health care, ~~or~~ medical condition, or age of an applicant where an application for such insurance is submitted

during the six-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B. This paragraph applies regardless of whether the individual has attained the age of 65 years. If an individual who is enrolled in Medicare Part B due to disability status is involuntarily disenrolled due to loss of disability status, the individual is eligible for the six-month enrollment period provided under this subdivision if the individual later becomes eligible for and enrolls again in Medicare Part B.

Sec. 30. Minnesota Statutes 1994, section 62A.31, subdivision 1i, is amended to read:

Subd. 1i. **REPLACEMENT COVERAGE.** If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the issuer of the replacing policy or certificate shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate for benefits to the extent the time was spent under the original policy or certificate. For purposes of this subdivision, "Medicare supplement policy or certificate" means all coverage described in section 62A.011, subdivision 4, clause (10).

Sec. 31. Minnesota Statutes 1994, section 62A.46, subdivision 2, is amended to read:

Subd. 2. **LONG-TERM CARE POLICY.** "Long-term care policy" means an individual or group policy, certificate, subscriber contract, or other evidence of coverage that provides benefits for prescribed long-term care, including nursing facility services and home care services, pursuant to the requirements of sections 62A.46 to 62A.56. ~~A long-term care policy must contain a designation specifying whether the policy is a long-term care policy AA or A and a caption stating that the commissioner has established two categories of long-term care insurance and the minimum standards for each.~~

Sections 62A.46, 62A.48, and 62A.52 to 62A.56 do not apply to a long-term care policy issued to (a) an employer or employers or to the trustee of a fund established by an employer where only employees or retirees, and dependents of employees or retirees, are eligible for coverage or (b) to a labor union or similar employee organization. The associations exempted from the requirements of sections 62A.31 to 62A.44 under 62A.31, subdivision 1, clause (c) shall not be subject to the provisions of sections 62A.46 to 62A.56 until July 1, 1988.

Sec. 32. Minnesota Statutes 1994, section 62A.46, is amended by adding a subdivision to read:

Subd. 13. **BENEFIT DAY.** "Benefit day" means each day of confinement in a nursing facility or each visit for home care services. For purposes of section 62A.48, subdivision 1, if the policyholder receives more than one home care service visit within a 24-hour period, each visit constitutes one benefit day.

Sec. 33. Minnesota Statutes 1994, section 62A.48, subdivision 1, is amended to read:

Subdivision 1. **POLICY REQUIREMENTS.** No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long-term care services shall be offered, issued, delivered, or renewed in this state, whether or not the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long-term care policy must cover prescribed long-term care in nursing facilities and at least the prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. ~~Coverage under a long-term care policy AA must include: a maximum lifetime benefit limit of at least $100,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums.~~ Coverage under a long-term care policy ~~A~~ must include: a ~~maximum~~ minimum lifetime benefit limit of at least ~~$50,000~~ $25,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums. Prior hospitalization may not be required under a long-term care policy.

~~Coverage under either~~ The policy ~~designation~~ must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage. Coverage under ~~either~~ the policy ~~designation~~ may include a waiting period of up to 90 days before benefits are paid, but there must be no more than one waiting period per benefit period; for purposes of this sentence, "days" ~~means~~ can mean calendar or benefit days. If benefit days are used, an appropriate premium reduction and disclosure must be made. No policy may exclude coverage for mental or nervous disorders which have a demonstrable organic cause, such as Alzheimer's and related dementias. No policy may require the insured to be homebound or house confined to receive home care services. The policy must include a provision that the plan will not be canceled or renewal refused except on the grounds of nonpayment of the premium, provided that the insurer may change the premium rate on a class basis on any policy anniversary date. A provision that the policyholder may elect to have the premium paid in full at age 65 by payment of a higher premium up to age 65 may be offered. A provision that the premium would be waived during any period in which benefits are being paid to the insured during confinement in a nursing facility must be included. A nongroup policyholder may return a policy within 30 days of its delivery and have the premium refunded in full, less any benefits paid under the policy, if the policyholder is not satisfied for any reason.

No individual long-term care policy shall be offered or delivered in this state until the insurer has received from the insured a written designation of at least one person, in addition to the insured, who is to receive notice of cancellation of the policy for nonpayment of premium. The insured has the right to designate up to a total of three persons who are to receive the notice of cancellation, in addition to the insured. The form used for the written designation must inform the insured that designation of one person is required and that designation of up to two additional persons is optional and must provide space clearly designated for listing between one and three persons. The designation shall

include each person's full name, home address, and telephone number. Each time an individual policy is renewed or continued, the insurer shall notify the insured of the right to change this written designation.

The insurer may file a policy form that utilizes a plan of care prepared as provided under section 62A.46, subdivision 5, clause (1) or (2).

Sec. 34. Minnesota Statutes 1994, section 62A.48, subdivision 2, is amended to read:

Subd. 2. **PER DIEM COVERAGE.** If benefits are provided on a per diem basis, the minimum daily benefit for care in a nursing facility must be the lesser ~~of $60 or actual charges under a long-term care policy AA or the lesser~~ of $40 or actual charges under a long-term care policy ~~A~~ and the minimum benefit per visit for home care under a long-term care policy ~~AA or A~~ must be the lesser of $25 or actual charges. The home care services benefit must cover at least seven paid visits per week.

Sec. 35. Minnesota Statutes 1994, section 62A.50, subdivision 3, is amended to read:

Subd. 3. **DISCLOSURES.** No long-term care policy shall be offered or delivered in this state, whether or not the policy is issued in this state, and no certificate of coverage under a group long-term care policy shall be offered or delivered in this state, unless a statement containing at least the following information is delivered to the applicant at the time the application is made:

(1) a description of the benefits and coverage provided by the policy and the differences between this policy, a supplemental Medicare policy and the benefits to which an individual is entitled under parts A and B of Medicare ~~and the differences between policy designations A and AA~~;

(2) a statement of the exceptions and limitations in the policy including the following language, as applicable, in bold print: "THIS POLICY DOES NOT COVER ALL NURSING CARE FACILITIES OR NURSING HOME, HOME CARE, OR ADULT DAY CARE EXPENSES AND DOES NOT COVER RESIDENTIAL CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.";

(3) a statement of the renewal provisions including any reservation by the insurer of the right to change premiums;

(4) a statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions;

(5) an explanation of the policy's loss ratio including at least the following language: "This means that, on the average, policyholders may expect that $..... of every $100 in premium will be returned as benefits to policyholders over the life of the contract.";

(6) a statement of the out-of-pocket expenses, including deductibles and copayments for which the insured is responsible, and an explanation of the specific out-of-pocket expenses that may be accumulated toward any out-of-pocket maximum as specified in the policy;

(7) the following language, in bold print: "YOUR PREMIUMS CAN BE INCREASED IN THE FUTURE. THE RATE SCHEDULE THAT LISTS YOUR PREMIUM NOW CAN CHANGE.";

(8) the following language, if applicable, in bold print: "IF YOU ARE NOT HOSPITALIZED PRIOR TO ENTERING A NURSING HOME OR NEEDING HOME CARE, YOU WILL NOT BE ABLE TO COLLECT ANY BENEFITS UNDER THIS PARTICULAR POLICY."; and

(9) a signed and completed copy of the application for insurance is left with the applicant at the time the application is made.

Sec. 36. **[62A.616] COVERAGE FOR NURSING HOME CARE FOR TERMINALLY ILL AND OTHER SERVICES.**

An insurer may offer a health plan that covers nursing home care for the terminally ill, personal care attendants, and hospice care. For the purposes of this section, "terminally ill" means a diagnosis certified by a physician that a person has less than six months to live.

Sec. 37. Minnesota Statutes 1994, section 62C.14, subdivision 5, is amended to read:

Subd. 5. **HANDICAPPED DEPENDENTS.** A subscriber's individual contract or any group contract delivered or issued for delivery in this state and providing that coverage of a dependent child of the subscriber or a dependent child of a covered group member shall terminate upon attainment of a specified age shall also provide in substance that attainment of that age shall not terminate coverage while the child is (a) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap, and (b) chiefly dependent upon the subscriber or employee for support and maintenance, provided proof of incapacity and dependency is furnished by the subscriber within 31 days of attainment of the age, and subsequently as required by the corporation, but not more frequently than annually after a two year period following attainment of the age.

Sec. 38. Minnesota Statutes 1994, section 62C.14, subdivision 14, is amended to read:

Subd. 14. No subscriber's individual contract or any group contract which provides for coverage of family members or other dependents of a subscriber or of an employee or other group member of a group subscriber, shall be renewed, delivered, or issued for delivery in this state unless such contract includes as covered family members or dependents any newborn infants, including depen-

dent grandchildren, immediately from the moment of birth and thereafter which insurance shall provide coverage for illness, injury, congenital malformation or premature birth.

Sec. 39. Minnesota Statutes 1994, section 62D.02, subdivision 8, is amended to read:

Subd. 8. "Health maintenance contract" means any contract whereby a health maintenance organization agrees to provide comprehensive health maintenance services to enrollees, provided that the contract may contain reasonable enrollee copayment provisions. An individual or group health maintenance contract may contain the copayment and deductible provisions specified in this subdivision. Copayment and deductible provisions in group contracts shall not discriminate on the basis of age, sex, race, length of enrollment in the plan, or economic status; and during every open enrollment period in which all offered health benefit plans, including those subject to the jurisdiction of the commissioners of commerce or health, fully participate without any underwriting restrictions, copayment and deductible provisions shall not discriminate on the basis of preexisting health status. In no event shall the sum of the annual ~~copayment~~ copayments and deductible exceed the maximum out-of-pocket expenses allowable for a number three qualified ~~insurance policy~~ plan under section 62E.06, nor shall that sum exceed $5,000 per family. The annual deductible must not exceed $1,000 per person. The annual deductible must not apply to preventive health services as described in Minnesota Rules, part 4685.0801, subpart 8. Where sections 62D.01 to 62D.30 permit a health maintenance organization to contain reasonable copayment provisions for preexisting health status, these provisions may vary with respect to length of enrollment in the plan. Any contract may provide for health care services in addition to those set forth in subdivision 7.

Sec. 40. Minnesota Statutes 1994, section 62E.02, subdivision 7, is amended to read:

Subd. 7. **DEPENDENT.** "Dependent" means a spouse or unmarried child under the age of 19 years, a dependent child who is a student under the age of 25 ~~and financially dependent upon the parent~~, or a dependent child of any age who is disabled.

Sec. 41. Minnesota Statutes 1994, section 62E.12, is amended to read:

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

The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan and a number two qualified plan, except that the maximum lifetime benefit on these plans shall be ~~$1,000,000~~ $1,500,000, and an extended basic plan and a basic Medicare plan as described in sections 62A.31 to 62A.44 and 62E.07. The requirement that a policy issued by the association must be a qualified plan is satisfied if the

association contracts with a preferred provider network and the level of benefits for services provided within the network satisfies the requirements of a qualified plan. If the association uses a preferred provider network, payments to nonparticipating providers must meet the minimum requirements of section 72A.20, subdivision 15. They shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier. Notwithstanding the provisions of section 62E.06 the state plan shall exclude coverage of services of a private duty nurse other than on an inpatient basis and any charges for treatment in a hospital located outside of the state of Minnesota in which the covered person is receiving treatment for a mental or nervous disorder, unless similar treatment for the mental or nervous disorder is medically necessary, unavailable in Minnesota and provided upon referral by a licensed Minnesota medical practitioner.

Sec. 42. Minnesota Statutes 1994, section 62F.02, subdivision 2, is amended to read:

Subd. 2. **DIRECTORS.** The association shall have a board of directors composed of 11 persons chosen ~~annually~~ for a term of four years as follows: five persons elected by members of the association at a meeting called by the commissioner; three members who are health care providers appointed by the commissioner prior to the election by the association; and three public members, as defined in section 214.02, appointed by the governor prior to the election by the association.

Sec. 43. Minnesota Statutes 1994, section 62I.09, subdivision 2, is amended to read:

Subd. 2. **TERMS AND VACANCIES.** In the event of a member's inability to continue to serve, the commissioner shall appoint a replacement. The committee shall elect a chair and vice-chair from among the members. The term of each member is ~~one year commencing~~ four years beginning on June 1~~, except that the first members to be appointed to the committee shall serve from the date of their appointment until June 1 immediately following their appointment~~.

Sec. 44. Minnesota Statutes 1994, section 62L.02, subdivision 16, is amended to read:

Subd. 16. **HEALTH CARRIER.** "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated services network and an integrated service network operating under chapter 62N; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; and a multiple employer welfare arrangement, as defined in United States Code, title 29, section 1002(40), as amended. ~~For purposes of sections 62L.01 to 62L.12, but not for purposes of sections 62L.13 to 62L.22, "health carrier"~~

~~includes a community integrated service network or integrated service network licensed under chapter 62N.~~ Any use of this definition in another chapter by reference does not include a community integrated service network or integrated service network, unless otherwise specified. For the purpose of this chapter, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one health carrier, except that any insurance company or health service plan corporation that is an affiliate of a health maintenance organization located in Minnesota, or any health maintenance organization located in Minnesota that is an affiliate of an insurance company or health service plan corporation, or any health maintenance organization that is an affiliate of another health maintenance organization in Minnesota, may treat the health maintenance organization as a separate health carrier.

Sec. 45. Minnesota Statutes 1994, section 62L.03, subdivision 5, is amended to read:

Subd. 5. **CANCELLATIONS AND FAILURES TO RENEW.** (a) No health carrier shall cancel, decline to issue, or fail to renew a health benefit plan as a result of the claim experience or health status of the persons covered or to be covered by the health benefit plan. A health carrier may cancel or fail to renew a health benefit plan:

(1) for nonpayment of the required premium;

(2) for fraud or misrepresentation by the small employer, or, with respect to coverage of an individual eligible employee or dependent, fraud or misrepresentation by the eligible employee or dependent, with respect to eligibility for coverage or any other material fact;

(3) if eligible employee participation during the preceding calendar year declines to less than 75 percent, subject to the waiver of coverage provision in subdivision 3;

(4) if the employer fails to comply with the minimum contribution percentage required under subdivision 3;

(5) if the health carrier ceases to do business in the small employer market under section 62L.09;

(6) if a failure to renew is based upon the health carrier's decision to discontinue the health benefit plan form previously issued to the small employer, but only if the health carrier permits each small employer covered under the prior form to switch to its choice of any other health benefit plan offered by the health carrier, without any underwriting restrictions that would not have been permitted for renewal purposes; or

(7) for any other reasons or grounds expressly permitted by the respective licensing laws and regulations governing a health carrier, including, but not limited to, service area restrictions imposed on health maintenance organizations

under section 62D.03, subdivision 4, paragraph (m), to the extent that these grounds are not expressly inconsistent with this chapter.

(b) A health carrier need not renew a health benefit plan, and shall not renew a small employer plan, if an employer ceases to qualify as a small employer as defined in section 62L.02. If a health benefit plan, other than a small employer plan, provides terms of renewal that do not exclude an employer that is no longer a small employer, the health benefit plan may be renewed according to its own terms. If a health carrier issues or renews a health plan to an employer that is no longer a small employer, without interruption of coverage, the health plan is subject to section 60A.082. Between July 1, 1994, and June 30, 1995, a health benefit plan in force during this time may be renewed, if the number of employees exceeds two, but does not exceed 49 employees.

Sec. 46. Minnesota Statutes 1994, section 65A.01, is amended by adding a subdivision to read:

Subd. 3b. **RESCISSION AND VOIDABILITY.** This policy must not be rescinded or voided except where the insured has willfully and with intent to defraud concealed or misrepresented a material fact or circumstance concerning this insurance or the subject of this insurance or the interests of the insured in this insurance. This provision must not operate to defeat a claim by a third party or a minor child of the named insured for damage or loss for which the policy provides coverage.

Sec. 47. Minnesota Statutes 1994, section 65B.06, subdivision 3, is amended to read:

Subd. 3. With respect to all automobiles not included in subdivisions 1 and 2, the facility shall provide:

(1) ~~Only the insurance~~ the minimum limits of coverage required by ~~law~~ section 65B.49, subdivisions 2, 3, 3a, and 4a, or higher limits of liability coverage as recommended by the governing committee and approved by the commissioner;

(2) for the equitable distribution of qualified applicants for this coverage among the members in accord with the applicable participation ratio, or among these insurance companies as selected under the provisions of the plan of operation; and

(3) for a school district or contractor transporting school children under contract with a school district, that amount of automobile liability insurance coverage, not to exceed $1,000,000, required by the school district by resolution or contract, or that portion of such $1,000,000 of coverage for which the school district or contractor applies and for which it is eligible under section 65B.10.

Sec. 48. Minnesota Statutes 1994, section 65B.08, subdivision 1, is amended to read:

Subdivision 1. **FILING.** As agent for members, the facility shall file with the commissioner all manuals of classification, all manuals of rules and rates, all rating plans, and any modifications of same, proposed for use for ~~private passenger nonfleet~~ automobile insurance placed through the facility. The classifications, rules and rates and any amendments thereto shall be subject to prior written approval by the commissioner. Rates, surcharge points, and increased limits factors filed by the facility shall not be excessive, inadequate, or unfairly discriminatory. No other entity, service or organization shall make filings for the facility or the members to apply to insurance placed through the facility.

Sec. 49. Minnesota Statutes 1994, section 65B.09, subdivision 1, is amended to read:

Subdivision 1. **AGENTS' RESPONSIBILITY.** Every person licensed under ~~chapter 60K~~ sections 60K.02 and 60K.03 who is authorized to solicit, negotiate or effect automobile insurance on behalf of any member shall:

(1) offer to place coverage through the facility for any qualified applicant who is ineligible or unacceptable for coverage in the insurer or insurers for whom the agent is authorized to solicit, negotiate or effect automobile insurance. Provided, that the failure of an agent to make such an offer to a qualified applicant shall not subject the agent to any liability to the applicant;

(2) forward to the facility all applications and any deposit premiums which are required by the plan of operation, rules and procedures of the facility, if the qualified applicant accepts the offer to have coverage placed through the facility;

(3) be entitled to receive compensation for placing insurance through the facility at the uniform rates of compensation as provided in the plan of operation, and all members shall pay such compensation.

Sec. 50. Minnesota Statutes 1994, section 65B.10, subdivision 3, is amended to read:

Subd. 3. **REVIEW OF INSUREDS.** At least annually, every member shall review every private passenger nonfleet applicant which it insures through the facility and determine whether or not such applicant is acceptable for voluntary insurance at a rate lower than the facility rate. If such applicant is acceptable, the member shall make an offer to insure the applicant under voluntary coverage at such lower rate.

Sec. 51. Minnesota Statutes 1994, section 65B.61, subdivision 1, is amended to read:

Subdivision 1. Basic economic loss benefits shall be primary with respect to benefits, except for those paid or payable under a workers' compensation law, which any person receives or is entitled to receive from any other source as a result of injury arising out of the maintenance or use of a motor vehicle. Where workers' compensation benefits paid or payable are primary, the reparation obli-

gor shall make an appropriate rebate or reduction in the premiums of the plan of reparation security. The amount of the rebate or rate reduction shall be not less than the amount of the projected reduction in benefits and claims for which the reparation obligor will be liable on that class of risks. The projected reduction or rebate in benefits and claims shall be based upon sound actuarial principles.

Sec. 52. Minnesota Statutes 1994, section 72A.20, subdivision 13, is amended to read:

Subd. 13. **REFUSAL TO RENEW.** Refusing to renew, declining to offer or write, or charging differential rates for an equivalent amount of homeowner's insurance coverage, as defined by section 65A.27, for property located in a town or statutory or home rule charter city, in which the insurer offers to sell or writes homeowner's insurance, solely because:

(a) of the geographic area in which the property is located;

(b) of the age of the primary structure sought to be insured;

(c) the insured or prospective insured was denied coverage of the property by another insurer, whether by cancellation, nonrenewal or declination to offer coverage, for a reason other than those specified in section 65A.01, subdivision 3a, clauses (a) to (e); or

(d) the property of the insured or prospective insured has been insured under the Minnesota FAIR plan act, shall constitute an unfair method of competition and an unfair and deceptive act or practice.

This subdivision prohibits an insurer from filing or charging different rates for different zip code areas within the same town or statutory or home rule charter city.

This subdivision shall not prohibit the insurer from applying underwriting or rating standards which the insurer applies generally in all other locations in the state and which are not specifically prohibited by clauses (a) to (d). Such underwriting or rating standards shall specifically include but not be limited to standards based upon the proximity of the insured property to an extraordinary hazard or based upon the quality or availability of fire protection services or based upon the density or concentration of the insurer's risks. Clause (b) shall not prohibit the use of rating standards based upon the age of the insured structure's plumbing, electrical, heating or cooling system or other part of the structure, the age of which affects the risk of loss. Any insurer's failure to comply with section 65A.29, subdivisions 2 to 4, either (1) by failing to give an insured or applicant the required notice or statement or (2) by failing to state specifically a bona fide underwriting or other reason for the refusal to write shall create a presumption that the insurer has violated this subdivision.

Sec. 53. Minnesota Statutes 1994, section 72A.20, is amended by adding a subdivision to read:

Subd. 34. **SUITABILITY OF INSURANCE FOR CUSTOMER.** In recommending or issuing life, endowment, individual accident and sickness, long-term care, annuity, life-endowment, or Medicare supplement insurance to a customer, an insurer, either directly or through its agent, must have reasonable grounds for believing that the recommendation is suitable for the customer.

In the case of group insurance marketed on a direct response basis without the use of direct agent contact, this subdivision is satisfied if the insurer has reasonable grounds to believe that the insurance offered is generally suitable for the group to whom the offer is made.

Sec. 54. Minnesota Statutes 1994, section 72B.05, is amended to read:

72B.05 **NONRESIDENTS.**

A nonresident person may become licensed under sections 72B.01 to 72B.14, provided that the person meets all of the requirements of sections 72B.01 to 72B.14, and complies with their provisions, and, on a form prescribed by the commissioner, appoints the commissioner as the attorney upon whom may be served all legal process issued in connection with any action or proceeding brought or pending in this state against or involving the licensee and relating to transactions under the license; the appointment shall be irrevocable and shall continue so long as any such action or proceeding could arise or exist.

~~Duplicate copies~~ Service of process ~~shall be served upon the commissioner, accompanied by payment of the fee specified in section 60A.14, subdivision 1(3)(d). Upon receiving such service, the commissioner shall promptly forward a copy thereof by registered or certified mail, with return receipt requested, to the nonresident licensee at that person's last known address. Process served upon the commissioner in this manner shall for all purposes constitute personal service thereof upon the licensee~~ must be made in compliance with section 45.028, subdivision 2.

Sec. 55. Minnesota Statutes 1994, section 79.251, subdivision 5, is amended to read:

Subd. 5. **ASSESSMENTS.** The commissioner shall assess all insurers licensed pursuant to section 60A.06, subdivision 1, clause (5), paragraph (b) an amount sufficient to fully fund the obligations of the assigned risk plan, if the commissioner determines that the assets of the assigned risk plan are insufficient to meet its obligations. The assessment of each insurer shall be in a proportion equal to the proportion which the amount of compensation insurance written in this state during the preceding calendar year by that insurer bears to the total compensation insurance written in this state during the preceding calendar year by all licensed insurers.

Amounts assessed under this subdivision are considered a liability of the assigned risk plan, to be repaid upon dissolution of the plan.

Sec. 56. Minnesota Statutes 1994, section 79.251, is amended by adding a subdivision to read:

Subd. 8. **DISSOLUTION.** Upon the dissolution of the assigned risk plan, the commissioner shall proceed to wind up the affairs of the plan, settle its accounts, and dispose of its assets. The assets and property of the assigned risk plan must be applied and distributed in the following order of priority:

(1) to the establishment of reserves for claims under policies and contracts of coverage issued by the assigned risk plan before termination;

(2) to the payment of all debts and liabilities of the assigned risk plan, including the repayment of loans and assessments;

(3) to the establishment of reserves considered necessary by the commissioner for contingent liabilities or obligations of the assigned risk plan other than claims arising under policies and contracts of coverage; and

(4) to the state of Minnesota.

If the commissioner determines that the assets of the assigned risk plan are insufficient to meet its obligations under clauses (1), (2), and (3), excluding the repayment of assessments, the commissioner shall assess all insurers licensed pursuant to section 60A.06, subdivision 1, clause (5), paragraph (b), an amount sufficient to fully fund these obligations.

Sec. 57. Minnesota Statutes 1994, section 79.34, subdivision 2, is amended to read:

Subd. 2. **LOSSES; RETENTION LIMITS.** The reinsurance association shall provide and each member shall accept indemnification for 100 percent of the amount of ultimate loss sustained in each loss occurrence relating to one or more claims arising out of a single compensable event, including aggregate losses related to a single event or occurrence which constitutes a single loss occurrence, under chapter 176 on and after October 1, 1979, in excess of ~~$300,000 or~~ $100,000 a low, a high, or a super retention limit, at the option of the member. In case of occupational disease causing disablement on and after October 1, 1979, each person suffering disablement due to occupational disease is considered to be involved in a separate loss occurrence. ~~The lower retention limit shall be increased to the nearest $10,000, on January 1, 1982 and on each January 1 thereafter by the percentage increase in the statewide average weekly wage, as determined in accordance with section 176.011, subdivision 20. On January 1, 1982 and on each January 1 thereafter, the higher retention limit shall be increased by the amount necessary to retain a $200,000 difference between the two retention limits.~~ On January 1, 1995, the lower retention limit is $250,000, which shall also be known as the 1995 base retention limit. On each January 1 thereafter, the cumulative annual percentage changes in the statewide average weekly wage after October 1, 1994, as determined in accordance with section 176.011, subdivision 20, shall first be multiplied by the 1995 base retention

limit, the result of which shall then be added to the 1995 base retention limit. The resulting figure shall be rounded to the nearest $10,000, yielding the low retention limit for that year, provided that the low retention limit shall not be reduced in any year. The high retention limit shall be two times the low retention limit and shall be adjusted when the low retention limit is adjusted. The super retention period shall be four times the low retention period and shall be adjusted when the low retention limit is adjusted. Ultimate loss as used in this section means the actual loss amount which a member is obligated to pay and which is paid by the member for workers' compensation benefits payable under chapter 176 and shall not include claim expenses, assessments, damages or penalties. For losses incurred on or after January 1, 1979, any amounts paid by a member pursuant to sections 176.183, 176.221, 176.225, and 176.82 shall not be included in ultimate loss and shall not be indemnified by the reinsurance association. A loss is incurred by the reinsurance association on the date on which the accident or other compensable event giving rise to the loss occurs, and a member is liable for a loss up to its retention limit in effect at the time that the loss was incurred, except that members which are determined by the reinsurance association to be controlled by or under common control with another member, and which are liable for claims from one or more employees entitled to compensation for a single compensable event, including aggregate losses relating to a single loss occurrence, may aggregate their losses and obtain indemnification from the reinsurance association for the aggregate losses in excess of the ~~higher~~ highest retention limit selected by any of the members in effect at the time the loss was incurred. Each member is liable for payment of its ultimate loss and shall be entitled to indemnification from the reinsurance association for the ultimate loss in excess of the member's retention limit in effect at the time of the loss occurrence.

A member that chooses the ~~higher~~ high or super retention limit shall retain the liability for all losses below the ~~higher~~ chosen retention limit itself and shall not transfer the liability to any other entity or reinsure or otherwise contract for reimbursement or indemnification for losses below its retention limit, except in the following cases: (a) when the reinsurance or contract is with another member which, directly or indirectly, through one or more intermediaries, control or are controlled by or are under common control with the member; (b) when the reinsurance or contract provides for reimbursement or indemnification of a member if and only if the total of all claims which the member pays or incurs, but which are not reimbursable or subject to indemnification by the reinsurance association for a given period of time, exceeds a dollar value or percentage of premium written or earned and stated in the reinsurance agreement or contract; (c) when the reinsurance or contract is a pooling arrangement with other insurers where liability of the member to pay claims pursuant to chapter 176 is incidental to participation in the pool and not as a result of providing workers' compensation insurance to employers on a direct basis under chapter 176; (d) when the reinsurance or contract is limited to all the claims of a specific insured of a member which are reimbursed or indemnified by a reinsurer which, directly or indirectly, through one or more intermediaries, controls or is controlled by or is under

common control with the insured of the member so long as any subsequent contract or reinsurance of the reinsurer relating to the claims of the insured of a member is not inconsistent with the bases of exception provided under clauses (a), (b) and (c); or (e) when the reinsurance or contract is limited to all claims of a specific self-insurer member which are reimbursed or indemnified by a reinsurer which, directly or indirectly, through one or more intermediaries, controls or is controlled by or is under common control with the self-insurer member so long as any subsequent contract or reinsurance of the reinsurer relating to the claims of the self-insurer member are not inconsistent with the bases for exception provided under clauses (a), (b) and (c).

Whenever it appears to the commissioner of labor and industry that any member that chooses the ~~higher~~ high or super retention limit has participated in the transfer of liability to any other entity or reinsured or otherwise contracted for reimbursement or indemnification of losses below its retention limit in a manner inconsistent with the bases for exception provided under clauses (a), (b), (c), (d), and (e), the commissioner may, after giving notice and an opportunity to be heard, order the member to pay to the state of Minnesota an amount not to exceed twice the difference between the reinsurance premium for the ~~higher and lower~~ high or super retention limit, as appropriate, and the low retention limit applicable to the member for each year in which the prohibited reinsurance or contract was in effect. Any member subject to this penalty provision shall continue to be bound by its selection of the ~~higher~~ high or super retention limit for purposes of membership in the reinsurance association.

Sec. 58. Minnesota Statutes 1994, section 79.35, is amended to read:

79.35 **DUTIES; RESPONSIBILITIES; POWERS.**

The reinsurance association shall do the following on behalf of its members:

(a) Assume 100 percent of the liability as provided in section 79.34;

(b) Establish procedures by which members shall promptly report to the reinsurance association each claim which, on the basis of the injury sustained, may reasonably be anticipated to involve liability to the reinsurance association if the member is held liable under chapter 176. Solely for the purpose of reporting claims, the member shall in all instances consider itself legally liable for the injury. The member shall advise the reinsurance association of subsequent developments likely to materially affect the interest of the reinsurance association in the claim;

(c) Maintain relevant loss and expense data relative to all liabilities of the reinsurance association and require each member to furnish statistics in connection with liabilities of the reinsurance association at the times and in the form and detail as may be required by the plan of operation;

(d) Calculate and charge to members a total premium sufficient to cover the expected liability which the reinsurance association will incur ~~in excess of the~~

~~higher retention limit but less than the prefunded limit~~, together with incurred or estimated to be incurred operating and administrative expenses for the period to which this premium applies and actual claim payments to be made by members, during the period to which this premium applies, for claims in excess of the prefunded limit in effect at the time the loss was incurred. Each member shall be charged a premium established by the board as sufficient to cover the reinsurance association's incurred liabilities and expenses between the member's selected retention limit and the prefunded limit. The prefunded limit shall be ~~$2,500,000 on and after October 1, 1979, provided that the prefunded limit shall be increased on January 1, 1983 and on each January 1 thereafter by the percentage increase in the statewide average weekly wage, to the nearest $100,000, as determined in accordance with section 176.011, subdivision~~ 20 times the lower retention limit established in section 79.34, subdivision 2. Each member shall be charged a proportion of the total premium calculated for its selected retention limit in an amount equal to its proportion of the exposure base of all members during the period to which the reinsurance association premium will apply. The exposure base shall be determined by the board and is subject to the approval of the commissioner of labor and industry. In determining the exposure base, the board shall consider, among other things, equity, administrative convenience, records maintained by members, amenability to audit, and degree of risk refinement. ~~Each member exercising the lower retention option shall also be charged a premium established by the board as sufficient to cover incurred or estimated to be incurred claims for the liability the reinsurance association is likely to incur between the lower and higher retention limits for the period to which the premium applies.~~ Each member shall also be charged a premium determined by the board to equitably distribute excess or deficient premiums from previous periods including any excess or deficient premiums resulting from a retroactive change in the prefunded limit. The premiums charged to members shall not be unfairly discriminatory as defined in section 79.074. All premiums shall be approved by the commissioner of labor and industry;

(e) Require and accept the payment of premiums from members of the reinsurance association;

(f) Receive and distribute all sums required by the operation of the reinsurance association;

(g) Establish procedures for reviewing claims procedures and practices of members of the reinsurance association. If the claims procedures or practices of a member are considered inadequate to properly service the liabilities of the reinsurance association, the reinsurance association may undertake, or may contract with another person, including another member, to adjust or assist in the adjustment of claims which create a potential liability to the association. The reinsurance association may charge the cost of the adjustment under this paragraph to the member, except that any penalties or interest incurred under sections 176.183, 176.221, 176.225, and 176.82 as a result of actions by the reinsurance association after it has undertaken adjustment of the claim shall not

be charged to the member but shall be included in the ultimate loss and listed as a separate item; and

(h) Provide each member of the reinsurance association with an annual report of the operations of the reinsurance association in a form the board of directors may specify.

Sec. 59. Minnesota Statutes 1994, section 79A.01, is amended by adding a subdivision to read:

Subd. 10. **COMMON CLAIMS FUND.** "Common claims fund," with respect to group self-insurers, are the cash, cash equivalents, or investment accounts maintained by the group to pay its workers' compensation liabilities.

Sec. 60. Minnesota Statutes 1994, section 79A.02, subdivision 4, is amended to read:

Subd. 4. **RECOMMENDATIONS TO COMMISSIONER REGARDING REVOCATION.** After each fifth anniversary from the date each individual and group self-insurer becomes certified to self-insure, the committee shall review all relevant financial data filed with the department of commerce that is otherwise available to the public and make a recommendation to the commissioner about whether each self-insurer's certificate should be revoked. For group self-insurers who have been in existence for five years or more and have been granted renewal authority, a level of funding in the common claims fund must be maintained at not less than the greater of either: (1) one year's claim losses paid in the most recent year; or (2) one-third of the security deposit posted with the department of commerce according to section 79A.04, subdivision 2.

Sec. 61. Minnesota Statutes 1994, section 79A.03, is amended by adding a subdivision to read:

Subd. 4a. **EXCEPTIONS.** Notwithstanding the requirements of subdivisions 3 and 4, the commissioner, pursuant to a review of an existing self-insurer's financial data, may continue a self-insurer's authority to self-insure for one year if, in the commissioner's judgment based on all factors relevant to the self-insurer's financial status, the self-insurer will be able to meet its obligations under this chapter for the following year. The relevant factors to be considered must include, but must not be limited to, the liquidity ratios, leverage ratios, and profitability ratios of the self-insurer. Where a self-insurer's authority to self-insure is continued under this subdivision, the self-insurer may be required to post security in the amount equal to two times the amount of security required under section 79A.04, subdivision 2.

Sec. 62. Minnesota Statutes 1994, section 176.181, subdivision 2, is amended to read:

Subd. 2. **COMPULSORY INSURANCE; SELF-INSURERS.** (1) Every employer, except the state and its municipal subdivisions, liable under this chap-

ter to pay compensation shall insure payment of compensation with some insurance carrier authorized to insure workers' compensation liability in this state, or obtain a written order from the commissioner of commerce exempting the employer from insuring liability for compensation and permitting self-insurance of the liability. The terms, conditions and requirements governing self-insurance shall be established by the commissioner pursuant to chapter 14. The commissioner of commerce shall also adopt, pursuant to clause (2)(c), rules permitting two or more employers, whether or not they are in the same industry, to enter into agreements to pool their liabilities under this chapter for the purpose of qualifying as group self-insurers. With the approval of the commissioner of commerce, any employer may exclude medical, chiropractic and hospital benefits as required by this chapter. An employer conducting distinct operations at different locations may either insure or self-insure the other portion of operations as a distinct and separate risk. An employer desiring to be exempted from insuring liability for compensation shall make application to the commissioner of commerce, showing financial ability to pay the compensation, whereupon by written order the commissioner of commerce, on deeming it proper, may make an exemption. An employer may establish financial ability to pay compensation by providing financial statements of the employer to the commissioner of commerce. Upon ten days' written notice the commissioner of commerce may revoke the order granting an exemption, in which event the employer shall immediately insure the liability. As a condition for the granting of an exemption the commissioner of commerce may require the employer to furnish security the commissioner of commerce considers sufficient to insure payment of all claims under this chapter, consistent with subdivision 2b. If the required security is in the form of currency or negotiable bonds, the commissioner of commerce shall deposit it with the state treasurer. In the event of any default upon the part of a self-insurer to abide by any final order or decision of the commissioner of labor and industry directing and awarding payment of compensation and benefits to any employee or the dependents of any deceased employee, then upon at least ten days notice to the self-insurer, the commissioner of commerce may by written order to the state treasurer require the treasurer to sell the pledged and assigned securities or a part thereof necessary to pay the full amount of any such claim or award with interest thereon. This authority to sell may be exercised from time to time to satisfy any order or award of the commissioner of labor and industry or any judgment obtained thereon. When securities are sold the money obtained shall be deposited in the state treasury to the credit of the commissioner of commerce and awards made against any such self-insurer by the commissioner of commerce shall be paid to the persons entitled thereto by the state treasurer upon warrants prepared by the commissioner of commerce and approved by the commissioner of finance out of the proceeds of the sale of securities. Where the security is in the form of a surety bond or personal guaranty the commissioner of commerce, at any time, upon at least ten days notice and opportunity to be heard, may require the surety to pay the amount of the award, the payments to be enforced in like manner as the award may be enforced.

(2)(a) No association, corporation, partnership, sole proprietorship, trust or

other business entity shall provide services in the design, establishment or administration of a group self-insurance plan under rules adopted pursuant to this subdivision unless it is licensed, or exempt from licensure, pursuant to section 60A.23, subdivision 8, to do so by the commissioner of commerce. An applicant for a license shall state in writing the type of activities it seeks authorization to engage in and the type of services it seeks authorization to provide. The license shall be granted only when the commissioner of commerce is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. The commissioner of commerce may issue a license subject to restrictions or limitations, including restrictions or limitations on the type of services which may be supplied or the activities which may be engaged in. The license is for a two-year period.

(b) To assure that group self-insurance plans are financially solvent, administered in a fair and capable fashion, and able to process claims and pay benefits in a prompt, fair and equitable manner, entities licensed to engage in such business are subject to supervision and examination by the commissioner of commerce.

(c) To carry out the purposes of this subdivision, the commissioner of commerce may promulgate administrative rules, including emergency rules, pursuant to sections 14.001 to 14.69. These rules may:

(i) establish reporting requirements for administrators of group self-insurance plans;

(ii) establish standards and guidelines consistent with subdivision 2b to assure the adequacy of the financing and administration of group self-insurance plans;

(iii) establish bonding requirements or other provisions assuring the financial integrity of entities administering group self-insurance plans;

(iv) establish standards, including but not limited to minimum terms of membership in self-insurance plans, as necessary to provide stability for those plans;

(v) establish standards or guidelines governing the formation, operation, administration, and dissolution of self-insurance plans; and

(vi) establish other reasonable requirements to further the purposes of this subdivision. ~~The rules may not require excessive cash payments to a common claims fund by group self-insurers. However, a level of funding in the common claims fund must always be maintained at not less than one year's claim losses paid in the most recent year.~~

Sec. 63. Minnesota Statutes 1994, section 299F.053, subdivision 2, is amended to read:

Subd. 2. **AUTHORIZED PERSON.** "Authorized person" means:

(a) the state fire marshal when authorized or charged with the investigation of fires at the place where the fire actually took place;

(b) superintendent of the bureau of criminal apprehension;

(c) the prosecuting attorney responsible for prosecutions in the county where the fire occurred;

(d) the sheriff or chief of police responsible for investigation in the county where the fire occurred;

(e) the county attorney responsible for the prosecution in the county where the fire occurred;

(f) the Federal Bureau of Investigation or any other federal agency;

(g) the United States attorney's office when authorized or charged with investigation or prosecution of a case involving a fire loss; ~~or~~

(h) the chief administrative officer of the municipal arson squad; or

(i) the commissioner of commerce.

Sec. 64. Minnesota Statutes 1994, section 515A.3-112, is amended to read:

515A.3-112 **INSURANCE.**

(a) Commencing not later than the time of the first conveyance of a unit to a unit owner other than a declarant, the association shall maintain, to the extent reasonably available:

(1) Property insurance on the common elements and units, exclusive of land, excavations, foundations, and other items normally excluded from property policies, insuring against all risks of direct physical loss. The total amount of insurance after application of any deductibles shall be not less than 80 percent of the full insurable replacement cost of the insured property. The association or its authorized agent may enter a unit at reasonable times upon reasonable notice for the purpose of making appraisals for insurance purposes.

(2) Comprehensive general liability insurance, in an amount determined by the board of directors but not less than any amount specified in the declaration, covering all occurrences commonly insured against for death, bodily injury, and property damage arising out of or in connection with the use, ownership, or maintenance of the common elements.

(b) If the insurance described in subsection (a) is not maintained, the association shall immediately cause notice of that fact to be sent postage prepaid by United States mail to all unit owners at their respective units and other addresses provided to the association. The declaration may require the association

to carry any other insurance, and the association in any event may carry any other insurance it deems appropriate to protect the association or the unit owners.

(c) Insurance policies carried pursuant to subsection (a) shall provide that:

(1) Each unit owner and holder of a vendor's interest in a contract for deed is an insured person under the policy with respect to liability arising out of ownership of an undivided interest in the common elements;

(2) The insurer waives its right to subrogation under the policy against any unit owner of the condominium or members of the unit owner's household and against the association and members of the board of directors;

(3) No act or omission by any unit owner or holder of an interest as security for an obligation, unless acting within the scope of authority on behalf of the association, shall void the policy or be a condition to recovery under the policy; and

(4) If, at the time of a loss under the policy, there is other insurance in the name of a unit owner covering the same property covered by the policy, the policy is primary insurance not contributing with the other insurance.

(d) Any loss covered by the property policy under subsection (a)(1) shall be adjusted with the association, but the insurance proceeds for that loss shall be payable to any insurance trustee designated for that purpose, or otherwise to the association. The insurance trustee or the association shall hold any insurance proceeds in trust for unit owners and holders of an interest as security for an obligation as their interests may appear. The proceeds shall be disbursed first for the repair or restoration of the damaged common elements and units, and unit owners and holders of an interest as security for an obligation are not entitled to receive payment of any portion of the proceeds unless there is a surplus of proceeds after the common elements and units have been completely repaired or restored, or the condominium is terminated.

(e) An insurance policy issued to the association does not prevent a unit owner from obtaining insurance for personal benefit.

(f) An insurer that has issued an insurance policy under this section shall issue certificates or memoranda of insurance, upon request, to any unit owner, or holder of an interest as security for an obligation. The insurance may not be canceled until ~~30~~ 60 days after notice of the proposed cancellation has been mailed to the association and to each unit owner and holder of an interest as security for an obligation to whom certificates of insurance have been issued.

(g) Any portion of the condominium damaged or destroyed shall be promptly repaired or replaced by the association unless (1) the condominium is terminated and the association votes not to repair or replace all or part thereof, (2) repair or replacement would be illegal under any state or local health or

safety statute or ordinance, or (3) 80 percent of the unit owners, including every owner and first mortgagee of a unit or assigned limited common element which will not be rebuilt, vote not to rebuild. The cost of repair or replacement of a unit or the common area in excess of insurance proceeds and reserves shall be a common expense. If less than the entire condominium is repaired or replaced, (1) the insurance proceeds attributable to the damaged common elements shall be used to restore the damaged area to a condition compatible with the remainder of the condominium, (2) the insurance proceeds attributable to units and limited common elements which are not rebuilt shall be distributed to the owners of those units and the holders of an interest as security for an obligation of those units and the owners and holders of an interest as security for an obligation of the units to which those limited common elements were assigned, as their interests may appear, and (3) the remainder of the proceeds shall be distributed to all the unit owners and holders of an interest as security for an obligation as their interests may appear in proportion to their common element interest. In the event the unit owners vote not to rebuild a unit, that unit's entire common element interest, votes in the association, and common expense liability are automatically reallocated upon the vote as if the unit had been condemned under section 515A.1-107(a), and the association shall promptly prepare, execute and record an amendment to the declaration reflecting the reallocations. Notwithstanding the provisions of this subsection, if the condominium is terminated, insurance proceeds not used for repair or replacement shall be distributed in the same manner as sales proceeds pursuant to section 515A.2-120.

(h) The provisions of this section may be varied or waived in the case of a condominium all of the units of which are restricted to nonresidential use.

Sec. 65. Minnesota Statutes 1994, section 515B.3-113, is amended to read:

515B.3-113 **INSURANCE.**

(a) Commencing not later than the time of the first conveyance of a unit to a unit owner other than a declarant, the association shall maintain, to the extent reasonably available:

(1) subject to subsection (b), property insurance (i) on the common elements and, in a planned community, also on property that must become common elements, (ii) for broad form covered causes of loss, and (iii) in a total amount of not less than the full insurable replacement cost of the insured property, less deductibles, at the time the insurance is purchased and at each renewal date, exclusive of items normally excluded from property policies; and

(2) commercial general liability insurance against claims and liabilities arising in connection with the ownership, existence, use or management of the property in an amount, if any, specified by the common interest community instruments or otherwise deemed sufficient in the judgment of the board, insuring the board, the association, the management agent, and their respective employees, agents and all persons acting as agents. The declarant shall be

included as an additional insured in its capacity as a unit owner or board member. The unit owners shall be included as additional insureds but only for claims and liabilities arising in connection with the ownership, existence, use or management of the common elements. The insurance shall cover claims of one or more insured parties against other insured parties.

(b) In the case of a common interest community that contains units sharing or having contiguous walls, siding or roofs, the insurance maintained under subsection (a)(1) shall include the units and the common elements. The insurance need not cover improvements and betterments to the units installed by unit owners, but if improvements and betterments are covered, any increased cost may be assessed by the association against the units affected. The association may, in the case of a claim for damage to a unit or units, (i) pay the deductible amount as a common expense, (ii) assess the deductible amount against the units affected in any reasonable manner, or (iii) require the unit owners of the units affected to pay the deductible amount directly.

(c) If the insurance described in subsections (a) and (b) is not reasonably available, the association shall promptly cause notice of that fact to be hand delivered or sent prepaid by United States mail to all unit owners. The declaration may require the association to carry any other insurance, and the association in any event may carry any other insurance it considers appropriate to protect the association, the unit owners or officers, directors or agents of the association.

(d) Insurance policies carried pursuant to subsections (a) and (b) shall provide that:

(1) each unit owner and secured party is an insured person under the policy with respect to liability arising out of the unit owner's interest in the common elements or membership in the association;

(2) the insurer waives its right to subrogation under the policy against any unit owner of the condominium or members of the unit owner's household and against the association and members of the board of directors;

(3) no act or omission by any unit owner or secured party, unless acting within the scope of authority on behalf of the association, shall void the policy or be a condition to recovery under the policy; and

(4) if at the time of a loss under the policy there is other insurance in the name of a unit owner covering the same property covered by the policy, the association's policy is primary insurance.

(e) Any loss covered by the property policy under subsection (a)(1) shall be adjusted by and with the association. The insurance proceeds for that loss shall be payable to the association, or to an insurance trustee designated by the association for that purpose. The insurance trustee or the association shall hold any insurance proceeds in trust for unit owners and secured parties as their interests

may appear. The proceeds shall be disbursed first for the repair or restoration of the damaged common elements and units. Unit owners and secured parties are not entitled to receive any portion of the proceeds unless there is a surplus of proceeds after the common elements and units have been completely repaired or restored or the common interest community is terminated.

(f) Unit owners may obtain insurance for personal benefit in addition to insurance carried by the association.

(g) An insurer that has issued an insurance policy under this section shall issue certificates or memoranda of insurance, upon request, to any unit owner or secured party. The insurance may not be canceled until ~~30~~ 60 days after notice of the proposed cancellation has been mailed to the association, each unit owner and each secured party for an obligation to whom certificates of insurance have been issued.

(h) Any portion of the common interest community which is damaged or destroyed as the result of a loss covered by the association's insurance shall be promptly repaired or replaced by the association unless (i) the common interest community is terminated and the association votes not to repair or replace all or part thereof, (ii) repair or replacement would be illegal under any state or local health or safety statute or ordinance, or (iii) 80 percent of the unit owners, including every owner and holder of a first mortgage on a unit or assigned limited common element which will not be rebuilt, vote not to rebuild. The cost of repair or replacement of the common elements in excess of insurance proceeds and reserves shall be paid as a common expense, and the cost of repair of a unit in excess of insurance proceeds shall be paid by the respective unit owner.

(i) If less than the entire common interest community is repaired or replaced, (i) the insurance proceeds attributable to the damaged common elements shall be used to restore the damaged area to a condition compatible with the remainder of the common interest community, (ii) the insurance proceeds attributable to units and limited common elements which are not rebuilt shall be distributed to the owners of those units, including units to which the limited common elements were assigned, and the secured parties of those units, as their interests may appear, and (iii) the remainder of the proceeds shall be distributed to all the unit owners and secured parties as their interests may appear in proportion to their common element interest in the case of a condominium or in proportion to their common expense liability in the case of a planned community or cooperative.

(j) If the unit owners and holders of first mortgages vote not to rebuild a unit, that unit's entire common element interest, votes in the association, and common expense liability are automatically reallocated upon the vote as if the unit had been condemned under section 515B.1-107, and the association shall promptly prepare, execute and record an amendment to the declaration reflecting the reallocations. Notwithstanding the provisions of this subsection, if the common interest community is terminated, insurance proceeds not used for

repair or replacement shall be distributed in the same manner as sales proceeds pursuant to section 515B.2-119.

(k) The provisions of this section may be varied or waived in the case of a common interest community in which all units are restricted to nonresidential use.

Sec. 66. **REPORT ON MANDATED INSURANCE DISCLOSURES AND NOTICES.**

The commissioner of commerce shall report to the legislature by February 1, 1996, on the status of insurance disclosures and notices that are required by law to be distributed with insurance applications, marketing materials, or claim forms. The report shall include recommendations on the disclosures or notices that are no longer necessary and a recommendation for consolidation of all legally required disclosures or notices on a single disclosure form.

Sec. 67. **REPEALER.**

Minnesota Statutes 1994, sections 61A.072, subdivision 3; and 65B.07, subdivision 5, are repealed.

Sec. 68. **EFFECTIVE DATES.**

Sections 1 to 4, 6 to 13, 16 to 18, 20, 22 to 25, 29, 31 to 35, 38, 40, 42, 43, 46, 53, 54, 56, 59 to 63, and 67 are effective the day following final enactment.

Section 14 is effective January 1, 1997.

Section 39 is effective July 1, 1995.

Section 44 is effective retroactive to January 1, 1995.

Sections 57 and 58 are effective January 1, 1996.

Sections 26, 27, and 37 are effective January 1, 1996, and apply to coverage issued or renewed on or after that date.

Section 28 is effective the day following final enactment and applies to health plans offered, issued, sold, or renewed to provide coverage to a Minnesota resident on or after that date.

Section 41 is effective July 1, 1995, and applies to coverage issued or renewed on or after that date.

Section 45 is effective retroactive to July 1, 1994.

Presented to the governor May 30, 1995

Signed by the governor June 1, 1995, 11:40 a.m.

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