

**CHAPTER 255—S.F.No. 3480**

*An act relating to commerce; regulating licensee education; regulating certain insurers, insurance forms, rates, minimum loss ratio guarantees, coverages, purchases, disclosures, filings, utilization reviews, and claims; enacting an interstate insurance product regulation compact; regulating the Minnesota uniform health care identification card; requiring health care provider pricing transparency; regulating charity care; requiring certain reports; amending Minnesota Statutes 2004, sections 61A.02, subdivision 3; 61A.092, subdivision 3; 62A.02, subdivision 3, by adding a subdivision; 62A.021, subdivision 1; 62A.095, subdivision 1; 62A.27; 62A.3093; 62A.65, subdivision 3; 62C.14, subdivisions 9, 10; 62E.13, subdivision 3; 62E.14, subdivision 5; 62J.60, subdivisions 2, 3; 62J.81, subdivision 1; 62L.02, subdivision 24; 62L.03, subdivision 3; 62L.08, subdivision 4; 62M.01, subdivision 2; 62M.09, subdivision 9; 62S.05, by adding a subdivision; 62S.08, subdivision 3; 62S.081, subdivision 4; 62S.10, subdivision 2; 62S.13, by adding a subdivision; 62S.14, subdivision 2; 62S.15; 62S.20, subdivision 1; 62S.24, subdivisions 1, 3, 4, by adding subdivisions; 62S.25, subdivision 6, by adding a subdivision; 62S.26; 62S.266, subdivision 2; 62S.29, subdivision 1; 62S.30; 65B.44, subdivision 3a; 70A.07; 72A.20, by adding a subdivision; 72C.10, subdivision 1; 79.01, by adding subdivisions; 79.251, subdivision 1, by adding a subdivision; 79.252, by adding subdivisions; 79A.23, subdivision 3; 79A.32; 123A.21, subdivision 7, by adding a subdivision; Minnesota Statutes 2005 Supplement, sections 45.22; 45.23; 62A.316; 62J.052; 62L.12, subdivision 2; 72A.201, subdivision 6; 79A.04, subdivision 2; 256B.0571; Laws 2005, First Special Session chapter 4, article 7, section 59; proposing coding for new law in Minnesota Statutes, chapters 60A; 62A; 62J; 62M; 62Q; 62S; repealing Minnesota Statutes 2005 Supplement, section 62Q.251; Minnesota Rules, parts 2781.0100; 2781.0200; 2781.0300; 2781.0400; 2781.0500; 2781.0600.*

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

Section 1. Minnesota Statutes 2005 Supplement, section 45.22, is amended to read:

**45.22 LICENSE EDUCATION APPROVAL.**

(a) License education courses must be approved in advance by the commissioner. Each sponsor who offers a license education course must ~~have at least one coordinator, approved by the commissioner, be approved by the commissioner.~~ Each approved sponsor must have at least one coordinator who meets the criteria specified in Minnesota Rules, chapter 2809, and who is responsible for supervising the educational program and assuring compliance with all laws and rules. "Sponsor" means any person or entity offering approved education.

~~(b) For coordinators with an initial approval date before August 1, 2005, approval will expire on December 31, 2005. For courses with an initial approval date on or before December 31, 2000, approval will expire on April 30, 2006. For courses with an initial approval date after January 1, 2001, but before August 1, 2005, approval will expire on April 30, 2007.~~

Sec. 2. Minnesota Statutes 2005 Supplement, section 45.23, is amended to read:

**45.23 LICENSE EDUCATION FEES.**

The following fees must be paid to the commissioner:

(1) initial course approval, \$10 for each hour or fraction of one hour of education course approval sought. Initial course approval expires on the last day of the 24th month after the course is approved;

(2) renewal of course approval, \$10 per course. Renewal of course approval expires on the last day of the 24th month after the course is renewed;

(3) initial ~~coordinator sponsor~~ approval, \$100. ~~Initial coordinator approval expires on the last day of the 24th month after the coordinator is approved;~~ Initial sponsor approval issued under this section is valid for a period not to exceed 24 months and expires on January 31 of the renewal year assigned by the commissioner. Active sponsors who have at least one approved coordinator as of the effective date of this section are deemed to be approved sponsors and are not required to submit an initial application for sponsor approval; and

(4) renewal of ~~coordinator sponsor~~ approval, \$10. ~~Renewal of coordinator approval expires on the last day of the 24th month after the coordinator is renewed;~~ Each renewal of sponsor approval is valid for a period of 24 months. Active sponsors who have at least one approved coordinator as of the effective date of this section will have an expiration date of January 31, 2008.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

### Sec. 3. **[60A.99] INTERSTATE INSURANCE PRODUCT REGULATION COMPACT.**

Subdivision 1. **Enactment and form.** The Interstate Insurance Product Regulation Compact is enacted into law and entered into with all other states legally joining in it in substantially the following form:

#### Article I. Purposes

The purposes of this Compact are, through means of joint and cooperative action among the Compacting States:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

2. To develop uniform standards for insurance products covered under the Compact;

3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;

4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

6. To create the Interstate Insurance Product Regulation Commission; and

7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

#### Article II. Definitions

For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.

2. "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

3. "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

4. "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.

5. "Commissioner" means the chief insurance regulatory official of a State including, but not limited to commissioner, superintendent, director or administrator.

6. "Domiciliary State" means the state in which an Insurer is incorporated or organized; or, in the case of an alien Insurer, its state of entry.

7. "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.

8. "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

9. "Noncompacting State" means any State which is not at the time a Compacting State.

10. "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard, or a provision of this Compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an Insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

13. "State" means any state, district, or territory of the United States of America.

14. "Third Party Filer" means an entity that submits a Product filing to the Commission on behalf of an Insurer.

15. "Uniform Standard" means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

### Article III. Establishment of the Commission and Venue

1. The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product

filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

#### Article IV. Powers of the Commission

The Commission shall have the following powers:

1. To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

2. To exercise its rulemaking authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

5. To exercise its rulemaking authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission;

6. To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;
9. To establish and maintain offices;
10. To purchase and maintain insurance and bonds;
11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compacting State;
12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;
13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;
14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;
15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;
16. To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules or Operating Procedures;
17. To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures and Bylaws;
18. To provide for dispute resolution among Compacting States;
19. To advise Compacting States on issues relating to Insurers domiciled or doing business in Noncompacting jurisdictions, consistent with the purposes of this Compact;
20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;
21. To establish a budget and make expenditures;
22. To borrow money;
23. To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;
24. To provide and receive information from, and to cooperate with law enforcement agencies;
25. To adopt and use a corporate seal; and
26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

#### Article V. Organization of the Commission

##### 1. Membership, Voting and Bylaws

a. Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

b. Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds of the Members vote in favor thereof.

c. The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

i. Establishing the fiscal year of the Commission;

ii. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

iii. Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;

iv. Providing reasonable procedures for calling and conducting meetings of the Commission that consist of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (ii) votes taken during such meeting;

v. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

vi. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

vii. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

viii. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

d. The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

## 2. Management Committee, Officers and Personnel

a. A Management Committee comprising no more than 14 members shall be established as follows:

i. One member from each of the six Compacting States with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;

ii. Four members from those Compacting States with at least two percent of the market based on the premium volume described above, other than the six Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws; and

iii. Four members from those Compacting States with less than two percent of the market, based on the premium volume described above, with one selected from each of the four zone regions of the NAIC as provided in the Bylaws.

b. The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

i. Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

ii. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds of the members of the Management Committee;

iii. Overseeing the offices of the Commission; and

iv. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

### 3. Legislative and Advisory Committees

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

b. The Commission shall establish two advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

### 4. Corporate Records of the Commission

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

### 5. Qualified Immunity, Defense, and Indemnification

a. The Members, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

b. The Commission shall defend any Member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful and wanton misconduct.

c. The Commission shall indemnify and hold harmless any Member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided, that the actual or alleged act, error, or omission did not result from the intentional or willful and wanton misconduct of that person.

### Article VI. Meetings and Acts of the Commission

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

2. Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meeting shall be held as set forth in the Bylaws.

### Article VII. Rules and Operating Procedures: Rulemaking Functions of the Commission and Opting Out of Uniform Standards

1. Rulemaking Authority. The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Act, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in



adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective Date and Opt Out of a Uniform Standard. A Uniform Standard shall become effective 90 days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure, or amendment.

4. Opt Out Procedure. A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the Products subject to this Act; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of Opt Out. If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. Stay of Uniform Standard. If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and while the regulatory opt out is pending, the Compacting State may petition the Commission, at least 15 days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to 90 days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge

which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than 30 days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

#### Article VIII. Commission Records and Enforcement

1. The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any noncomplying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a noncomplying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

4. The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

a. With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

#### Article IX. Dispute Resolution

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more Compacting States, or between Compacting States and Noncompacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

#### Article X. Product Filing and Approval

1. Insurers and Third Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

3. Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

#### Article XI. Review of Commission Decisions Regarding Filings

1. Not later than 30 days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section 4.

2. The Commission shall have authority to monitor, review and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 above.

#### Article XII. Finance

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each Insurer and Third Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the Compacting states.

5. The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

#### Article XIII. Compacting States, Effective Date and Amendment

1. Any State is eligible to become a Compacting State.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after 26 States are Compacting States or, alternatively, by States representing greater than 40 percent of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

3. Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

#### Article XIV. Withdrawal, Default and Termination

1. Withdrawal

a. Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph e of this section.

c. The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

d. The Commission shall notify the other Compacting States of the introduction of such legislation within ten days after its receipt of notice thereof.

e. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

f. Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

## 2. Default

a. If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

b. Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section 1 of this article.

c. Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

## 3. Dissolution of Compact

a. The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

## Article XV. Severability and Construction

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

## Article XVI. Binding Effect of Compact and Other Laws

### 1. Other Laws

a. Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph b of this section.

b. For any Product approved or certified to the Commission, the Rules, Uniform Standards, and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval, and certification of such Products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard, or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings, as authorized by law.

c. All insurance products filed with individual States shall be subject to the laws of those States.

## 2. Binding Effect of this Compact

a. All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

b. All agreements between the Commission and the Compacting States are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers, or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers, or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

Subd. 2. **Commission representative.** The commissioner of commerce is the representative of this state to the commission.

## Sec. 4. **[60A.991] INTERSTATE INSURANCE PRODUCT REGULATION COMPACT OPT OUT ADMINISTRATION.**

Subdivision 1. **Access to courts.** The commissioner must opt out by regulation of any uniform standard that permits a product to deny a consumer's access to the courts to resolve a dispute related to the product. In addition to opting out, the commissioner must petition the commission for a stay of the effective date of the standard.

Subd. 2. **Deference by courts.** A decision by the commissioner to opt out by regulation shall be given deference by the courts.

Sec. 5. Minnesota Statutes 2004, section 61A.02, subdivision 3, is amended to read:

Subd. 3. **Disapproval.** (a) The commissioner shall, within 60 days after the filing of any form, disapprove the form:

(1) if the benefits provided are unreasonable in relation to the premium charged;

(2) if the safety and soundness of the company would be threatened by the offering of an excess rate of interest on the policy or contract;

(3) if it contains a provision or provisions which are unlawful, unfair, inequitable, misleading, or encourages misrepresentation of the policy; or

(4) if the form, or its provisions, is otherwise not in the public interest. It shall be unlawful for the company to issue any policy in the form so disapproved. If the commissioner does not within 60 days after the filing of any form, disapprove or otherwise object, the form shall be deemed approved.

(b) When an insurer or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission.

(c) For purposes of paragraph (a), clause (2), an excess rate of interest is a rate of interest exceeding the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available.

Sec. 6. Minnesota Statutes 2004, 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~~ beneficiary previously selected by 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. 7. Minnesota Statutes 2004, section 62A.02, subdivision 3, is amended to read:

Subd. 3. **Standards for disapproval.** (a) The commissioner shall, within 60 days after the filing of any form or rate, disapprove the form or rate:

- (1) if the benefits provided are not reasonable in relation to the premium charged;

(2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A;

(3) if the proposed premium rate is excessive or not adequate; or

(4) the actuarial reasons and data submitted do not justify the rate.

The party proposing a rate has the burden of proving by a preponderance of the evidence that it does not violate this subdivision.

In determining the reasonableness of a rate, the commissioner shall also review all administrative contracts, service contracts, and other agreements to determine the reasonableness of the cost of the contracts or agreement and effect of the contracts on the rate. If the commissioner determines that a contract or agreement is not reasonable, the commissioner shall disapprove any rate that reflects any unreasonable cost arising out of the contract or agreement. The commissioner may require any information that the commissioner deems necessary to determine the reasonableness of the cost.

For the purposes of this subdivision, the commissioner shall establish by rule a schedule of minimum anticipated loss ratios which shall be based on (i) the type or types of coverage provided, (ii) whether the policy is for group or individual coverage, and (iii) the size of the group for group policies. Except for individual policies of disability or income protection insurance, the minimum anticipated loss ratio shall not be less than 50 percent after the first year that a policy is in force. All applicants for a policy shall be informed in writing at the time of application of the anticipated loss ratio of the policy. "Anticipated loss ratio" means the ratio at the time of filing, at the time of notice of withdrawal under subdivision 4a, or at the time of subsequent rate revision of the present value of all expected future benefits, excluding dividends, to the present value of all expected future premiums.

If the commissioner notifies a health carrier that has filed any form or rate that it does not comply with this chapter, chapter 62L, or chapter 72A, it shall be unlawful for the health carrier to issue or use the form or rate. In the notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the health carrier.

The 60-day period within which the commissioner is to approve or disapprove the form or rate does not begin to run until a complete filing of all data and materials required by statute or requested by the commissioner has been submitted.

However, if the supporting data is not filed within 30 days after a request by the commissioner, the rate is not effective and is presumed to be an excessive rate.

(b) When an insurer or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission.

Sec. 8. Minnesota Statutes 2004, section 62A.02, is amended by adding a subdivision to read:

Subd. 3a. **Individual policy rates file and use; minimum lifetime loss ratio guarantee.** (a) Notwithstanding subdivisions 2, 3, 4a, 5a, and 6, individual premium rates may be used upon filing with the department of an individual policy form if the filing is accompanied by the individual policy form filing and a minimum lifetime loss ratio guarantee. Insurers may use the filing procedure specified in this subdivision only if the affected individual policy forms disclose the benefit of a minimum lifetime loss ratio guarantee. Insurers may amend individual policy forms to provide for a minimum lifetime loss ratio guarantee. If an insurer elects to use the filing procedure in this subdivision for an individual policy rate, the insurer shall



not use a filing of premium rates that does not provide a minimum lifetime loss ratio guarantee for that individual policy rate.

(b) The minimum lifetime loss ratio guarantee must be in writing and must contain at least the following:

(1) an actuarial memorandum specifying the expected loss ratio that complies with the standards as set forth in this subdivision;

(2) a statement certifying that all rates, fees, dues, and other charges are not excessive, inadequate, or unfairly discriminatory;

(3) detailed experience information concerning the policy forms;

(4) a step-by-step description of the process used to develop the minimum lifetime loss ratio, including demonstration with supporting data;

(5) guarantee of specific minimum lifetime loss ratio that must be greater than or equal to 65 percent for policies issued to individuals or for certificates issued to members of an association that does not offer coverage to small employers, taking into consideration adjustments for duration;

(6) a guarantee that the actual Minnesota loss ratio for the calendar year in which the new rates take effect, and for each year thereafter until new rates are filed, will meet or exceed the minimum lifetime loss ratio standards referred to in clause (5), adjusted for duration;

(7) a guarantee that the actual Minnesota lifetime loss ratio shall meet or exceed the minimum lifetime loss ratio standards referred to in clause (5); and

(8) if the annual earned premium volume in Minnesota under the particular policy form is less than \$2,500,000, the minimum lifetime loss ratio guarantee must be based partially on the Minnesota earned premium and other credible factors as specified by the commissioner.

(c) The actual Minnesota minimum loss ratio results for each year at issue must be independently audited at the insurer's expense, and the audit report must be filed with the commissioner not later than 120 days after the end of the year at issue.

(d) The insurer shall refund premiums in the amount necessary to bring the actual loss ratio up to the guaranteed minimum lifetime loss ratio. For the purpose of this paragraph, loss ratio and guaranteed minimum lifetime loss ratio are the expected aggregate loss ratio of all approved individual policy forms that provide for a minimum lifetime loss ratio guarantee.

(e) A Minnesota policyholder affected by the guaranteed minimum lifetime loss ratio shall receive a portion of the premium refund relative to the premium paid by the policyholder. The refund must be made to all Minnesota policyholders insured under the applicable policy form during the year at issue if the refund would equal \$10 or more per policy. The refund must include statutory interest from July 1 of the year at issue until the date of payment. Payment must be made not later than 180 days after the end of the year at issue.

(f) Premium refunds of less than \$10 per insured must be credited to the policyholder's account.

(g) Subdivisions 2 and 3 do not apply if premium rates are filed with the department and accompanied by a minimum lifetime loss ratio guarantee that meets the requirements of this subdivision. Such filings are deemed approved. When determining a loss ratio for the purposes of a minimum lifetime loss ratio guarantee, the insurer shall divide the total of the claims incurred, plus preferred provider organization expenses, case management, and utilization review expenses, plus reinsurance premiums less reinsurance recoveries by the premiums earned less state and local taxes less other assessments. The insurer shall identify any assessment allocated.

(h) The policy form filing of an insurer using the filing procedure with a minimum lifetime loss ratio guarantee must disclose to the enrollee, member, or subscriber an explanation of the minimum lifetime loss ratio guarantee, and the actual loss ratio, and any adjustments for duration.

(i) The insurer who elects to use the filing procedure with a minimum lifetime loss ratio guarantee shall notify all policyholders of the refund calculation, the result of the refund calculation, the percentage of premium on an aggregate basis to be refunded, if any, any amount of the refund attributed to the payment of interests, and an explanation of amounts less than \$10.

Sec. 9. Minnesota Statutes 2004, section 62A.021, subdivision 1, is amended to read:

Subdivision 1. **Loss ratio standards.** (a) Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, and except as otherwise authorized by section 62A.02, subdivision 3a, for individual policies or certificates, health care policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate benefits not including anticipated refunds or credits, provided under the policies or certificates, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27, calculated on an aggregate basis; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of each policy form or certificate form issued in the individual market; calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. Assessments by the reinsurance association created in chapter 62L and all types of taxes, surcharges, or assessments created by Laws 1992, chapter 549, or created on or after April 23, 1992, are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for policies and certificates issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until a 72 percent loss ratio is reached on July 1, 2000. A health carrier that enters a market after July 1, 1993, does not start at the beginning of the phase-in schedule and must instead comply with the loss ratio requirements applicable to other health carriers in that market for each time period. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

(b) All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy form or certificate form shall equal or exceed the appropriate loss ratio standards.

(c) A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the

deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner shall order that the health carrier's filed rates for the nonconforming policy form or certificate form 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 health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

(d) Each sale of a policy or certificate that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

(e)(1) For purposes of this section, health care policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

(2) For purposes of this section, (i) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and (ii) "health carrier" has the meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

(f) The loss ratio phase-in as described in paragraph (a) does not apply to individual policies and small employer policies issued by a health plan company that is assessed less than three percent of the total annual amount assessed by the Minnesota Comprehensive Health Association. These policies must meet a 68 percent loss ratio for individual policies, a 71 percent loss ratio for small employer policies with fewer than ten employees, and a 75 percent loss ratio for all other small employer policies.

(g) Notwithstanding paragraphs (a) and (f), the loss ratio shall be 60 percent for a health plan as defined in section 62A.011, offered by an insurance company licensed under chapter 60A that is assessed less than ten percent of the total annual amount assessed by the Minnesota Comprehensive Health Association. For purposes of the percentage calculation of the association's assessments, an insurance company's assessments include those of its affiliates.

(h) The commissioners of commerce and health shall each annually issue a public report listing, by health plan company, the actual loss ratios experienced in the individual and small employer markets in this state by the health plan companies that the commissioners respectively regulate. The commissioners shall coordinate release of these reports so as to release them as a joint report or as separate reports issued the same day. The report or reports shall be released no later than June 1 for loss ratios experienced for the preceding calendar year. Health plan companies shall provide to the commissioners any information requested by the commissioners for purposes of this paragraph.

Sec. 10. Minnesota Statutes 2004, section 62A.095, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) No health plan shall be offered, sold, or issued to a resident of this state, or to cover a resident of this state, unless the health plan complies with subdivision 2.

(b) Health plans providing benefits under health care programs administered by the commissioner of human services are not subject to the limits described in subdivision 2 but are subject to the right of subrogation provisions under section 256B.37 and the lien provisions under section 256.015; 256B.042; 256D.03, subdivision 8; or 256L.03, subdivision 6.

For purposes of this section, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clauses (4), (7), and (10).

Sec. 11. Minnesota Statutes 2004, section 62A.27, is amended to read:

**62A.27 COVERAGE OF ADOPTED CHILDREN.**

(a) A health plan that provides coverage to a Minnesota resident must cover adopted children of the insured, subscriber, participant, or enrollee on the same basis as other dependents. Consequently, the plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning children placed for adoption with the participant.

(b) The coverage required by this section is effective from the date of placement for adoption. For purposes of this section, placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation for total or partial support.

(c) For the purpose of this section, health plan includes:

- (1) coverage offered by community integrated service networks;
- (2) coverage that is designed solely to provide dental or vision care; and

(3) any plan under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461.

(d) No policy or contract covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy or contract mandates an additional premium for each dependent, the health carrier is entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may withhold payment of any health benefits for the new dependent until it has been compensated with the applicable premium which would have been owed if the health carrier had been informed of the additional dependent immediately.

Sec. 12. Minnesota Statutes 2004, section 62A.3093, is amended to read:

**62A.3093 COVERAGE FOR DIABETES.**

Subdivision 1. Required coverage. A health plan, including a plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), must provide coverage for: (1) all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes; and (2) diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage must include persons with gestational, type I or type II diabetes. Coverage required under this section is subject to the same deductible or coinsurance provisions applicable to the plan's hospital, medical expense, medical equipment, or prescription drug benefits. A health carrier may not reduce or eliminate coverage due to this requirement.

Subd. 2. Medicare Part D exception. A health plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), is not subject to the requirements of subdivision 1, clause (1), with respect to equipment and supplies covered under the Medicare Part D Prescription Drug program, whether or not the covered person is enrolled in a Medicare Part D plan.

This subdivision does not apply to a health plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), that was in effect on December 31, 2005, if the covered person remains enrolled in the plan and does not enroll in a Medicare Part D plan.

**EFFECTIVE DATE.** This section is effective retroactive to January 1, 2006.

Sec. 13. Minnesota Statutes 2005 Supplement, section 62A.316, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses. An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare policy or certificate issued on or after January 1, 2006;

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

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

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

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association

current procedural terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for a procedure covered by Medicare;

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

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

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

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

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

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

(ii) Coverage requirements and limitations:

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

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

(C) coverage is limited to:

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

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

(III) \$1,600 per calendar year;

(IV) seven visits in any one week;

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

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

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

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

(iii) Coverage is excluded for:

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

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

(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses to a maximum of \$1,200 paid by the issuer annually under this benefit. An issuer of Medicare supplement insurance policies that elects to offer this benefit rider shall also make available coverage that contains the rider specified in clause (4). An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare policy or certificate issued on or after January 1, 2006.

**EFFECTIVE DATE.** This section is effective retroactively from January 1, 2006.

**Sec. 14. [62A.3161] MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT COVERAGE.**

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

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

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

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

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

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

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

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

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

**Sec. 15. [62A.3162] MEDICARE SUPPLEMENT PLAN WITH 75 PERCENT COVERAGE.**

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

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

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

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

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

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

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

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

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

Sec. 16. Minnesota Statutes 2004, section 62A.65, subdivision 3, is amended to read:

Subd. 3. **Premium rate restrictions.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(c) A health carrier may request approval by the commissioner to establish ~~no more than three separate geographic regions determined by the health carrier~~ and to establish separate index rates for each such region; ~~provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. The commissioner may shall grant approval if the following conditions are met:~~

(1) the geographic regions must be applied uniformly by the health carrier;

~~(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;~~

~~(3) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area, and~~

(2) each geographic region must be composed of no fewer than seven counties that create a contiguous region; and



~~(4)~~ (3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

- (1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and
- (2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

(i) An insurer may, as part of a minimum lifetime loss ratio guarantee filing under section 62A.02, subdivision 3a, include a rating practices guarantee as provided in this paragraph. The rating practices guarantee must be in writing and must guarantee that the policy form will be offered, sold, issued, and renewed only with premium rates and premium rating practices that comply with subdivisions 2, 3, 4, and 5. The rating practices guarantee must be accompanied by an actuarial memorandum that demonstrates that the premium rates and premium rating system used in connection with the policy form will satisfy the guarantee. The guarantee must guarantee refunds of any excess premiums to policyholders charged premiums that exceed those permitted under subdivision 2, 3, 4, or 5. An insurer that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs (c), (f), and (h).

**EFFECTIVE DATE.** The amendments to paragraph (c) of this section are effective January 1, 2007, and apply to policies issued or renewed on or after that date.

Sec. 17. Minnesota Statutes 2004, section 62C.14, subdivision 9, is amended to read:

Subd. 9. **Required filing.** No service plan corporation shall deliver or issue for delivery in this state any subscriber contract, endorsement, rider, amendment or application until a copy of the form thereof has been filed with the commissioner, subject to disapproval by the commissioner. Any such form issued or in use on August 1, 1971, if filed with the commissioner within 60 days after August 1, 1971, shall be deemed filed upon receipt by the commissioner. When an insurer, service plan corporation, or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission. The commissioner also may by regulation exempt from filing those subscriber contracts issued to a group of not less than 300 subscribers, or to other groups upon such reasonable conditions and restrictions as the commissioner may require.

Sec. 18. Minnesota Statutes 2004, section 62C.14, subdivision 10, is amended to read:

Subd. 10. **Filing or disapproval.** Except as otherwise provided in subdivision 9, all forms received by the commissioner shall be deemed filed 60 days after received unless disapproved by order transmitted to the corporation stating that the form used in a specified respect is contrary to law, contains a provision or provisions which are unfair, inequitable, misleading, inconsistent or ambiguous, or is in part illegible. It shall be unlawful to issue or use a document disapproved by the commissioner. When an insurer, service plan corporation, or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission.

Sec. 19. Minnesota Statutes 2004, section 62E.13, subdivision 3, is amended to read:

Subd. 3. **Duties of writing carrier.** The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of ~~three~~ five years, unless a request to terminate is approved by the commissioner. The commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. Six months prior to the expiration of each ~~three-year~~ five-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of subdivision 2 in selecting a writing carrier for the subsequent ~~three-year~~ five-year period.

Sec. 20. Minnesota Statutes 2004, section 62E.14, subdivision 5, is amended to read:

Subd. 5. **Terminated employees.** An employee who is voluntarily or involuntarily terminated or laid off from employment and unable to exercise the option to continue coverage under section 62A.17<sub>2</sub> and who is a Minnesota resident and who is otherwise eligible, may enroll in the comprehensive health insurance plan, by submitting an application that is received by the writing carrier no later than 90 days after termination or layoff, with a waiver of the preexisting condition limitation set forth in subdivision 3 ~~and a waiver of the evidence of rejection set forth in subdivision 1, paragraph (c).~~

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 21. Minnesota Statutes 2005 Supplement, section 62J.052, is amended to read:

**62J.052 PROVIDER COST DISCLOSURE.**

Subdivision 1. Health care providers. (a) Each health care provider, as defined by section 62J.03, subdivision 8, except hospitals and outpatient surgical centers subject to the requirements of section 62J.823, shall provide the following information:

(1) the average allowable payment from private third-party payers for the ~~20~~ 50 services or procedures most commonly performed;

(2) the average payment rates for those services and procedures for medical assistance;

(3) the average charge for those services and procedures for individuals who have no applicable private or public coverage; and

(4) the average charge for those services and procedures, including all patients.

(b) This information shall be updated annually and be readily available at no cost to the public on site.

Subd. 2. Pharmacies. (a) Each pharmacy, as defined in section 151.01, subdivision 2, shall provide the following information to a patient upon request:

(1) the pharmacy's own usual and customary price for a prescription drug;

(2) a record, including all transactions on record with the pharmacy both past and present, of all co-payments and other cost-sharing paid to the pharmacy by the patient for up to two years; and

(3) the total amount of all co-payments and other cost-sharing paid to the pharmacy by the patient over the previous two years.

(b) The information required under paragraph (a) must be readily available at no cost to the patient.

**EFFECTIVE DATE.** This section is effective October 1, 2006.

Sec. 22. Minnesota Statutes 2004, section 62J.60, subdivision 2, is amended to read:

Subd. 2. **General characteristics.** (a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements ~~left justified in the following top to bottom sequence:~~ card issuer name, electronic transaction routing information, card issuer identification number, cardholder (insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements. ~~The window must be left justified.~~

(c) Standardized labels are required next to human readable data elements ~~and must come before the human readable data elements.~~

Sec. 23. Minnesota Statutes 2004, section 62J.60, subdivision 3, is amended to read:

Subd. 3. **Human readable data elements.** (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota uniform health care identification card:

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be "Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;

~~(3) card issuer identification number. The standardized label for this element is "Issuer";~~

~~(4)~~ cardholder (insured) identification number, which is the unique identification number of the individual card holder established and defined under this section. The standardized label for the data element is "ID";

~~(5)~~ (4) cardholder (insured) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

~~(6)~~ (5) care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

~~(7)~~ (6) service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health. ~~The standard label for this data element is "Svc Type"; and~~

~~(8)~~ (7) provider/clinic name, which is the name of the primary care clinic the card holder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the card holder.

(b) The following human readable data elements shall be present on the back side of the Minnesota uniform health care identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

(1) claims submission names and addresses, which are the names and addresses of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;

(2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies or other providers with assistance or with the telephone numbers and names of contacts for assistance; and

(3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:

- (i) eligibility and benefit information;
- (ii) utilization review;
- (iii) precertification; or
- (iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

(1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and

(2) one of the following:

- (i) telephone number to call to appeal to or file a complaint with the commissioner of health; or
- (ii) for persons enrolled under section 256B.69, 256D.03, or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 and the address to appeal to the commissioner of human services. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion.

Sec. 24. Minnesota Statutes 2004, section 62J.81, subdivision 1, is amended to read:

Subdivision 1. **Required disclosure of estimated payment.** (a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, provide that consumer with a good faith estimate of the reimbursement the provider expects to receive from the health plan company in which the consumer is enrolled. Health plan companies must allow contracted providers, or their designee, to release this information. A good faith estimate must also be made available at the request of a consumer who is not enrolled in a health plan company. Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the cost of services.

(b) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee or the enrollee's designee, provide that enrollee with a good faith estimate of the reimbursement the health plan company would expect to pay to a specified provider within the network for a health care service specified by the enrollee. If requested by the enrollee, the health plan company shall also provide to the enrollee a good faith estimate of the enrollee's out-of-pocket cost for the health care service. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the reimbursement or out-of-pocket cost.

**EFFECTIVE DATE.** Paragraph (a) is effective the day following final enactment. Paragraph (b) is effective January 1, 2007.

Sec. 25. **[62J.823] HOSPITAL PRICING TRANSPARENCY.**

Subdivision 1. **Short title.** This section may be cited as the Hospital Pricing Transparency Act.

Subd. 2. **Definition.** For the purposes of this section, "estimate" means the actual price expected to be billed to the individual or to the individual's health plan company based on the specific diagnostic-related group code or specific procedure code or codes, reflecting any known discounts the individual would receive.

Subd. 3. **Applicability and scope.** Any hospital, as defined in section 144.696, subdivision 3, and outpatient surgical center, as defined in section 144.696, subdivision 4, shall provide a written estimate of the cost of a specific service or stay upon the request of a patient, doctor, or the patient's representative. The request must include:

(1) the health coverage status of the patient, including the specific health plan or other health coverage under which the patient is enrolled, if any; and

(2) at least one of the following:

(i) the specific diagnostic-related group code;

(ii) the name of the procedure or procedures to be performed;

(iii) the type of treatment to be received; or

(iv) any other information that will allow the hospital or outpatient surgical center to determine the specific diagnostic-related group or procedure code or codes.

Subd. 4. **Estimate.** (a) An estimate provided by the hospital or outpatient surgical center must contain:

(1) the method used to calculate the estimate;

(2) the specific diagnostic-related group or procedure code or codes used to calculate the estimate, and a description of the diagnostic-related group or procedure code or codes that is reasonably understandable to a patient; and

(3) a statement indicating that the estimate, while accurate, may not reflect the actual billed charges and that the final bill may be higher or lower depending on the patient's specific circumstances.

(b) The estimate may be provided in any method that meets the needs of the patient and the hospital or outpatient surgical center, including electronically; however, a paper copy must be provided if specifically requested.

**EFFECTIVE DATE.** This section is effective October 1, 2006.

Sec. 26. **[62J.83] REDUCED PAYMENT AMOUNTS PERMITTED.**

(a) Notwithstanding any provision of chapter 148 or any other provision of law to the contrary, a health care provider may provide care to a patient at a discounted payment amount, including care provided for free.

(b) This section does not apply in a situation in which the discounted payment amount is not permitted under federal law.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 27. Minnesota Statutes 2004, section 62L.02, subdivision 24, is amended to read:

Subd. 24. **Qualifying coverage.** "Qualifying coverage" means health benefits or health coverage provided under:

(1) a health benefit plan, as defined in this section, but without regard to whether it is issued to a small employer and including blanket accident and sickness insurance, other than accident-only coverage, as defined in section 62A.11;

(2) part A or part B of Medicare;

(3) medical assistance under chapter 256B;

(4) general assistance medical care under chapter 256D;

(5) MCHA;

(6) a self-insured health plan;

(7) the MinnesotaCare program established under section 256L.02;

(8) a plan provided under section 43A.316, 43A.317, or 471.617;

(9) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or other coverage provided under United States Code, title 10, chapter 55;

(10) coverage provided by a health care network cooperative under chapter 62R;

(11) a medical care program of the Indian Health Service or of a tribal organization;

(12) the federal Employees Health Benefits Plan, or other coverage provided under United States Code, title 5, chapter 89;

(13) a health benefit plan under section 5(e) of the Peace Corps Act, codified as United States Code, title 22, section 2504(e);

(14) a health plan; ~~or~~

(15) a plan similar to any of the above plans provided in this state or in another state as determined by the commissioner; ~~or~~

(16) any plan established or maintained by a state, the United States government, or a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan; or

(17) the State Children's Health Insurance Program (SCHIP).

Sec. 28. Minnesota Statutes 2004, section 62L.03, subdivision 3, is amended to read:

Subd. 3. **Minimum participation and contribution.** (a) A small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan and that contributes at least 50 percent toward the cost of coverage of each eligible employee must be guaranteed coverage on a guaranteed issue basis from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. A health carrier must not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdivision, waiver of coverage includes only waivers due to: (1) coverage under another group health plan; (2) coverage under Medicare Parts A and B; (3) coverage under MCHA permitted under section 62E.141; or (4) coverage under medical assistance under chapter 256B or general assistance medical care under chapter 256D.

(b) If a small employer does not satisfy the contribution or participation requirements under this subdivision, a health carrier may voluntarily issue or renew individual health plans, or a health benefit plan which must fully comply with this chapter. A health carrier that provides a health benefit plan to a small employer that does not meet the contribution or participation requirements of this subdivision must maintain this information in its files for audit by the commissioner. A health carrier may not offer an individual health plan, purchased through an arrangement between the employer and the health carrier, to any employee unless the health carrier also offers the individual health plan, on a guaranteed issue basis, to all other employees of the same employer. An arrangement permitted under section 62L.12, subdivision 2, paragraph (k), is not an arrangement between the employer and the health carrier for purposes of this paragraph.

(c) Nothing in this section obligates a health carrier to issue coverage to a small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer. This paragraph does not apply if the small employer will meet the required participation level with respect to the new coverage.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 29. Minnesota Statutes 2004, section 62L.08, subdivision 4, is amended to read:

Subd. 4. **Geographic premium variations.** A health carrier may request approval by the commissioner to establish ~~no more than three separate~~ geographic regions ~~determined by the health carrier~~ and to establish separate index rates for each ~~such region~~, ~~provided that the index rates do not vary between any two regions by more than 20 percent.~~ Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. A health carrier may also request approval to establish one or more additional geographic regions and one or more separate index rates for premiums for employees working and residing outside of Minnesota. The commissioner ~~may~~ shall grant approval if the following conditions are met:

- (1) the geographic regions must be applied uniformly by the health carrier;
- ~~(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;~~
- ~~(3) if one geographic region is rural, the index rate for the rural region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area;~~
- (2) each geographic region must be composed of no fewer than seven counties that create a contiguous region; and
- ~~(3)~~ (3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

**EFFECTIVE DATE.** This section is effective January 1, 2007, and applies to policies issued or renewed on or after that date.

Sec. 30. Minnesota Statutes 2005 Supplement, section 62L.12, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees as required.

(e) A health carrier may sell, issue, or renew individual health plans if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group health plan or due to the person's need for health care services not covered under the employer's group health plan.

(f) A health carrier may sell, issue, or renew an individual health plan, if the individual has elected to buy the individual health plan not as part of a general plan to substitute individual health plans for a group health plan nor as a result of any violation of subdivision 3 or 4.

(g) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

(h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage issued as a supplement to Medicare under sections 62A.31 to 62A.44, or policies or contracts that supplement Medicare issued by health maintenance organizations, or those contracts governed by sections 1833, 1851 to 1859, 1860D, or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., as amended.

(i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans necessary to comply with a court order.

(j) A health carrier may offer, issue, sell, or renew an individual health plan to persons eligible for an employer group health plan, if the individual health plan is a high deductible health plan for use in connection with an existing health savings account, in compliance with the Internal Revenue Code, section 223. In that



situation, the same or a different health carrier may offer, issue, sell, or renew a group health plan to cover the other eligible employees in the group.

(k) A health carrier may offer, sell, issue, or renew an individual health plan to one or more employees of a small employer if the individual health plan is marketed directly to all employees of the small employer and the small employer does not contribute directly or indirectly to the premiums or facilitate the administration of the individual health plan. The requirement to market an individual health plan to all employees does not require the health carrier to offer or issue an individual health plan to any employee. For purposes of this paragraph, an employer is not contributing to the premiums or facilitating the administration of the individual health plan if the employer does not contribute to the premium and merely collects the premiums from an employee's wages or salary through payroll deductions and submits payment for the premiums of one or more employees in a lump sum to the health carrier. Except for coverage under section 62A.65, subdivision 5, paragraph (b), or 62E.16, at the request of an employee, the health carrier may bill the employer for the premiums payable by the employee, provided that the employer is not liable for payment except from payroll deductions for that purpose. If an employer is submitting payments under this paragraph, the health carrier shall provide a cancellation notice directly to the primary insured at least ten days prior to termination of coverage for nonpayment of premium. Individual coverage under this paragraph may be offered only if the small employer has not provided coverage under section 62L.03 to the employees within the past 12 months.

The employer must provide a written and signed statement to the health carrier that the employer is not contributing directly or indirectly to the employee's premiums. The health carrier may rely on the employer's statement and is not required to guarantee-issue individual health plans to the employer's other current or future employees.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 31. Minnesota Statutes 2004, section 62M.01, subdivision 2, is amended to read:

Subd. 2. **Jurisdiction.** Sections 62M.01 to 62M.16 apply to any 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; the Minnesota Comprehensive Health Association created under chapter 62E; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, that provides utilization review services for the administration of benefits under a health benefit plan as defined in section 62M.02; or any entity performing utilization review on behalf of a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

Sec. 32. **[62M.072] USE OF EVIDENCE-BASED STANDARDS.**

If no independently developed evidence-based standards exist for a particular treatment, testing, or imaging procedure, then an insurer or utilization review organization shall not deny coverage of the treatment, testing, or imaging based solely on the grounds that the treatment, testing, or imaging does not meet an evidence-based standard. This section does not prohibit an insurer or utilization review organization from denying coverage for services that are investigational, experimental, or not medically necessary.

Sec. 33. Minnesota Statutes 2004, section 62M.09, subdivision 9, is amended to read:

Subd. 9. **Annual report.** A utilization review organization shall file an annual report with the annual financial statement it submits to the commissioner of commerce that includes:

- (1) per 1,000 ~~claims~~ utilization reviews, the number and rate of ~~claims denied~~ determinations not to certify based on medical necessity for each procedure or service; and
- (2) the number and rate of denials overturned on appeal.

A utilization review organization that is not a licensed health carrier must submit the annual report required by this subdivision on April 1 of each year.

Sec. 34. **[62Q.645] DISTRIBUTION OF INFORMATION; ADMINISTRATIVE EFFICIENCY AND COVERAGE OPTIONS.**

(a) The commissioner may use reports submitted by health plan companies, service cooperatives, and the public employee insurance program created in section 43A.316 to compile entity specific administrative efficiency reports; may make these reports available on state agency Web sites, including minnesotahealthinfo.com; and may include information on:

- (1) number of covered lives;
- (2) covered services;
- (3) geographic availability;
- (4) whom to contact to obtain current premium rates;
- (5) administrative costs, using the definition of administrative costs developed under section 62J.38;
- (6) Internet links to information on the health plan, if available; and
- (7) any other information about the health plan identified by the commissioner as being useful for employers, consumers, providers, and others in evaluating health plan options.

(b) This section does not apply to a health plan company unless its annual Minnesota premiums exceed \$50,000,000 based on the most recent assessment base of the Minnesota Comprehensive Health Association. For purposes of this determination, the premiums of a health plan company include those of its affiliates.

Sec. 35. **[62Q.80] COMMUNITY-BASED HEALTH CARE COVERAGE PROGRAM.**

Subdivision 1. **Scope.** (a) A community-based health care initiative may develop and operate a community-based health care coverage program that offers to eligible individuals and their dependents the option of purchasing through their employer health care coverage on a fixed prepaid basis without meeting the requirements of chapter 60A, 62A, 62C, 62D, 62Q, or 62T, or any other law or rule that applies to entities licensed under these chapters.

(b) The initiative shall establish health outcomes to be achieved through the program and performance measurements in order to determine whether these outcomes have been met. The outcomes must include, but are not limited to:

- (1) a reduction in uncompensated care provided by providers participating in the community-based health network;
- (2) an increase in the delivery of preventive health care services; and
- (3) health improvement for enrollees with chronic health conditions through the management of these conditions.

In establishing performance measurements, the initiative shall use measures that are consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures.

(c) Any program established under this section shall not constitute a financial liability for the state, in that any financial risk involved in the operation or termination of the program shall be borne by the community-based initiative and the participating health care providers.

Subd. 2. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Community-based" means located in or primarily relating to the community of geographically contiguous political subdivisions, as determined by the board of a community-based health initiative that is served by the community-based health care coverage program.

(b) "Community-based health care coverage program" or "program" means a program administered by a community-based health initiative that provides health care services through provider members of a community-based health network or combination of networks to eligible individuals and their dependents who are enrolled in the program.

(c) "Community-based health initiative" means a nonprofit corporation that is governed by a board that has at least 80 percent of its members residing in the community and includes representatives of the participating network providers and employers.

(d) "Community-based health network" means a contract-based network of health care providers organized by the community-based health initiative to provide or support the delivery of health care services to enrollees of the community-based health care coverage program on a risk-sharing or nonrisk-sharing basis.

(e) "Dependent" means an eligible employee's spouse or unmarried child who is under the age of 19 years.

Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care coverage program, a community-based health initiative shall submit to the commissioner of health for approval the community-based health care coverage program developed by the initiative. The commissioner shall only approve a program that has been awarded a community access program grant from the United States Department of Health and Human Services. The commissioner shall ensure that the program meets the federal grant requirements and any requirements described in this section and is actuarially sound based on a review of appropriate records and methods utilized by the community-based health initiative in establishing premium rates for the community-based health care coverage program.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community-based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Subd. 4. **Establishment.** (a) The initiative shall establish and operate upon approval by the commissioner of health a community-based health care coverage program. The operational structure established by the initiative shall include, but is not limited to:

(1) establishing a process for enrolling eligible individuals and their dependents;

(2) collecting and coordinating premiums from enrollees and employers of enrollees;

(3) providing payment to participating providers;

(4) establishing a benefit set according to subdivision 8 and establishing premium rates and cost-sharing requirements;

(5) creating incentives to encourage primary care and wellness services; and

(6) initiating disease management services, as appropriate.

(b) The payments collected under paragraph (a), clause (2), may be used to capture available federal funds.

Subd. 5. **Qualifying employees.** To be eligible for the community-based health care coverage program, an individual must:

(1) reside in or work within the designated community-based geographic area served by the program;

(2) be employed by a qualifying employer or be an employee's dependent;

(3) not be enrolled in or have currently available health coverage; and

(4) not be enrolled in medical assistance, general assistance medical care, MinnesotaCare, or Medicare.

Subd. 6. **Qualifying employers.** (a) To qualify for participation in the community-based health care coverage program, an employer must:

(1) employ at least one but no more than 50 employees at the time of initial enrollment in the program;

(2) pay its employees a median wage of \$12.50 per hour or less; and

(3) not have offered employer-subsidized health coverage to its employees for at least 12 months prior to the initial enrollment in the program. For purposes of this section, "employer-subsidized health coverage" means health care coverage for which the employer pays at least 50 percent of the cost of coverage for the employee.

(b) To participate in the program, a qualifying employer agrees to:

(1) offer health care coverage through the program to all eligible employees and their dependents regardless of health status;

(2) participate in the program for an initial term of at least one year;

(3) pay a percentage of the premium established by the initiative for the employee; and

(4) provide the initiative with any employee information deemed necessary by the initiative to determine eligibility and premium payments.

Subd. 7. **Participating providers.** Any health care provider participating in the community-based health network must accept as payment in full the payment rate established by the initiative and may not charge to or collect from an enrollee any amount in excess of this amount for any service covered under the program.

Subd. 8. **Coverage.** (a) The initiative shall establish the health care benefits offered through the community-based health care coverage program. The benefits established shall include, at a minimum:

(1) child health supervision services up to age 18, as defined under section 62A.047; and

(2) preventive services, including:

- (i) health education and wellness services;
- (ii) health supervision, evaluation, and follow-up;
- (iii) immunizations; and
- (iv) early disease detection.

(b) Coverage of health care services offered by the program may be limited to participating health care providers or health networks. All services covered under the program must be services that are offered within the scope of practice of the participating health care providers.

(c) The initiative may establish cost-sharing requirements. Any co-payment or deductible provisions established may not discriminate on the basis of age, sex, race, disability, economic status, or length of enrollment in the program.

(d) If the initiative amends or alters the benefits offered through the program from the initial offering, the initiative must notify the commissioner of health and all enrollees of the benefit change.

**Subd. 9. Enrollee information.** (a) The initiative must provide an individual or family who enrolls in the program a clear and concise written statement that includes the following information:

- (1) health care services that are provided under the program;
- (2) any exclusions or limitations on the health care services offered, including any cost-sharing arrangements or prior authorization requirements;
- (3) a list of where the health care services can be obtained and that all health care services must be provided by or through a participating health care provider or community-based health network;
- (4) a description of the program's complaint resolution process, including how to submit a complaint; how to file a complaint with the commissioner of health; and how to obtain an external review of any adverse decisions as provided under subdivision 10;
- (5) the conditions under which the program or coverage under the program may be canceled or terminated; and
- (6) a precise statement specifying that this program is not an insurance product and, as such, is exempt from state regulation of insurance products.

(b) The commissioner of health must approve a copy of the written statement prior to the operation of the program.

**Subd. 10. Complaint resolution process.** (a) The initiative must establish a complaint resolution process. The process must make reasonable efforts to resolve complaints and to inform complainants in writing of the initiative's decision within 60 days of receiving the complaint. Any decision that is adverse to the enrollee shall include a description of the right to an external review as provided in paragraph (c) and how to exercise this right.

(b) The initiative must report any complaint that is not resolved within 60 days to the commissioner of health.

(c) The initiative must include in the complaint resolution process the ability of an enrollee to pursue the external review process provided under section 62Q.73 with any decision rendered under this external review process binding on the initiative.

**Subd. 11. Data privacy.** The initiative shall establish data privacy policies and procedures for the program that comply with state and federal data privacy laws.

Subd. 12. **Limitations on enrollment.** (a) The initiative may limit enrollment in the program. If enrollment is limited, a waiting list must be established.

(b) The initiative shall not restrict or deny enrollment in the program except for nonpayment of premiums, fraud or misrepresentation, or as otherwise permitted under this section.

(c) The initiative may require a certain percentage of participation from eligible employees of a qualifying employer before coverage can be offered through the program.

Subd. 13. **Report.** (a) The initiative shall submit quarterly status reports to the commissioner of health on January 15, April 15, July 15, and October 15 of each year, with the first report due January 15, 2007. The status report shall include:

(1) the financial status of the program, including the premium rates, cost per member per month, claims paid out, premiums received, and administrative expenses;

(2) a description of the health care benefits offered and the services utilized;

(3) the number of employers participating, the number of employees and dependents covered under the program, and the number of health care providers participating;

(4) a description of the health outcomes to be achieved by the program and a status report on the performance measurements to be used and collected; and

(5) any other information requested by the commissioner of health or commerce or the legislature.

(b) The initiative shall contract with an independent entity to conduct an evaluation of the program to be submitted to the commissioners of health and commerce and the legislature by January 15, 2009. The evaluation shall include:

(1) an analysis of the health outcomes established by the initiative and the performance measurements to determine whether the outcomes are being achieved;

(2) an analysis of the financial status of the program, including the claims to premiums loss ratio and utilization and cost experience;

(3) the demographics of the enrollees, including their age, gender, family income, and the number of dependents;

(4) the number of employers and employees who have been denied access to the program and the basis for the denial;

(5) specific analysis on enrollees who have aggregate medical claims totaling over \$5,000 per year, including data on the enrollee's main diagnosis and whether all the medical claims were covered by the program;

(6) number of enrollees referred to state public assistance programs;

(7) a comparison of employer-subsidized health coverage provided in a comparable geographic area to the designated community-based geographic area served by the program, including, to the extent available:

(i) the difference in the number of employers with 50 or fewer employees offering employer-subsidized health coverage;

(ii) the difference in uncompensated care being provided in each area; and

(iii) a comparison of health care outcomes and measurements established by the initiative; and

(8) any other information requested by the commissioner of health or commerce.

Subd. 14. **Sunset.** This section expires December 31, 2011.

Sec. 36. Minnesota Statutes 2004, section 62S.05, is amended by adding a subdivision to read:

Subd. 4. **Extension of limitation periods.** The commissioner may extend the limitation periods set forth in subdivisions 1 and 2 as to specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 37. Minnesota Statutes 2004, section 62S.08, subdivision 3, is amended to read:

Subd. 3. **Mandatory format.** The following standard format outline of coverage must be used, unless otherwise specifically indicated:

COMPANY NAME  
ADDRESS - CITY AND STATE  
TELEPHONE NUMBER  
LONG-TERM CARE INSURANCE  
OUTLINE OF COVERAGE

Policy Number or Group Master Policy and Certificate Number

(Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.)

CAUTION: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address).

(1) This policy is (an individual policy of insurance) (a group policy) which was issued in the (indicate jurisdiction in which group policy was issued).

(2) **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY.**

(3) **THIS PLAN IS INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702(B)(b) OF THE INTERNAL REVENUE CODE OF 1986.**

(4) **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

(a) (For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:)

(1) (Policies and certificates that are guaranteed renewable shall contain the following statement:)  
**RENEWABILITY: THIS POLICY (CERTIFICATE) IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, (certificate) to continue this policy as long as you pay

your premiums on time. (Company name) cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) (Policies and certificates that are noncancelable shall contain the following statement:) RENEWABILITY: THIS POLICY (CERTIFICATE) IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. (Company name) cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, (company name) may increase your premium at that time for those additional benefits.

(b) (For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.)

(c) (Describe waiver of premium provisions or state that there are not such provisions.)

(5) TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

(In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium and, if a right exists, describe clearly and concisely each circumstance under which the premium may change.)

(6) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) (Provide a brief description of the right to return – "free look" provision of the policy.)

(b) (Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.)

~~(7)~~ (7) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) (For agents) neither (insert company name) nor its agents represent Medicare, the federal government, or any state government.

(b) (For direct response) (insert company name) is not representing Medicare, the federal government, or any state government.

~~(8)~~ (8) LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy (limitations), (waiting periods), and (coinsurance) requirements. (Modify this paragraph if the policy is not an indemnity policy.)

~~(9)~~ (9) BENEFITS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.)

(b) (Institutional benefits, by skill level.)

(c) (Noninstitutional benefits, by skill level.)

(d) (Eligibility for payment of benefits.)



(Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.)

(Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.)

~~(8)~~ (10) LIMITATIONS AND EXCLUSIONS:

Describe:

- (a) preexisting conditions;
- (b) noneligible facilities/provider;
- (c) noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
- (d) exclusions/exceptions; and
- (e) limitations.

(This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph ~~(6)~~ (8).)

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

~~(9)~~ (11) RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. As applicable, indicate the following:

- (a) that the benefit level will not increase over time;
- (b) any automatic benefit adjustment provisions;
- (c) whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
- (d) if there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations; and
- (e) whether there will be any additional premium charge imposed and how that is to be calculated.

~~(10)~~ (12) ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. (State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically, describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.)

~~(11)~~ (13) PREMIUM.

- (a) State the total annual premium for the policy.
- (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.

~~(12)~~ (14) ADDITIONAL FEATURES.

- (a) Indicate if medical underwriting is used.
- (b) Describe other important features.

(15) CONTACT THE STATE DEPARTMENT OF COMMERCE OR SENIOR LINKAGE LINE IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 38. Minnesota Statutes 2004, section 62S.081, subdivision 4, is amended to read:

Subd. 4. **Forms.** An insurer shall use the forms in Appendices B (Personal Worksheet) and F (Potential Rate Increase Disclosure Form) of the Long-term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners to comply with the requirements of subdivisions 1 and 2.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 39. Minnesota Statutes 2004, section 62S.10, subdivision 2, is amended to read:

Subd. 2. **Contents.** The summary must include the following information:

- (1) an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
- (2) an illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits, if any, for each covered person; ~~and~~
- (3) any exclusions, reductions, and limitations on benefits of long-term care; and
- (4) a statement that any long-term care inflation protection option required by section 62S.23 is not available under this policy.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 40. Minnesota Statutes 2004, section 62S.13, is amended by adding a subdivision to read:

Subd. 6. **Death of insured.** In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by section 61A.03, subdivision 1, paragraph (c). In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 41. Minnesota Statutes 2004, section 62S.14, subdivision 2, is amended to read:

Subd. 2. **Terms.** The terms "guaranteed renewable" and "noncancelable" may not be used in an individual long-term care insurance policy without further explanatory language that complies with the disclosure requirements of section 62S.20. The term "level premium" may only be used when the insurer does not have the right to change the premium.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 42. Minnesota Statutes 2004, section 62S.15, is amended to read:

**62S.15 AUTHORIZED LIMITATIONS AND EXCLUSIONS.**

No policy may be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

- (1) preexisting conditions or diseases;
- (2) mental or nervous disorders; except that the exclusion or limitation of benefits on the basis of Alzheimer's disease is prohibited;
- (3) alcoholism and drug addiction;
- (4) illness, treatment, or medical condition arising out of war or act of war; participation in a felony, riot, or insurrection; service in the armed forces or auxiliary units; suicide, attempted suicide, or intentionally self-inflicted injury; or non-fare-paying aviation; ~~and~~
- (5) treatment provided in a government facility unless otherwise required by law, services for which benefits are available under Medicare or other government program except Medicaid, state or federal workers' compensation, employer's liability or occupational disease law, motor vehicle no-fault law; services provided by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance; and
- (6) expenses for services or items available or paid under another long-term care insurance or health insurance policy.

This subdivision does not prohibit exclusions and limitations by type of provider or territorial limitations.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 43. Minnesota Statutes 2004, section 62S.20, subdivision 1, is amended to read:

Subdivision 1. **Renewability.** (a) Individual long-term care insurance policies must contain a renewability provision that is appropriately captioned, appears on the first page of the policy, and clearly states the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed that the coverage is guaranteed renewable or noncancelable. This subdivision does not apply to policies which are part of or combined with life insurance policies which do not contain a renewability provision and under which the right to nonrenew is reserved solely to the policyholder.

(b) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 44. Minnesota Statutes 2004, section 62S.24, subdivision 1, is amended to read:

Subdivision 1. **Required questions.** An application form must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the following questions may be used. If a replacement policy is issued to a group as defined under section 62S.01, subdivision 15, clause (1), the following questions may be modified

only to the extent necessary to elicit information about long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement:

(1) do you have another long-term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?;

(2) did you have another long-term care insurance policy or certificate in force during the last 12 months?;

(i) if so, with which company?; and

(ii) if that policy lapsed, when did it lapse?; ~~and~~

(3) are you covered by Medicaid?; and

(4) do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 45. Minnesota Statutes 2004, section 62S.24, is amended by adding a subdivision to read:

**Subd. 1a. Other health insurance policies sold by agent.** Agents shall list all other health insurance policies they have sold to the applicant that are still in force or were sold in the past five years and are no longer in force.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 46. Minnesota Statutes 2004, section 62S.24, subdivision 3, is amended to read:

**Subd. 3. Solicitations other than direct response.** After determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods or its agent, shall furnish the applicant, before issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice must be retained by the applicant and an additional copy signed by the applicant must be retained by the insurer. The required notice must be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF  
INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by (company name) insurance company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT

(BROKER OR OTHER REPRESENTATIVE):

(Use additional sheets, as necessary.)

I have reviewed your current medical health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

(a) Health conditions which you presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(b) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(c) If you are replacing existing accident and sickness or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(d) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

.....  
(Signature of Agent, Broker, or Other Representative)

(Typed Name and Address of Agency or Broker)

The above "Notice to Applicant" was delivered to me on:

.....  
(Date)

.....  
(Applicant's Signature)

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 47. Minnesota Statutes 2004, section 62S.24, subdivision 4, is amended to read:

Subd. 4. **Direct response solicitations.** Insurers using direct response solicitation methods shall deliver a notice regarding replacement of long-term care coverage to the applicant upon issuance of the policy. The required notice must be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT  
AND SICKNESS OR LONG-TERM CARE INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE

IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by (company name) insurance company.

Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

(a) Health conditions which you presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(b) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(c) If you are replacing existing accident and sickness or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(d) (To be included only if the application is attached to the policy.)

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (company name and address) within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

.....  
(Company Name)

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 48. Minnesota Statutes 2004, section 62S.24, is amended by adding a subdivision to read:

Subd. 7. **Life insurance policies.** Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of sections 61A.53 to 61A.60. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 49. Minnesota Statutes 2004, section 62S.24, is amended by adding a subdivision to read:

Subd. 8. **Exchange for long-term care partnership policy; addition of policy rider.** (a) If authorized by federal law or a federal waiver is granted with respect to the long-term care partnership program referenced in section 256B.0571, issuers of long-term care policies may voluntarily exchange a current long-term care insurance policy for a long-term care partnership policy that meets the requirements of Public Law 109-171, section 6021, after the effective date of the state plan amendment implementing the partnership program in this state.

(b) If authorized by federal law or a federal waiver is granted with respect to the long-term care partnership program referenced in section 256B.0571 allowing an existing long-term care insurance policy to qualify as a partnership policy by addition of a policy rider, the issuer of the policy is authorized to add the rider to the policy after the effective date of the state plan amendment implementing the partnership program in this state.

(c) The commissioner, in cooperation with the commissioner of human services, shall pursue any federal law changes or waivers necessary to allow the implementation of paragraphs (a) and (b).

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 50. Minnesota Statutes 2004, section 62S.25, subdivision 6, is amended to read:

Subd. 6. **Claims denied.** Each insurer shall report annually by June 30 the number of claims denied for any reason during the reporting period for each class of business, expressed as a percentage of claims denied, other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition. For purposes of this subdivision, "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 51. Minnesota Statutes 2004, section 62S.25, is amended by adding a subdivision to read:

Subd. 7. **Reports.** Reports under this section shall be done on a statewide basis and filed with the commissioner. They shall include, at a minimum, the information in the format contained in Appendix E (Claim Denial Reporting Form) and in Appendix G (Replacement and Lapse Reporting Form) of the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 52. Minnesota Statutes 2004, section 62S.26, is amended to read:

**62S.26 LOSS RATIO.**

Subdivision 1. **Minimum loss ratio.** ~~(a)~~ The minimum loss ratio must be at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, the commissioner shall give consideration to all relevant factors, including:

- (1) statistical credibility of incurred claims experience and earned premiums;
- (2) the period for which rates are computed to provide coverage;
- (3) experienced and projected trends;
- (4) concentration of experience within early policy duration;
- (5) expected claim fluctuation;

- (6) experience refunds, adjustments, or dividends;
- (7) renewability features;
- (8) all appropriate expense factors;
- (9) interest;
- (10) experimental nature of the coverage;
- (11) policy reserves;
- (12) mix of business by risk classification; and
- (13) product features such as long elimination periods, high deductibles, and high maximum limits.

Subd. 2. **Life insurance policies.** Subdivision 1 shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(1) the interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) the portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of section 61A.24;

(3) the policy meets the disclosure requirements of sections 62S.09, 62S.10, and 62S.11; and

(4) an actuarial memorandum is filed with the commissioner that includes:

(i) a description of the basis on which the long-term care rates were determined;

(ii) a description of the basis for the reserves;

(iii) a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) a description and a table of each actuarial assumption used. For expenses, an insurer must include percentage of premium dollars per policy and dollars per unit of benefits, if any;

(v) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) the estimated average annual premium per policy and the average issue age;

(vii) a statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Subd. 3. **Nonapplication.** ~~(b)~~ This section does not apply to policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265, and that comply with those sections.

**EFFECTIVE DATE.** This section is effective July 1, 2006.



Sec. 53. Minnesota Statutes 2004, section 62S.266, subdivision 2, is amended to read:

Subd. 2. **Requirement.** (a) An insurer must offer each prospective policyholder a nonforfeiture benefit in compliance with the following requirements:

(1) a policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer must be the benefit described in subdivision 5; and

(2) the offer must be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(b) When a group long-term care insurance policy is issued, the offer required in paragraph (a) shall be made to the group policy holder. However, if the policy is issued as group long-term care insurance as defined in section 62S.01, subdivision 15, clause (4), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 54. Minnesota Statutes 2004, section 62S.29, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** An insurer or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(1) establish marketing procedures and agent training requirements to assure that ~~any~~ any marketing activities, including any comparison of policies by its agents or other producers, are fair and accurate;

(2) establish marketing procedures to assure excessive insurance is not sold or issued;

(3) display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy, the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.";

(4) provide copies of the disclosure forms required in section 62S.081, subdivision 4, to the applicant;

(5) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has long-term care insurance and the types and amounts of the insurance;

~~(5) (6) establish auditable procedures for verifying compliance with this subdivision; and~~

~~(6) (7) if applicable, provide written notice to the prospective policyholder and certificate holder, at solicitation, that a senior insurance counseling program approved by the commissioner is available and the name, address, and telephone number of the program;~~

(8) use the terms "noncancelable" or "level premium" only when the policy or certificate conforms to section 62S.14; and

(9) provide an explanation of contingent benefit upon lapse provided for in section 62S.266.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 55. Minnesota Statutes 2004, section 62S.30, is amended to read:

**62S.30 ~~APPROPRIATENESS OF RECOMMENDED PURCHASE~~ SUITABILITY.**

Subdivision 1. **Standards.** ~~In recommending the purchase or replacement of a long-term care insurance policy or certificate, an agent shall comply with section 60K.46, subdivision 4. Every insurer or other entity marketing long-term care insurance shall:~~

(1) develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) train its agents in the use of its suitability standards; and

(3) maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

Subd. 2. **Procedures.** (a) To determine whether the applicant meets the standards developed by the insurer or other entity marketing long-term care insurance, the agent and insurer or other entity marketing long-term care insurance shall develop procedures that take the following into consideration:

(1) the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet those goals or needs; and

(3) the values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(b) The insurer or other entity marketing long-term care insurance, and the agent, where an agent is involved, shall make reasonable efforts to obtain the information set forth in paragraph (a). The efforts shall include presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the insurer or other entity marketing long-term care insurance shall contain, at a minimum, the information in the format contained in Appendix B of the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners, in not less than 12-point type. The insurer or other entity marketing long-term care insurance may request the applicant to provide additional information to comply with its suitability standards. The insurer or other entity marketing long-term care insurance shall file a copy of its personal worksheet with the commissioner.

(c) A completed personal worksheet shall be returned to the insurer or other entity marketing long-term care insurance prior to consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses. The sale or dissemination by the insurer or other entity marketing long-term care insurance, or the agent, of information obtained through the personal worksheet is prohibited.

(d) The insurer or other entity marketing long-term care insurance shall use the suitability standards it has developed under this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate. Agents shall use the suitability standards developed by the insurer or other entity marketing long-term care insurance in marketing long-term care insurance.

(e) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in not less than 12-point type.

(f) If the insurer or other entity marketing long-term care insurance determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer or other entity marketing long-term care insurance may reject the application. In the alternative, the insurer or other entity marketing long-term care insurance shall send the applicant a letter similar to Appendix D of the Long-Term Care Insurance Model Regulation adopted by the National Association

of Insurance Commissioners. However, if the applicant has declined to provide financial information, the insurer or other entity marketing long-term care insurance may use some other method to verify the applicant's intent. The applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

Subd. 3. **Reports.** The insurer or other entity marketing long-term care insurance shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

Subd. 4. **Application.** This section shall not apply to life insurance policies that accelerate benefits for long-term care.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 56. **[62S.315] PRODUCER TRAINING.**

The commissioner shall approve insurer and producer training requirements according to the NAIC Long-Term Care Insurance Model Act provisions. The commissioner of human services shall provide technical assistance and information to the commissioner according to Public Law 109-171, section 6021.

**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 57. Minnesota Statutes 2004, section 65B.44, subdivision 3a, is amended to read:

Subd. 3a. **Disability and income loss benefits election; senior citizens.** A plan of reparation security issued to or renewed with a person who has attained the age of 65 or who has attained the age of 60 years and is retired and receiving a pension, must provide disability and income loss benefits under section 65B.44, subdivision 3, unless the insured elects not to have this coverage. An election by the insured not to have this coverage remains in effect until revoked by the insured. The reparation obligor shall notify a person of the person's rights under this section at the time of the sale or the first renewal of the policy after the insured has attained the age of ~~65~~ 60 years; and at least annually after that. The rate for any plan for which coverage has been excluded or reduced pursuant to this section must be reduced accordingly. This section does apply to self-insurance.

**EFFECTIVE DATE.** This section is effective August 1, 2006, and applies to plans of reparation security issued or renewed on or after that date.

Sec. 58. Minnesota Statutes 2004, section 70A.07, is amended to read:

**70A.07 RATES AND FORMS OPEN TO INSPECTION.**

All rates, supplementary rate information, and forms furnished to the commissioner under this chapter shall, ~~as soon as the commissioner's review has been completed~~ within ten days after their effective date, be open to public inspection at any reasonable time.

Sec. 59. Minnesota Statutes 2004, section 72A.20, is amended by adding a subdivision to read:

Subd. 39. **Discounted payments by health care providers; effect on use of usual and customary payments.** An insurer, including, but not limited to, a health plan company as defined in section 62Q.01, subdivision 4; a reparation obligor as defined in section 65B.43, subdivision 9; and a workers' compensation insurer shall not consider in determining a health care provider's usual and customary payment, standard

payment, or allowable payment used as a basis for determining the provider's payment by the insurer, the following discounted payment situations:

- (1) care provided to relatives of the provider;
- (2) care for which a discount or free care is given in hardship situations; and
- (3) care for which a discount is given in exchange for cash payment.

For purposes of this subdivision, "health care provider" and "provider" have the meaning given in section 62J.03, subdivision 8.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 60. Minnesota Statutes 2005 Supplement, section 72A.201, subdivision 6, is amended to read:

Subd. 6. **Standards for automobile insurance claims handling, settlement offers, and agreements.** In addition to the acts specified in subdivisions 4, 5, 7, 8, and 9, the following acts by an insurer, adjuster, or a self-insured or self-insurance administrator constitute unfair settlement practices:

(1) if an automobile insurance policy provides for the adjustment and settlement of an automobile total loss on the basis of actual cash value or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) comparable and available replacement automobile, with all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to the transfer or evidence of ownership of the automobile paid, at no cost to the insured other than the deductible amount as provided in the policy;

(b) a cash settlement based upon the actual cost of purchase of a comparable automobile, including all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to transfer of evidence of ownership, less the deductible amount as provided in the policy. The costs must be determined by:

(i) the cost of a comparable automobile, adjusted for mileage, condition, and options, in the local market area of the insured, if such an automobile is available in that area; or

(ii) one of two or more quotations obtained from two or more qualified sources located within the local market area when a comparable automobile is not available in the local market area. The insured shall be provided the information contained in all quotations prior to settlement; or

(iii) any settlement or offer of settlement which deviates from the procedure above must be documented and justified in detail. The basis for the settlement or offer of settlement must be explained to the insured;

(2) if an automobile insurance policy provides for the adjustment and settlement of an automobile partial loss on the basis of repair or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) to assume all costs, including reasonable towing costs, for the satisfactory repair of the motor vehicle. Satisfactory repair includes repair of both obvious and hidden damage as caused by the claim incident. This assumption of cost may be reduced by applicable policy provision; or

(b) to offer a cash settlement sufficient to pay for satisfactory repair of the vehicle. Satisfactory repair includes repair of obvious and hidden damage caused by the claim incident, and includes reasonable towing costs;

(3) regardless of whether the loss was total or partial, in the event that a damaged vehicle of an insured cannot be safely driven, failing to exercise the right to inspect automobile damage prior to repair within five business days following receipt of notification of claim. In other cases the inspection must be made in 15 days;

(4) regardless of whether the loss was total or partial, requiring unreasonable travel of a claimant or insured to inspect a replacement automobile, to obtain a repair estimate, to allow an insurer to inspect a repair estimate, to allow an insurer to inspect repairs made pursuant to policy requirements, or to have the automobile repaired;

(5) regardless of whether the loss was total or partial, if loss of use coverage exists under the insurance policy, failing to notify an insured at the time of the insurer's acknowledgment of claim, or sooner if inquiry is made, of the fact of the coverage, including the policy terms and conditions affecting the coverage and the manner in which the insured can apply for this coverage;

(6) regardless of whether the loss was total or partial, failing to include the insured's deductible in the insurer's demands under its subrogation rights. Subrogation recovery must be shared at least on a proportionate basis with the insured, unless the deductible amount has been otherwise recovered by the insured, except that when an insurer is recovering directly from an uninsured third party by means of installments, the insured must receive the full deductible share as soon as that amount is collected and before any part of the total recovery is applied to any other use. No deduction for expenses may be made from the deductible recovery unless an attorney is retained to collect the recovery, in which case deduction may be made only for a pro rata share of the cost of retaining the attorney. An insured is not bound by any settlement of its insurer's subrogation claim with respect to the deductible amount, unless the insured receives, as a result of the subrogation settlement, the full amount of the deductible. Recovery by the insurer and receipt by the insured of less than all of the insured's deductible amount does not affect the insured's rights to recover any unreimbursed portion of the deductible from parties liable for the loss;

(7) requiring as a condition of payment of a claim that repairs to any damaged vehicle must be made by a particular contractor or repair shop or that parts, other than window glass, must be replaced with parts other than original equipment parts or engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an insured to use a particular contractor or repair shop. Consumer benefits included within preferred vendor programs must not be considered an incentive or inducement. At the time a claim is reported, the insurer must provide the following advisory to the insured or claimant:

"~~Minnesota law gives~~ You have the legal right to choose a repair shop to fix your vehicle. Your policy will cover the reasonable costs of repairing your vehicle to its pre-accident condition no matter where you have repairs made. Have you selected a repair shop or would you like a referral?"

After an insured has indicated that the insured has selected a repair shop, the insurer must cease all efforts to influence the insured's or claimant's choice of repair shop;

(8) where liability is reasonably clear, failing to inform the claimant in an automobile property damage liability claim that the claimant may have a claim for loss of use of the vehicle;

(9) failing to make a good faith assignment of comparative negligence percentages in ascertaining the issue of liability;

(10) failing to pay any interest required by statute on overdue payment for an automobile personal injury protection claim;

(11) if an automobile insurance policy contains either or both of the time limitation provisions as permitted by section 65B.55, subdivisions 1 and 2, failing to notify the insured in writing of those limitations at least 60 days prior to the expiration of that time limitation;

(12) if an insurer chooses to have an insured examined as permitted by section 65B.56, subdivision 1, failing to notify the insured of all of the insured's rights and obligations under that statute, including the right to request, in writing, and to receive a copy of the report of the examination;

(13) failing to provide, to an insured who has submitted a claim for benefits described in section 65B.44, a complete copy of the insurer's claim file on the insured, excluding internal company memoranda, all materials that relate to any insurance fraud investigation, materials that constitute attorney work-product or that qualify for the attorney-client privilege, and medical reviews that are subject to section 145.64, within ten business days of receiving a written request from the insured. The insurer may charge the insured a reasonable copying fee. This clause supersedes any inconsistent provisions of sections 72A.49 to 72A.505;

(14) if an automobile policy provides for the adjustment or settlement of an automobile loss due to damaged window glass, failing to provide payment to the insured's chosen vendor based on a competitive price that is fair and reasonable within the local industry at large.

Where facts establish that a different rate in a specific geographic area actually served by the vendor is required by that market, that geographic area must be considered. This clause does not prohibit an insurer from recommending a vendor to the insured or from agreeing with a vendor to perform work at an agreed-upon price, provided, however, that before recommending a vendor, the insurer shall offer its insured the opportunity to choose the vendor. If the insurer recommends a vendor, the insurer must also provide the following advisory:

"Minnesota law gives you the right to go to any glass vendor you choose, and prohibits me from pressuring you to choose a particular vendor.";

(15) requiring that the repair or replacement of motor vehicle glass and related products and services be made in a particular place or shop or by a particular entity, or by otherwise limiting the ability of the insured to select the place, shop, or entity to repair or replace the motor vehicle glass and related products and services; or

(16) engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an insured to use a particular company or location to provide the motor vehicle glass repair or replacement services or products. For purposes of this section, a warranty shall not be considered an inducement or incentive.

Sec. 61. Minnesota Statutes 2004, section 72C.10, subdivision 1, is amended to read:

Subdivision 1. **Readability compliance; filing and approval.** No insurer shall make, issue, amend, or renew any policy or contract after the dates specified in section 72C.11 for the applicable type of policy unless the contract is in compliance with the requirements of sections 72C.06 to 72C.09 and unless the contract is filed with the commissioner for approval. The contract shall be deemed approved ~~90~~ 60 days after filing unless disapproved by the commissioner within the ~~90-day~~ 60-day period. When an insurer, service plan corporation, or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission. The commissioner shall not unreasonably withhold approval. Any disapproval shall be delivered to the insurer in writing, stating the grounds therefor. Any policy filed with the commissioner shall be accompanied by a Flesch scale readability analysis and test score and by the insurer's certification that the policy or contract is in its judgment readable based on the factors specified in sections 72C.06 to 72C.08.

Sec. 62. Minnesota Statutes 2004, section 79.01, is amended by adding a subdivision to read:

Subd. 1a. **Assigned risk plan.** "Assigned risk plan" means:

(1) the method to provide workers' compensation coverage to employers unable to obtain coverage through licensed workers' compensation companies; and

(2) the procedures established by the commissioner to implement that method of providing coverage including administration of all assigned risk losses and reserves.

Sec. 63. Minnesota Statutes 2004, section 79.01, is amended by adding a subdivision to read:

Subd. 1b. **Employer.** "Employer" has the meaning given in section 176.011, subdivision 10.

Sec. 64. Minnesota Statutes 2004, section 79.251, subdivision 1, is amended to read:

Subdivision 1. **General duties of commissioner.** (a)(1) The commissioner shall have all the usual powers and authorities necessary for the discharge of the commissioner's duties under this section and may contract with individuals in discharge of those duties. The commissioner shall audit the reserves established (a) for individual cases arising under policies and contracts of coverage issued under subdivision 4 and (b) for the total book of business issued under subdivision 4. If the commissioner determines on the basis of an audit that there is an excess surplus in the assigned risk plan, the commissioner must notify the commissioner of finance who shall transfer assets of the plan equal to the excess surplus to the budget reserve account in the general fund.

(2) The commissioner shall monitor the operations of section 79.252 and this section and shall periodically make recommendations to the governor and legislature when appropriate, for improvement in the operation of those sections.

(3) All insurers and self-insurance administrators issuing policies or contracts under subdivision 4 shall pay to the commissioner a .25 percent assessment on premiums for policies and contracts of coverage issued under subdivision 4 for the purpose of defraying the costs of performing the duties under clauses (1) and (2). Proceeds of the assessment shall be deposited in the state treasury and credited to the general fund.

(4) The assigned risk plan shall not be deemed a state agency.

(5) The commissioner shall monitor and have jurisdiction over all reserves maintained for assigned risk plan losses.

(b) As used in this subdivision, "excess surplus" means the amount of assigned risk plan assets in excess of the amount needed to pay all current liabilities of the plan, including, but not limited to:

(1) administrative expenses;

(2) benefit claims; and

(3) if the assigned risk plan is dissolved under subdivision 8, the amounts that would be due insurers who have paid assessments to the plan.

Sec. 65. Minnesota Statutes 2004, section 79.251, is amended by adding a subdivision to read:

Subd. 2a. **Assigned risk rating plan.** (a) Employers insured through the assigned risk plan are subject to paragraphs (b) and (c).

(b) Classifications must be assigned according to a uniform classification system approved by the commissioner.

(c) Rates must be modified according to an experience rating plan approved by the commissioner. Any experience rating plan is subject to Minnesota Rules, parts 2700.2800 and 2700.2900.

Sec. 66. Minnesota Statutes 2004, section 79.252, is amended by adding a subdivision to read:

Subd. 2a. **Minimum qualifications.** Any employer that (1) is required to carry workers' compensation insurance pursuant to chapter 176 and (2) has a current written notice of refusal to insure pursuant to subdivision 2, is entitled to coverage upon making written application to the assigned risk plan, and paying the applicable premium.

Sec. 67. Minnesota Statutes 2004, section 79.252, is amended by adding a subdivision to read:

Subd. 3a. **Disqualifying factors.** An employer may be denied or terminated from coverage through the assigned risk plan if the employer:

(1) applies for coverage for only a portion of the employer's statutory liability under chapter 176, excluding wrap-up policies;

(2) has an outstanding debt due and owing to the assigned risk plan at the time of renewal arising from a prior policy;

(3) persistently refuses to permit completion of an adequate payroll audit;

(4) repeatedly submits misleading or erroneous payroll information; or

(5) flagrantly disregards safety or loss control recommendations. Cancellation for nonpayment of premium may be initiated by the service contractor upon 60 days' written notice to the employer pursuant to section 176.185, subdivision 1.

Sec. 68. Minnesota Statutes 2004, section 79.252, is amended by adding a subdivision to read:

Subd. 3b. **Occupational disease exposure.** An employer having a significant occupational disease exposure, as determined by the commissioner, to be entitled to coverage shall have physical examinations made:

(a) of employees who have not been examined within one year of the date of application for assignment;

(b) of new employees before hiring; and

(c) of terminated employees. Upon request, the findings and reports of doctors making examinations, together with x-rays and other original exhibits, must be furnished to the assigned risk plan or the Department of Labor and Industry.

Sec. 69. Minnesota Statutes 2005 Supplement, section 79A.04, subdivision 2, is amended to read:

**Subd. 2. Minimum deposit.** The minimum deposit is 110 percent of the private self-insurer's estimated future liability. The deposit may be used to secure payment of all administrative and legal costs, and unpaid assessments required by section 79A.12, subdivision 2, relating to or arising from its or other employers' self-insuring. As used in this section, "private self-insurer" includes both current and former members of the self-insurers' security fund; and "private self-insurers' estimated future liability" means the private self-insurers' total of estimated future liability as determined by an Associate or Fellow of the Casualty Actuarial Society every year for group member private self-insurers and, for a nongroup member private self-insurer's authority to self-insure, every year for the first five years. After the first five years, the nongroup member's total shall be as determined by an Associate or Fellow of the Casualty Actuarial Society at least every two years, and each such actuarial study shall include a projection of future losses during the period until the next scheduled actuarial study, less payments anticipated to be made during that time.

All data and information furnished by a private self-insurer to an Associate or Fellow of the Casualty Actuarial Society for purposes of determining private self-insurers' estimated future liability must be certified by an officer of the private self-insurer to be true and correct with respect to payroll and paid losses, and must



be certified, upon information and belief, to be true and correct with respect to reserves. The certification must be made by sworn affidavit. In addition to any other remedies provided by law, the certification of false data or information pursuant to this subdivision may result in a fine imposed by the commissioner of commerce on the private self-insurer up to the amount of \$5,000, and termination of the private self-insurers' authority to self-insure. The determination of private self-insurers' estimated future liability by an Associate or Fellow of the Casualty Actuarial Society shall be conducted in accordance with standards and principles for establishing loss and loss adjustment expense reserves by the Actuarial Standards Board, an affiliate of the American Academy of Actuaries. The commissioner may reject an actuarial report that does not meet the standards and principles of the Actuarial Standards Board, and may further disqualify the actuary who prepared the report from submitting any future actuarial reports pursuant to this chapter. Within 30 days after the actuary has been served by the commissioner with a notice of disqualification, an actuary who is aggrieved by the disqualification may request a hearing to be conducted in accordance with chapter 14. Based on a review of the actuarial report, the commissioner of commerce may require an increase in the minimum security deposit in an amount the commissioner considers sufficient.

In addition, the Minnesota self-insurers' security fund may, at its sole discretion and cost, undertake an independent actuarial review or an actuarial study of a private self-insurer's estimated future liability as defined in this subdivision. The review or study must be conducted by an associate or fellow of the Casualty Actuarial Society. The actuary has the right to receive and review data and information of the self-insurer necessary for the actuary to complete its review or study. A copy of this report must be filed with the commissioner and a copy must be furnished to the self-insurer.

Estimated future liability is determined by first taking the total amount of the self-insured's future liability of workers' compensation claims and then deducting the total amount which is estimated to be returned to the self-insurer from any specific excess insurance coverage, aggregate excess insurance coverage, and any supplementary benefits or second injury benefits which are estimated to be reimbursed by the special compensation fund. However, in the determination of estimated future liability, the actuary for the self-insurer shall not take a credit for any excess insurance or reinsurance which is provided by a captive insurance company which is wholly owned by the self-insurer. Supplementary benefits or second injury benefits will not be reimbursed by the special compensation fund unless the special compensation fund assessment pursuant to section 176.129 is paid and the reports required thereunder are filed with the special compensation fund. In the case of surety bonds, bonds shall secure administrative and legal costs in addition to the liability for payment of compensation reflected on the face of the bond. In no event shall the security be less than the last retention limit selected by the self-insurer with the Workers' Compensation Reinsurance Association, provided that the commissioner may allow former members to post less than the Workers' Compensation Reinsurance Association retention level if that amount is adequate to secure payment of the self-insurers' estimated future liability, as defined in this subdivision, including payment of claims, administrative and legal costs, and unpaid assessments required by section 79A.12, subdivision 2. The posting or depositing of security pursuant to this section shall release all previously posted or deposited security from any obligations under the posting or depositing and any surety bond so released shall be returned to the surety. Any other security shall be returned to the depositor or the person posting the bond.

As a condition for the granting or renewing of a certificate to self-insure, the commissioner may require a private self-insurer to furnish any additional security the commissioner considers sufficient to insure payment of all claims under chapter 176.

Sec. 70. Minnesota Statutes 2004, section 79A.23, subdivision 3, is amended to read:

Subd. 3. **Operational audit.** (a) ~~The commissioner, prior to authorizing surplus distribution of a commercial self-insurance group's first fund year or no later than after the third anniversary of the group's authority to self-insure,~~ may conduct an operational audit of the commercial self-insurance group's claim handling and reserve practices as well as its underwriting procedures to determine if they adhere to the

group's business plan and sound business practices. The commissioner may select outside consultants to assist in conducting the audit. After completion of the audit, the commissioner shall either renew or revoke the commercial self-insurance group's authority to self-insure. The commissioner may also order any changes deemed necessary in the claims handling, reserving practices, or underwriting procedures of the group.

(b) The cost of the operational audit shall be borne by the commercial self-insurance group.

Sec. 71. Minnesota Statutes 2004, section 79A.32, is amended to read:

**79A.32 REPORTING TO ~~MINNESOTA WORKERS' COMPENSATION INSURERS' ASSOCIATION~~ LICENSED DATA SERVICE ORGANIZATIONS.**

~~Subdivision 1. **Required activity.** Each self-insurer shall perform the following activities:~~

~~(1) maintain membership in and report loss experience data to the Minnesota Workers' Compensation Insurers Association, or a licensed data service organization, in accordance with the statistical plan and rules of the organization as approved by the commissioner;~~

~~(2) establish a plan for merit rating which shall be consistently applied to all insureds, provided that members of a data service organization may use merit rating plans developed by that data service organization;~~

~~(3) provide an annual report to the commissioner containing the information and prepared in the form required by the commissioner, and~~

~~(4) keep a record of the losses paid by the self-insurers and premiums for the group self-insurers.~~

~~Subd. 2. **Permitted activity.** In addition to any other activities not prohibited by this chapter, self-insurers may~~ Through data service organizations licensed under chapter 79, self insurers may:

(1) through licensed data service organizations, individually, or with self-insurers commonly owned, managed, or controlled, conduct research and collect statistics to investigate, identify, and classify information relating to causes or prevention of losses; and

(2) at the request of a private self insurer or self insurer group, submit and collect data, including payroll and loss data; and perform calculations, including calculations of experience modifications of individual self-insured employers.

~~(2) develop and use classification plans and rates based upon any reasonable factors, and~~

~~(3) develop rules for the assignment of risks to classifications.~~

~~Subd. 3. **Delayed reporting.** Private self-insurers established under sections 79A.01 to 79A.18 prior to August 1, 1995, need not begin filing the reports required under subdivision 1 until January 1, 1998.~~

Sec. 72. Minnesota Statutes 2004, section 123A.21, subdivision 7, is amended to read:

Subd. 7. **Educational programs and services.** (a) The board of directors of each SC shall submit annually a plan to the members. The plan shall identify the programs and services which are suggested for implementation by the SC during the following year and shall contain components of long-range planning determined by the SC. These programs and services may include, but are not limited to, the following areas:

(1) administrative services;

(2) curriculum development;

(3) data processing;

- (4) distance learning and other telecommunication services;
- (5) evaluation and research;
- (6) staff development;
- (7) media and technology centers;
- (8) publication and dissemination of materials;
- (9) pupil personnel services;
- (10) planning;
- (11) secondary, postsecondary, community, adult, and adult vocational education;
- (12) teaching and learning services, including services for students with special talents and special needs;
- (13) employee personnel services;
- (14) vocational rehabilitation;
- (15) health, diagnostic, and child development services and centers;
- (16) leadership or direction in early childhood and family education;
- (17) community services;
- (18) shared time programs;
- (19) fiscal services and risk management programs, including health insurance programs providing reinsurance or stop loss coverage;
- (20) technology planning, training, and support services;
- (21) health and safety services;
- (22) student academic challenges; and
- (23) cooperative purchasing services.

An SC is subject to regulation and oversight by the commissioner of commerce under the insurance laws of this state when operating a health reinsurance program pursuant to clause (19) providing reinsurance or stop loss coverage.

(b) A group health, dental, or long-term disability coverage program provided by one or more service cooperatives may provide coverage to nursing homes licensed under chapter 144A and to boarding care homes licensed under sections 144.50 to 144.56 and certified for participation in the medical assistance program located in this state.

(c) A group health, dental, or long-term disability coverage program provided by one or more service cooperatives:

(1) must rebid contracts for insurance and third-party administration at least every four years. The contracts may be regional or statewide in the discretion of the SC; and

(2) may determine premiums for its health, dental, or long-term disability coverage individually for specific employers or may determine them on a pooled or other basis established by the SC.

**EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 73. Minnesota Statutes 2004, section 123A.21, is amended by adding a subdivision to read:

Subd. 12. **Health Coverage Pool Comparison Shopping.** (a) Service cooperatives must permit school districts and other political subdivisions participating in a service cooperative health coverage pool to solicit bids and other information from competing sources of health coverage at any time other than within five months prior to the end of a master agreement.

(b) A service cooperative must not impose a fine or other penalty against an enrolled entity for soliciting a bid or other information during the allowed period. The service cooperative may prohibit the entity from participating in service cooperative coverage for a period of up to one year, if the entity leaves the service cooperative pool and obtains other health coverage.

(c) A service cooperative must provide each enrolled entity with the entity's monthly claims data. This paragraph applies notwithstanding section 13.203.

Sec. 74. Minnesota Statutes 2005 Supplement, section 256B.0571, is amended to read:

**256B.0571 LONG-TERM CARE PARTNERSHIP PROGRAM.**

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

~~Subd. 2. **Home care service.** "Home care service" means care described in section 144A.43.~~

Subd. 3. **Long-term care insurance.** "Long-term care insurance" means a policy described in section 62S.01.

Subd. 4. **Medical assistance.** "Medical assistance" means the program of medical assistance established under section 256B.01.

~~Subd. 5. **Nursing home.** "Nursing home" means a nursing home as described in section 144A.01.~~

Subd. 6. **Partnership policy.** "Partnership policy" means a long-term care insurance policy that meets the requirements under subdivision 10 ~~or 11, regardless of when the policy and was first issued on or after the effective date of the state plan amendment implementing the partnership program in Minnesota.~~

Subd. 7. **Partnership program.** "Partnership program" means the Minnesota partnership for long-term care program established under this section.

Subd. 7a. **Protected assets.** "Protected assets" means assets or proceeds of assets that are protected from recovery under subdivisions 13 and 15.

Subd. 8. **Program established.** (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in this paragraph is eligible to participate in the partnership program. The individual must:

(1) be a Minnesota resident at the time coverage first became effective under the partnership policy;

(2) ~~purchase a partnership policy that is delivered, issued for delivery, or renewed on or after the effective date of Laws 2005, First Special Session chapter 4, article 7, section 5, and maintain the partnership policy in effect throughout the period of participation in the partnership program~~ be a beneficiary of a partnership policy that (i) is issued on or after the effective date of the state plan amendment implementing the partnership program in Minnesota, or (ii) qualifies as a partnership policy under the provisions of subdivision 8a; and

(3) ~~exhaust the minimum~~ have exhausted all of the benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before the effective date of Laws 2005, First Special Session chapter 4, article 7, section 5 July 1, 2006, do not count toward the exhaustion of benefits required in this subdivision.

Subd. 8a. **Exchange for long-term care partnership policy; addition of policy rider.** (a) If authorized by federal law or if federal approval is granted with respect to the partnership program established in this section, a long-term care insurance policy that was issued before the effective date of the state plan amendment implementing the partnership program in Minnesota that was exchanged after the effective date of the state plan amendment for a long-term care partnership policy that meets the requirements of Public Law 109-171, section 6021, qualifies as a long-term care partnership policy under this section, unless the policy is paying benefits on the date the policy is exchanged.

(b) If authorized by federal law or if federal approval is granted with respect to the partnership program established in this section, a long-term care insurance policy that was issued before the effective date of the state plan amendment implementing the partnership program in Minnesota that has a rider added after the effective date of the state plan amendment that meets the requirements of Public Law 109-171, section 6021, qualifies as a long-term care partnership policy under this section, unless the policy is paying benefits on the date the rider is added.

Subd. 9. **Medical assistance eligibility.** (a) Upon application ~~of~~ for medical assistance program payment of long-term care services by an individual who meets the requirements described in subdivision 8, the commissioner shall determine the individual's eligibility for medical assistance according to paragraphs (b) ~~and (c)~~ to (i).

(b) After ~~disregarding financial~~ determining assets exempted under medical assistance eligibility requirements subject to the asset limit under section 256B.056, subdivision 3 or 3c, or 256B.057, subdivision 9 or 10, the commissioner shall ~~disregard an additional amount of financial assets equal~~ allow the individual to designate assets to be protected from recovery under subdivisions 13 and 15 up to the dollar amount of ~~coverage~~ the benefits utilized under the partnership policy. Designated assets shall be disregarded for purposes of determining eligibility for payment of long-term care services.

(c) ~~The commissioner shall consider the individual's income according to medical assistance eligibility requirements.~~ The individual shall identify the designated assets and the full fair market value of those assets and designate them as assets to be protected at the time of initial application for medical assistance. The full fair market value of real property or interests in real property shall be based on the most recent full assessed value for property tax purposes for the real property, unless the individual provides a complete professional appraisal by a licensed appraiser to establish the full fair market value. The extent of a life estate in real property shall be determined using the life estate table in the health care program's manual. Ownership of any asset in joint tenancy shall be treated as ownership as tenants in common for purposes of its designation as a disregarded asset. The unprotected value of any protected asset is subject to estate recovery according to subdivisions 13 and 15.

(d) The right to designate assets to be protected is personal to the individual and ends when the individual dies, except as otherwise provided in subdivisions 13 and 15. It does not include the increase in the value of the protected asset and the income, dividends, or profits from the asset. It may be exercised by the individual or by anyone with the legal authority to do so on the individual's behalf. It shall not be sold, assigned, transferred, or given away.

(e) If the dollar amount of the benefits utilized under a partnership policy is greater than the full fair market value of all assets protected at the time of the application for medical assistance long-term care services, the individual may designate additional assets that become available during the individual's lifetime for protection under this section. The individual must make the designation in writing to the county agency

no later than the last date on which the individual must report a change in circumstances to the county agency, as provided for under the medical assistance program. Any excess used for this purpose shall not be available to the individual's estate to protect assets in the estate from recovery under section 256B.15 or 524.3-1202, or otherwise.

(f) This section applies only to estate recovery under United States Code, title 42, section 1396p, subsections (a) and (b), and does not apply to recovery authorized by other provisions of federal law, including, but not limited to, recovery from trusts under United States Code, title 42, section 1396p, subsection (d)(4)(A) and (C), or to recovery from annuities, or similar legal instruments, subject to section 6012, subsections (a) and (b), of the Deficit Reduction Act of 2005, Public Law 109-171.

(g) An individual's protected assets owned by the individual's spouse who applies for payment of medical assistance long-term care services shall not be protected assets or disregarded for purposes of eligibility of the individual's spouse solely because they were protected assets of the individual.

(h) Assets designated under this subdivision shall not be subject to penalty under section 256B.0595.

(i) The commissioner shall otherwise determine the individual's eligibility for payment of long-term care services according to medical assistance eligibility requirements.

Subd. 10. **~~Dollar-for-dollar asset protection policies~~ Long-term care partnership policy inflation protection.** (a) ~~A dollar-for-dollar asset protection policy must meet all of the requirements in paragraphs (b) to (e):~~

~~(b) The policy must satisfy the requirements of chapter 62S;~~

~~(c) The policy must offer an elimination period of not more than 180 days for an adjusted premium;~~

~~(d) The policy must satisfy the requirements established by the commissioner of human services under subdivision 14;~~

~~(e) Minimum daily benefits shall be \$130 for nursing home care or \$65 for home care, with inflation protection provided in the policy as described in section 62S.23, subdivision 1, clause (1). These minimum daily benefit amounts shall be adjusted by the commissioner on October 1 of each year by a percentage equal to the inflation protection feature described in section 62S.23, subdivision 1, clause (1), for purposes of setting minimum requirements that a policy must meet in future years in order to initially qualify as an approved policy under this subdivision. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar. A long-term care partnership policy must provide the inflation protection described in this subdivision. If the policy is sold to an individual who:~~

~~(1) has not attained age 61 as of the date of purchase, the policy must provide compound annual inflation protection;~~

~~(2) has attained age 61, but has not attained age 76 as of such date, the policy must provide some level of inflation protection; and~~

~~(3) has attained age 76 as of such date, the policy may, but is not required to, provide some level of inflation protection.~~

Subd. 11. **~~Total asset protection policies.~~** (a) ~~A total asset protection policy must meet all of the requirements in subdivision 10, paragraphs (b) to (d), and this subdivision:~~

~~(b) Minimum coverage shall be for a period of not less than three years and for a dollar amount equal to 36 months of nursing home care at the minimum daily benefit rate determined and adjusted under paragraph (c);~~

~~(c) Minimum daily benefits shall be \$150 for nursing home care or \$75 for home care, with inflation protection provided in the policy as described in section 62S.23, subdivision 1, clause (1). These minimum~~

~~daily benefit amounts shall also be adjusted by the commissioner on October 1 of each year by a percentage equal to the inflation protection feature described in section 62S.23, subdivision 1, clause (1), for purposes of setting minimum requirements that a policy must meet in future years in order to initially qualify as an approved policy under this subdivision. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.~~

~~(d) The policy must cover all of the following services:~~

- ~~(1) nursing home stay,~~
- ~~(2) home care service, and~~
- ~~(3) care management.~~

~~Subd. 12. **Compliance with federal law.** An issuer of a partnership policy must comply with any federal law authorizing partnership policies in Minnesota Public Law 109-171, section 6021, including any federal regulations, as amended, adopted under that law. This subdivision does not require compliance with any provision of this federal law until the date upon which the law requires compliance with the provision. The commissioner has authority to enforce this subdivision.~~

~~Subd. 13. **Limitations on estate recovery.** (a) For an individual who exhausts the minimum benefits of a dollar-for-dollar asset protection policy under subdivision 10, and is determined eligible for medical assistance under subdivision 9, the state shall limit recovery under the provisions of section 256B.15 against the estate of the individual or individual's spouse for medical assistance benefits received by that individual to an amount that exceeds the dollar amount of coverage utilized under the partnership policy. Protected assets of the individual shall not be subject to recovery under section 256B.15 or section 524.3-1201 for medical assistance or alternative care paid on behalf of the individual. Protected assets of the individual in the estate of the individual's surviving spouse shall not be liable to pay a claim for recovery of medical assistance paid for the predeceased individual that is filed in the estate of the surviving spouse under section 256B.15. Protected assets of the individual shall not be protected assets in the surviving spouse's estate by reason of the preceding sentence and shall be subject to recovery under section 256B.15 or 524.3-1201 for medical assistance paid on behalf of the surviving spouse.~~

~~(b) For an individual who exhausts the minimum benefits of a total asset protection policy under subdivision 11, and is determined eligible for medical assistance under subdivision 9, the state shall not seek recovery under the provisions of section 256B.15 against the estate of the individual or individual's spouse for medical assistance benefits received by that individual. The personal representative may protect the full fair market value of an individual's unprotected assets in the individual's estate in an amount equal to the unused amount of asset protection the individual had on the date of death. The personal representative shall apply the asset protection so that the full fair market value of any unprotected asset in the estate is protected. When or if the asset protection available to the personal representative is or becomes less than the full fair market value of any remaining unprotected asset, it shall be applied to partially protect one unprotected asset.~~

~~(c) The asset protection described in paragraph (a) terminates with respect to an asset includable in the individual's estate under chapter 524 or section 256B.15:~~

- ~~(1) when the estate distributes the asset; or~~
- ~~(2) if the estate of the individual has not been probated within one year from the date of death.~~

~~(d) If an individual owns a protected asset on the date of death and the estate is opened for probate more than one year after death, the state or a county agency may file and collect claims in the estate under section 256B.15, and no statute of limitations in chapter 524 that would otherwise limit or bar the claim shall apply.~~

(e) Except as otherwise provided, nothing in this section shall limit or prevent recovery of medical assistance.

~~Subd. 14. **Implementation.** (a) If federal law is amended or a federal waiver is granted to permit implementation of this section, the commissioner, in consultation with the commissioner of commerce, may alter the requirements of subdivisions 10 and 11, and may establish additional requirements for approved policies in order to conform with federal law or waiver authority. In establishing these requirements, the commissioner shall seek to maximize purchase of qualifying policies by Minnesota residents while controlling medical assistance costs.~~

~~(b) The commissioner is authorized to suspend implementation of this section until the next session of the legislature if the commissioner, in consultation with the commissioner of commerce, determines that the federal legislation or federal waiver authorizing a partnership program in Minnesota is likely to impose substantial unforeseen costs on the state budget.~~

~~(c) The commissioner must take action under paragraph (a) or (b) within 45 days of final federal action authorizing a partnership policy in Minnesota.~~

~~(d) The commissioner must notify the appropriate legislative committees of action taken under this subdivision within 50 days of final federal action authorizing a partnership policy in Minnesota.~~

~~(e) The commissioner must publish a notice in the State Register of implementation decisions made under this subdivision as soon as practicable.~~

(a) The commissioner, in cooperation with the commissioner of commerce, may alter the requirements of this section so as to be in compliance with forthcoming requirements of the Department of Health and Human Services and the National Association of Insurance Commissioners necessary to implement the long-term care partnership program requirements of Public Law 109-171, section 6021.

(b) The commissioner shall submit a state plan amendment to the federal government to implement the long-term care partnership program in accordance with this section.

Subd. 15. **Limitation on liens.** (a) An individual's interest in real property shall not be subject to a medical assistance lien or a notice of potential claim while and to the extent it is protected under subdivision 9.

(b) Medical assistance liens or liens arising under notices of potential claims against an individual's interests in real property in the individual's estate that are designated as protected under subdivision 13, paragraph (b), shall be released to the extent of the dollar value of the protection applied to the interest.

(c) If an interest in real property is protected from a lien for recovery of medical assistance paid on behalf of the individual under paragraph (a) or (b), no lien for recovery of medical assistance paid on behalf of that individual shall be filed against the protected interest in real property after it is distributed to the individual's heirs or devisees.

Subd. 16. **Burden of proof.** Any individual or the personal representative of the individual's estate who asserts that an asset is a disregarded or protected asset under this section in connection with any determination of eligibility for benefits under the medical assistance program or any appeal, case, controversy, or other proceedings, shall have the initial burden of:

(1) documenting and proving by clear and convincing evidence that the asset or source of funds for the asset in question was designated as disregarded or protected;

(2) tracing the asset and the proceeds of the asset from that time forward; and

(3) documenting that the asset or proceeds of the asset remained disregarded or protected at all relevant times.



**EFFECTIVE DATE.** This section is effective July 1, 2006.

Sec. 75. Laws 2005, First Special Session chapter 4, article 7, section 59, is amended to read:

Sec. 59. **REPORT TO LEGISLATURE.**

The commissioner shall report to the legislature by December 15, 2006, on the redesign of case management services. In preparing the report, the commissioner shall consult with representatives for consumers, consumer advocates, counties, labor organizations representing county social service workers, and service providers. The report shall include draft legislation for case management changes that will:

- (1) streamline administration;
- (2) improve consumer access to case management services;
- (3) address the use of a comprehensive universal assessment protocol for persons seeking community supports;
- (4) establish case management performance measures;
- (5) provide for consumer choice of the case management service vendor; and
- (6) provide a method of payment for case management services that is cost-effective and best supports the draft legislation in clauses (1) to (5).

Sec. 76. **MEDICAL MALPRACTICE INSURANCE REPORT.**

(a) The commissioner of commerce shall provide to the legislature annually a brief written report on the status of the market for medical malpractice insurance in Minnesota. The report must summarize, interpret, explain, and analyze information on that subject available to the commissioner, through annual statements filed by insurance companies, information obtained under paragraph (c), and other sources.

(b) The annual report must consider, to the extent possible, using definitions developed by the commissioner, Minnesota-specific data on market shares; premiums received; amounts paid to settle claims that were not litigated, claims that were settled after litigation began, and claims that were litigated to court judgment; amounts spent on processing, investigation, litigation, and otherwise handling claims; other sales and administrative costs; and the loss ratios of the insurers.

(c) Each insurance company that provides medical malpractice insurance in this state shall, no later than June 1 each year, file with the commissioner of commerce, on a form prescribed by the commissioner and using definitions developed by the commissioner, the Minnesota-specific data referenced in paragraph (b), other than market share, for the previous calendar year for that insurance company, shown separately for various categories of coverages including, if possible, hospitals, medical clinics, nursing homes, physicians who provide emergency medical care, obstetrician gynecologists, and ambulance services. An insurance company need not comply with this paragraph if its direct premium written in the state for the previous calendar year is less than \$2,000,000.

Sec. 77. **REPEALER.**

(a) Minnesota Statutes 2005 Supplement, section 62Q.251, is repealed, effective the day following final enactment.

(b) Minnesota Rules, parts 2781.0100; 2781.0200; 2781.0300; 2781.0400; 2781.0500; and 2781.0600, are repealed, effective July 1, 2006.

Presented to the governor May 22, 2006

Signed by the governor May 31, 2006, 11:25 p.m.