CHAPTER 2765
DEPARTMENT OF COMMERCE
EMPLOYEE JOINT SELF-INSURANCE

2765.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of this chapter, the terms defined in this part have the meanings given them.

Subp. 2. **Board.** "Board" means a plan's board of trustees.

Subp. 3. **Bylaws.** "Bylaws" means the statements adopted by a plan that prescribe its purpose, government, and administration.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Commerce.

Subp. 5. **Coverage.** "Coverage" means the right of a covered person to benefits provided directly or indirectly by a plan, by virtue of the coverage document.

Subp. 6. **Coverage document.** "Coverage document" means the document specifying the characteristics and duration of coverage provided through a plan.

Subp. 7. **Covered employee.** "Covered employee" means a plan member's employee who is covered through the plan, and a plan member's former employee receiving continued coverage under Minnesota Statutes, section 62A.17, subdivisions 1 to 5. "Covered employee" does not include dependents or other persons included under the coverage extended to a plan member's current or former employee.

Subp. 8. **Days.** "Days" means calendar days.

Subp. 9. **Financial administrator.** "Financial administrator" means an entity employing persons trained and experienced in money management and investments, and possessing no less than five years experience as an organization with demonstrated competence in money management and investments.

Subp. 10. **Fund year.** "Fund year" means a plan's fiscal year, and must be the calendar year.

Subp. 11. **Incurred basis stop–loss insurance.** "Incurred basis stop–loss insurance" means the aggregate excess stop–loss insurance required by part 2765.1300, if on an incurred basis. The insurance is on an incurred basis if payments are charged against a fund year's deductible according to when liability for the payment was incurred.

Subp. 12. **Insurer.** "Insurer" means an insurance company licensed under Minnesota Statutes, section 60A.07, subdivision 4, and authorized by Minnesota Statutes, section 60A.06 to write sickness and disability insurance, or a service plan corporation licensed under Minnesota Statutes, section 62C.08.

Subp. 13. **Member.** "Member" means an employer that belongs to or participates in a plan. Reference to actions of a member includes actions on behalf of the member's covered employees and other covered persons.

Subp. 14. **Paid basis stop–loss insurance.** "Paid basis stop–loss insurance" means the aggregate excess stop–loss insurance required by part 2765.1300, if on a paid basis. The insurance is on a paid basis if payments are charged against a fund year's deductible according to when the payment was made.

Subp. 15. **Plan.** "Plan" means a joint self–insurance employee benefit plan approved under parts 2765.0100 to 2765.0250. Reference to actions of a plan includes actions by the plan's designated agents.

Subp. 16. **Premium.** "Premium" means the amount paid or to be paid for coverage by members. Premium does not include assessments or penalties.

Subp. 17. **Runoff plan.** "Runoff plan" means a plan that no longer has authority to self–insure, but that continues to exist for the purpose of paying claims, preparing reports, and administering transactions associated with the period when the plan provided coverage.

Subp. 18. **Self–insure.** "Self–insure" means to assume primary liability or responsibility for certain risks or benefits, rather than transferring liability or responsibility to some other entity.

Subp. 19. **Separate employer.** "Separate employer," for the purposes of meeting the minimum three–employer requirement, means an employer that is not the parent, subsidiary, or affiliate with a common parent of any other employer in the plan.

Subp. 20. **Service company.** "Service company" means an entity licensed under Minnesota Statutes, section 60A.23, subdivision 8 and rules adopted thereunder as a self–insurance plan administrator, or an entity named in Minnesota Statutes, section 60A.23, subdivision 8, paragraph (1), clause (a) or (b).

Subp. 21. **Short–term disability benefit.** "Short–term disability benefit" means income replacement payments of not more than one year's duration.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989*

2765.0200 PURPOSE.

This chapter governs the formation, operation, and dissolution of multiple employer plans for joint self–insurance of employee health, dental, or short–term disability benefits. They are intended to ensure that the financial integrity of these plans is maintained, and that they are administered competently and equitably.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989*

2765.0300 SCOPE.

The following are subject to the requirements of this chapter:

A. employers authorized to transact business in Minnesota that seek to jointly self–insure employee health, dental, or short–term disability benefits;

B. service companies that provide services to a plan; and

C. insurance companies licensed under Minnesota Statutes, section 60A.07, subdivision 4, or service plan corporations licensed under Minnesota Statutes, section 62C.08, that provide required stop–loss insurance to a plan.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989*

2765.0400 BYLAWS.

Subpart 1. **Content.** Bylaws may contain any provisions that do not conflict with this chapter. Bylaws must, at a minimum, contain the following provisions:

A. the plan's name, purpose, and initial date of existence;

B. definitions of key terms;

C. a statement of the powers, duties, and responsibilities assigned to the board, the service company, and the financial administrator, and reserved to the membership;

D. the number, term of office, method of selection, and method of replacement of the members of the board;

E. the procedure for calling board meetings;

F. the method of periodic selection and review of the service company and financial administrator;

G. the procedure for amending the bylaws;

H. the procedure for resolving disputes among members, which must not include submitting disputes to the commissioner;

I. the criteria for membership in the plan, including standards of financial integrity and loss experience;

J. the procedure for admitting new members to the plan;

K. the criteria for expelling members from the plan, including nonpayment of premium;

L. the procedure for withdrawal and expulsion of members from the plan, including the minimum required period of membership;

M. a statement of the coverages the plan intends to provide;

N. the procedure for adding and dropping a member's participation in a particular coverage;

O. a schedule for premium payments by members and, if applicable, their employees;

P. the procedure for changing premium rates;

Q. the procedure for levying and collecting an assessment;

R. a statement of who may have access to plan funds and for what purposes;

S. the procedure for distributing dividends, and the eligibility of past members and past covered employees for dividends; and

T. the procedure for distributing assets remaining upon the plan's dissolution.

Subp. 2. **Adoption and changes.** The bylaws must be adopted in writing by all initial members. Authority to change the bylaws must reside with the membership or the board, according to the terms of the bylaws. Authority to change the bylaws may not be delegated to a contractor or other outside party. The plan must file bylaw changes with the commissioner not less than 30 days after adoption.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989*

2765.0500 BOARD.

Subpart 1. **Structure.** A plan must have a board of trustees consisting of officials or employees of the members. No member may have more than one representative on the board. No trustee may be an employee, agent, or representative of the plan's service company, financial administrator, insurer, or other person or entity under contract with the plan. Trustees shall be elected by vote of the membership. There shall be an odd number of trustees, with staggered terms to provide continuity. One trustee shall be designated the chairperson. The board shall meet no less than four times annually.

Subp. 2. **Duties.** The board is responsible for operation of the plan. The board may delegate some or all of its responsibilities to the chairperson or other trustees between board meetings. All responsibilities of the plan not expressly delegated by the board or this chapter are the responsibility of the board. The board shall, at a minimum, have the following responsibilities:

A. fiduciary responsibility for the plan's operation and financial condition;

B. selection, supervision, and evaluation of the service company, financial administrator, accountant, insurer, and any other contractors;

C. on the basis of the plan's overall financial condition, authorizing changes in premium, reserve, or investment practices; and declaring assessments or dividends as appropriate;

D. approving all reports concerning the plan's operations and status to the commissioner and the members;

E. monitoring delinquent premiums, loss experience, and the financial condition of individual members; and authorizing disciplinary action or expulsion as appropriate;

F. authorizing acceptance or rejection of applications for membership;

G. as permitted by the bylaws, making or recommending changes to the bylaws for the improvement of the plan's operation and financial integrity; and

H. monitoring the plan's compliance with all statutes and rules governing its operation.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989*

2765.0600 APPLICATION.

Subpart 1. **Initial application.** Three or more separate employers may apply to the commissioner for authority to form a joint self-insurance plan, using forms available from the commissioner. Applications must be submitted not later than 60 days prior to the requested date for authority to self-insure. All reinsurance contracts must be submitted not later than 30 days prior to the requested date. Applications submitted without responses to certain questions, or with responses that are inadequate must be returned to the applicant for resubmission. Applications not returned to the applicant for resubmission within 14 days of receipt must be approved or disapproved within 60 days of receipt.

Subp. 2. **Renewal application.** Existing plans may apply for renewal of their self-insurance authority by so indicating on their annual status report preceding expiration of their current authority. Applications must be approved or disapproved within 60 days of receipt of the status report.

Subp. 3. **Exemptions.** Joint self-insurance plans that offer a program of coverage qualified under the Employees Retirements Income Security Act (ERISA), United States Code, title 29, sections 1001 et seq., are exempted from this chapter upon filing with the commissioner notice of this qualification from the United States Department of Labor.

Subp. 4. **Merger.** Two or more existing plans may apply to merge if the new plan assumes all obligations of the former plans. Merger applications are subject to the same requirements as prospective new plans.

Subp. 5. **Approval and disapproval.** Upon approval of an application, the commissioner shall issue an order authorizing the proposed joint self-insurance plan. Initial authorization orders for new plans are effective until the third May 1st after the initial authorization date. Renewal authorization orders are for two-year periods commencing May 1st. Approval of applications for authority to self-insure must be granted if the proposed plan conforms with:

A. all requirements of this chapter;

B. all applicable requirements of Minnesota Statutes, chapters 62A and 62E, and related rules, as described in part 2765.1000, subpart 1;

C. Minnesota Statutes, sections 72A.19 to 72A.32; and

D. other applicable Minnesota statutes and rules.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989*

2765.0700 ENDING SELF-INSURANCE, RUNOFF PERIOD, AND PLAN DISSOLUTION.

Subpart 1. **Ending self-insurance authority.** A plan may decide to end its self-insurance authority and cease to provide coverage, effective at the end of a fund year. The plan must notify the commissioner within 14 days of such a decision. A plan may not elect to end its self-insurance authority less than 45 days prior to the end of the fund year in question. Voluntary ending of self-insurance authority does not constitute plan dissolution under subpart 4.

Subp. 2. **Revocation of self-insurance authority.** The commissioner shall, by order, revoke the authority of a plan to self-insure upon ten days written notice if any of the following events occur or conditions develop, and if the commissioner judges them to be material:

A. failure of the plan to comply with this chapter; with all applicable requirements of Minnesota Statutes, chapters 62A, 62D, 62E, and related rules, as described in part 2765.1000, subpart 1; or with other applicable Minnesota statutes or rules;

B. failure of the plan to comply with any lawful order of the commissioner;

C. commission by the plan of an unfair or deceptive practice as defined in Minnesota Statutes, sections 72A.17 to 72A.32, or in related rules; or

D. a deterioration of the plan's financial integrity to the extent that its present or future ability to meet obligations promptly and in full is or will be significantly impaired.

Subp. 3. **Runoff period.** A plan shall continue to exist as a runoff plan after its authority to self-insure has ended, for the purpose of paying claims, preparing reports, and administer-

ing transactions associated with the period when the plan provided coverage. A runoff plan must continue to comply with all appropriate provisions of this chapter, and with all other applicable Minnesota statutes and rules. Authority to exist as a runoff plan is open-ended, and does not require renewal of authority under part 2765.0600, subpart 2.

Subp. 4. **Dissolution.** A plan, including a runoff plan, that desires to cease existence shall apply to the commissioner for authorization to dissolve. Applications must be approved or disapproved within 60 days of receipt. Dissolution without authorization is prohibited and void, and does not absolve a plan or runoff plan from fulfilling its continuing obligations, and does not absolve its members from assessment under part 2765.1400, subpart 6. The plan's assets at the time of dissolution must be distributed to the members and covered employees as provided in the bylaws. Authorization to dissolve must be granted if either of the following conditions are met:

A. the plan demonstrates that it has no outstanding liabilities, including incurred but not reported liabilities; or

B. the plan has obtained an irrevocable commitment from a licensed insurer that provides for payment of all outstanding liabilities, and for providing all related services, including payment of claims, preparation of reports, and administration of transactions associated with the period when the plan provided coverage.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989*

2765.0800 ADMINISTRATION.

Subpart 1. **Service company.** A plan must contract with a service company for services necessary to the plan's day-to-day operations, except services and responsibilities reserved to the members, the board, individual trustees, the financial administrator, or other contractors. The service company must have expertise in and be licensed for administering health benefits. Subject to the oversight of the board, the service company shall, directly or through subcontractors, provide all services directly related to the administration of coverage. These services include but are not limited to:

A. accounting and recordkeeping;

B. billing and collection of premiums and assessments;

C. claims investigation, settlement, and reserving;

D. claims payment, including claims wholly or partially subject to stop-loss insurance or member deductibles;

E. general administration;

F. loss control, safety programs, or both; and

G. underwriting.

Subp. 2. **Financial administrator.** A plan must contract with a financial administrator for investment of the plan's assets and other financial or accounting services. No staff members of the financial administrator may be an owner, officer, employee, or agent of the service company, or of a subcontractor of the service company.

Subp. 3. **Recordkeeping.** A plan must maintain within the state of Minnesota all records necessary to verify the accuracy and completeness of all reports submitted to the commissioner under part 2765.1500. The commissioner may examine the plan's records in order to ascertain the plan's compliance with this chapter, and with other applicable statutes and rules. All records concerning claims, reserves, financial transactions, and other matters necessary to the plan's operations are the plan's property.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989*

2765.0900 MEMBERSHIP.

Subpart 1. **Availability.** Plan membership is available to employers domiciled and authorized to transact business in Minnesota. Plans may also cover nonresident employers if the portion of the plan covering Minnesota resident employees is treated as a separate plan. A plan may establish other nondiscriminatory criteria for membership. Nothing in this chapter

requires a plan to offer membership to an employer that does not meet the plan's underwriting standards.

Subp. 2. **Joining.** New members must be admitted according to the standards and procedures specified in the bylaws. Membership is not effective before the applicant has signed a membership agreement affirming its commitment to comply with the bylaws and this chapter. The membership agreement must disclose that under the rules governing this plan, the Minnesota commissioner of commerce may order that an assessment be levied against member employers, if necessary to maintain the plan's sound financial condition.

Subp. 3. **Leaving.** The membership agreement must state the procedures for leaving the plan. A member must notify the plan of its desire to withdraw not less than 30 days before the date upon which it desires to withdraw. If the board determines that the withdrawal would cause the plan to be in violation of the minimum number of employers and covered employees requirement of Minnesota Statutes, section 62H.01, or any other requirement of this chapter the plan shall notify the commissioner as required under subpart 5. Withdrawal from a plan is prohibited and void unless:

A. the member will have belonged to the plan continuously:

(1) until the end of the current fund year; or

(2) until the end of the succeeding fund year for new members that join in the last three months of the fund year; or

(3) for a longer period if required by the bylaws; and

B. all outstanding premiums and assessments owed by the member have been paid.

Subp. 4. **Expulsion.** At least annually the plan shall review the status and experience of each member by comparison with the criteria for expulsion in the bylaws. Expulsion is subject to the procedures and requirements for voluntary withdrawal of a member, except that:

A. a member may be expelled with outstanding premiums or assessments owing; and

B. a member may be expelled notwithstanding that the minimum term of membership has not been satisfied.

Subp. 5. **Minimum covered employees and employers.** A plan shall monitor the number of employees it covers. If the number of covered employees is less than 300, the plan shall notify the commissioner at monthly intervals of the number of covered employees, until the number exceeds 300 for two consecutive months. If the number of covered employees becomes less than 250, or the number of members becomes less than three, the plan shall notify the commissioner:

A. of its intent to end its self-insurance authority; or

B. of its proposal for restoring compliance with Minnesota Statutes, section 62H.01.

If the proposal is unlikely, in the commissioner's judgment, to restore compliance within 90 days, or if after 90 days the plan continues to have less than 250 covered employees or less than three members, the commissioner shall revoke the plan's self-insurance authority.

Subp. 6. **Runoff plan membership.** After revocation of a plan's self-insurance authority, or after a plan notifies the commissioner in writing of its intent to end self-insurance authority voluntarily, no member may join, leave, or be expelled from the plan.

Statutory Authority: *MS s 45.023; 62H.06*

History: *9 SR 989; 12 SR 845*

2765.1000 COVERAGE.

Subpart 1. **Coverage administration and related requirements.** Plans are subject to the requirements of Minnesota statutes and rules applicable to insurance companies providing insurance in Minnesota similar to the plan's coverage. These include requirements concerning coverage content, coverage administration, rates, underwriting, and related matters, including but not limited to:

A. the requirements of Minnesota Statutes, section 60A.082, and related rules, as applicable to group medical expense insurance and group disability income insurance;

B. the requirements of Minnesota Statutes, chapter 62A, and related rules, as applicable to group accident and health insurance as defined in Minnesota Statutes, section 62A.10, including but not limited to:

(1) filing and requesting approval for coverage documents and rates;

(2) coverage document language requirements;

(3) mandated benefits;

(4) employee notice requirements;

(5) requirements to offer continuation of coverage to employees and other covered persons; and

(6) requirements to offer conversion coverage through licensed insurers or health maintenance organizations to employees and other covered persons;

C. the requirements of Minnesota Statutes, sections 62A.23 and 62A.24, and related rules, as applicable to group disability income insurance;

D. the requirements of Minnesota Statutes, sections 62A.31 to 62A.42, and related rules, as applicable to insurance covering persons covered by medicare; and

E. the requirements of Minnesota Statutes, chapter 62E, and related rules, as applicable to plans of health coverage as defined in Minnesota Statutes, section 62E.02, subdivision 9.

Subp. 2. **Coverage to individuals.** Joint self–insurance plans shall not offer coverage to individuals other than members' employees and their dependents, except as required following termination of employment under Minnesota Statutes, section 62A.17, subdivisions 1 to 5. Plans must comply with the conversion coverage requirements of Minnesota Statutes, sections 62A.17, subdivision 6, and 62E.16, by arrangements with licensed insurers or health maintenance organizations.

Subp. 3. **Health maintenance organization coverage.** A plan may arrange for covered persons to have an option of health maintenance organization coverage, including employees of employers required to provide such an option by Minnesota Statutes, section 62E.16. Such an arrangement must be through a licensed health maintenance organization.

Subp. 4. **Uniform underwriting.** All coverages offered by a plan must be available according to the same underwriting standards to all employees of all members.

Subp. 5. **Term of coverage.** A plan shall not commit itself to providing coverage for any period which extends beyond the term of any stop–loss insurance policies required under part 2765.1300.

Subp. 6. **Continuing responsibility.** Notwithstanding cancellation or termination of coverage to a particular member, ceasing to offer a particular coverage, or ending or revocation of authority to self–insure, a plan retains indefinitely all responsibilities to covered employees and other covered persons associated with the period while coverage was in force. This responsibility ceases only after a plan dissolves under part 2765.0700, subpart 4.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989; L 1987 c 384 art 2 s 1*

2765.1100 PREMIUMS AND DIVIDENDS.

Subpart 1. **Premium payments.** The fund year must be the basis for calculating members' premiums. A plan may permit installment payments if payment is always due before premium is to be earned. Any delinquencies in payments by employees must be paid on their behalf by the employer, with the employer having the right to seek reimbursement from the employee. A plan shall promptly take appropriate action to collect any members' premiums or assessments that are past due. Collection costs are the obligation of the delinquent member. Payments determined to be uncollectible must be presented to the stop–loss insurer for reimbursement, as required by part 2765.1300, subpart 4.

Subp. 2. **Dividends.** A plan may declare and pay a dividend or distribution from its surplus only if:

A. the dividend would not cause the plan's surplus to be negative;

B. the plan does not have a stop–loss aggregate advancement liability; and

C. the dividend is apportioned on the basis of the relative amounts of premium paid by members and covered employees, and provides for proportional payments to members and covered employees.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989*

2765.1200 RESERVES.

Subpart 1. **Loss and premium reserves.** A plan must establish reserves for all incurred losses, both reported and unreported, and for unearned premiums. To the extent that the amount of a loss is uncertain, reserves must be set conservatively. As the degree of uncertainty concerning a loss is changed by new events or information, the amount of the reserve must be changed appropriately. Accounting for reserves must be as required by the financial statement forms and instructions, under part 2765.1500, subpart 1.

Subp. 2. **Full funding reserves.** To comply with the full funding requirement of Minnesota Statutes, section 62H.02, a plan must establish full funding reserves corresponding to its aggregate excess stop-loss insurance for each fund year.

A. The amount of the reserves must be calculated as required by the financial statement forms and instructions, under part 2765.1500, subpart 1. The forms and instructions must provide that the base amount of the full funding reserves is equal to the plan's maximum possible liability under the aggregate excess stop-loss insurance, with credits for:

(1) individual excess stop-loss insurance reimbursements; and

(2) losses paid and reserves expected to be chargeable against the aggregate excess stop-loss insurance deductible.

B. Separate full funding reserves must be maintained for each fund year, beginning at the fund year's inception. Plans with paid basis stop-loss insurance must maintain each year's full funding reserve until 90 days after the fund year's end. Plans with incurred basis stop-loss insurance must maintain each year's full funding reserve until one year after the fund year's end.

C. Plans with paid basis stop-loss insurance must also maintain a separate runoff full funding reserve. The runoff reserve's purpose is to fully fund the plan's liability in the event of stop-loss insurance nonrenewal. The runoff full funding reserve must be maintained until plan dissolution.

Subp. 3. **Surplus or aggregate advancement.** A plan must protect itself from cash flow difficulties by either of the following two methods.

A. Establishing and maintaining a surplus equal to the greater of:

(1) three times the average paid monthly premium during the most recent fund year;

(2) three times estimated monthly premium, for plans that do not yet have one fund year's experience; or

(3) $100,000.

B. Obtaining language in the plan's aggregate excess stop-loss insurance policy requiring the insurer to advance funds to the plan under the conditions prescribed by this item. Any funds so advanced must be included in the fund-year settle up calculation under the stop-loss insurance terms, if not previously repaid. No limit may be set on the amount of funds that the plan may require to be advanced. The policy language must include these sentences: "If, in good faith, the plan judges that it is suffering, or will soon suffer cash flow difficulties, to the extent that its ability to meet its obligations promptly and in full is or will be significantly impaired, the plan may borrow from the insurer funds sufficient in the plan's good faith judgment to correct the difficulties. Such funds shall be considered an advance against the insurer's potential aggregate excess insurance liability for the current fund year. If, as of the final reporting for that fund year, the insurer's liability is determined to be less than the amount of the aggregate advancement, the difference shall then be considered a debt of the plan to the insurer, and reasonable interest may be charged commencing at that time. Until the final reporting, no interest may be charged. The plan shall, in good faith, repay the advance or debt as rapidly as its financial resources permit, without incurring further cash

flow difficulties." The policy must not alter or qualify these terms to harm the plan's rights materially.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989*

2765.1300 STOP-LOSS INSURANCE.

Subpart 1. **Purchase and alteration.** The plan must inform the commissioner at least 180 days prior to expiration of any required stop-loss insurance policy whether it intends to renew the policy, and whether the insurer is willing to renew the policy. Alteration of a required stop-loss insurance policy midterm with the effect of reducing coverage, and cancellation by the plan midterm, are prohibited. If more than one stop-loss insurance policy is obtained in fulfillment of this part's requirements, their expiration dates must be the same.

Subp. 2. **Individual excess.** A plan must have and maintain individual excess stop-loss insurance, that provides for the insurer to assume all liability in excess of $25,000 per person per year under all coverages the plan offers. The reporting period under this coverage must be no less than one year after the fund year's conclusion. A plan may apply to the commissioner for increasing the individual excess stop-loss insurance limit, up to $50,000. The commissioner must approve this application if the increased limit would not be detrimental to the solvency and stability of the plan, considering the plan's experience, size, surplus, and other factors affecting financial integrity.

Subp. 3. **Aggregate excess.** A plan must have and maintain aggregate excess stop-loss insurance that provides for the insurer to assume all liability in excess of a specified amount of losses for each fund year. The aggregate excess coverage may be in the form of incurred basis stop-loss insurance or paid basis stop-loss insurance. Plans using paid basis stop-loss insurance must have and maintain extended or runoff aggregate excess stop-loss insurance on an incurred basis. The extended or runoff coverage must provide for the insurer to assume all liability in excess of a specified amount of losses incurred while the paid basis stop-loss insurance was in force, but paid after its termination or nonrenewal. The reporting period under paid basis insurance must be no less than three months after the fund year's conclusion. The reporting period under incurred basis insurance, including extended or runoff insurance, must be no less than one year after the fund year's conclusion.

Subp. 4. [Repealed, 12 SR 845]

Subp. 5. **Surety coverage.** A plan must have and maintain the following language in its required aggregate excess stop-loss insurance policy: "The insurer shall, at the commissioner's request, assume direct responsibility for the plan's coverage and all other responsibilities under this chapter and related statutes, if the plan becomes insolvent, ceases operations without authorization, or otherwise fails to fulfill its responsibilities under this chapter and related statutes. The insurer may attempt to collect reimbursement from the plan or a member on whose behalf the insurer is called upon to pay premium, pay claims, or incur other extraordinary expenses. However, the insurer must fulfill its responsibilities under this section while any collection attempts are pending. The insurer's responsibilities extend to all matters arising during or attributable to the policy period, and do not terminate with the end of the policy period." The policy must not alter or qualify these terms to harm the plan's rights materially.

Subp. 6. **Return of liability.** No liability or other responsibilities transferred to an insurer under this part may, directly or indirectly, be returned to a plan, a member, or a member's parent, subsidiary, or affiliate. This does not prohibit the insurer from seeking reimbursement from the plan or a member, as permitted under subparts 4 and 5.

Statutory Authority: *MS s 45.023; 62H.06*

History: *9 SR 989; 12 SR 845*

2765.1400 FINANCIAL INTEGRITY.

Subpart 1. **Fidelity bond.** All contractors and individuals who handle plan funds or who will have authority to gain access to plan funds, including trustees, must be covered by a fidelity bond. The bond must cover losses from dishonesty, robbery, forgery or alteration, misplacement, and mysterious and unexplainable disappearance. The amount of coverage

for each occurrence must be $300,000 or more. The plan must purchase a fidelity bond covering the required contractors and individuals, or submit separate proof of coverage for all required contractors and individuals not covered under the plan's bond.

Subp. 2. **Integrity of assets.** A plan's assets:

A. must not be commingled with the assets of any member;

B. must not be loaned to anyone for any purpose, or used as security for a loan, except as permitted under subpart 5 for investments;

C. must be employed solely for the purposes stated in the bylaws, and in compliance with this chapter and related statutes; and

D. must not be considered the property or right of any member, covered employee, or other covered person, except:

(1) for benefits under the coverage documents;

(2) for dividends declared in accordance with part 2765.1100, subpart 2; and

(3) for a portion of the assets remaining after the plan's dissolution, in accordance with part 2765.0700, subpart 4.

Subp. 3. **Sources and uses of funds.** A plan may expend funds for payment of losses and expenses, and for other costs customarily borne by insurers under conventional insurance policies in Minnesota. Except as provided in part 2765.1200, subpart 3, item B, a plan must not borrow money or issue debt instruments. A plan may bring legal suits to collect delinquent debts. A plan must not obtain funds through subrogation of the rights of covered employees or other covered persons. A plan may receive funds only from:

A. its members as premiums, assessments, or penalties;

B. its insurers or indemnitors pursuant to insurance or indemnification agreements;

C. dividends, interest, or the proceeds of sale of investments;

D. refunds of excess payments;

E. coordination of benefits with automobile coverage, workers' compensation coverage, and other employee health benefit coverage; or

F. collection of money owed to the plan.

Subp. 4. **Separate accounts.** A plan may establish separate accounts for the payment of claims or certain types of expenses. These accounts must be used only by the service company, its authorized subcontractors, or the financial administrator, as appropriate to the account's purpose. The amount in these special accounts must not exceed an amount reasonably sufficient to pay the claims or expenses for which it is established. All monetary and investment assets not in these accounts must be under the control of the financial administrator.

Subp. 5. **Investments.** A plan's investments are subject to the requirements of Minnesota Statutes, section 118A.04, as regards both permitted types of investments, maturities, and depositories. In addition, a plan must not invest in securities or debt of a member, or a member's parent, subsidiary, or affiliate; or any person or entity under contract with the plan.

Subp. 6. **Monitoring financial condition.** The board must regularly monitor the plan's revenues, expenses, and loss development, and evaluate its current and expected financial condition. The board must attempt in good faith to maintain or restore the plan's sound financial condition, using any means at its disposal. These means include but are not limited to adjusting premium rates, underwriting standards, dividend rates, expulsion standards, and other powers granted in this chapter and the bylaws. If the commissioner judges that the board's actions are inadequate to maintain or restore the plan's sound financial condition, the commissioner shall, as appropriate: order an increase in the premium rates; revoke the plan's self–insurance authority; or order that an assessment be levied against the members.

Members must not require covered employees to pay a portion of an assessment, nor must covered employees be required to pay any amount for premium increases on coverage in force. The amount of assessments must not be more than the amount of members' most recent annual premium, including the portion paid by covered employees.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989; L 1996 c 399 art 2 s 12*

2765.1500 REPORTING.

Subpart 1. **Financial statements.** A plan must prepare annual financial statements containing a balance sheet; a full funding reserves calculation worksheet; a statement of revenues, expenses, and surplus; a statement of changes in financial position; and a schedule of investments. The statements must be prepared on forms and according to instructions prescribed by the commissioner. The financial statements must be filed with the commissioner no later than 30 days after the fund year's conclusion. The financial statements must be audited by an independent certified public accountant, and an audit report must be filed with the commissioner no later than 180 days after the fund year's conclusion. A plan's first annual financial statement, and every second annual financial statement thereafter must be accompanied by a statement from a qualified actuary concerning the balance sheet items that are based on actuarial assumptions and methods. The form of the actuary's statement and the scope of the actuarial review must be according to instructions prescribed by the commissioner.

Subp. 2. **Quarterly reports.** A plan must file quarterly reports with the commissioner no later than 30 days after the end of the first, second, and third quarters of each fund year. Quarterly reports must contain statements of the plan's:

A. current total cash on hand and on deposit, and total investments;

B. current total reserve for unearned and advance premiums, total reserve for outstanding losses reported and unreported, total operating full funding reserve, and total runoff full funding reserve;

C. dividends declared during the quarter;

D. gross premiums written during the quarter;

E. losses paid during the quarter;

F. proximity to the aggregate excess stop–loss insurance attachment point for the current fund year and, if applicable, the past fund year;

G. current total members and covered employees; and

H. any other matters the commissioner requests that the board address.

Subp. 3. **Extraordinary audits.** Upon sufficient cause, the commissioner shall require a plan to investigate the accuracy of one or more entries on its financial statements or quarterly reports, and to report its findings. If necessary for the investigation's purposes, the commissioner shall require a plan to contract with a qualified actuary, claims specialist, auditor, or other specialists as appropriate to the type of entry being investigated. If warranted by investigation's findings, the commissioner shall require changes in the plan's reserving, accounting, or recordkeeping practices. These extraordinary audits are in addition to the commissioner's rights to examine self–insurance plans under Minnesota Statutes, section 60A.03, subdivisions 3, 5, and 6, and section 60A.031. Sufficient cause includes:

A. losses that appear significantly different than losses experienced by other self–insurance plans or insurance companies for similar coverage;

B. unusual changes in the amount of entries from period to period that are not sufficiently explained by the financial statements, quarterly reports, or footnotes; or

C. other indications that a plan's financial statements or quarterly reports may not accurately reflect the plan's status and transactions.

Subp. 4. **Annual status report.** No later than 30 days after the fund year's conclusion, a plan must file with the commissioner a statement describing any changes that have occurred in the information filed with its initial application for authority to self–insure, or with the plan's most recent status report. The status report must be filed in a form and according to instructions prescribed by the commissioner.

Subp. 5. **Penalty.** The financial statements and status report required under subparts 1 and 4 are considered together to be a plan's annual statement. This filing and other filings required by this chapter and related statutes are subject to Minnesota Statutes, section 72A.061, as applicable to licensed insurance companies for comparable filings.

Subp. 6. **Revenue fee.** No later than 60 days after each fund year's conclusion, a plan must file a report with the commissioner of revenue disclosing the total amount of claims paid during the fund year, with no deduction for claims wholly or partially reimbursed

through stop–loss insurance. The report must be filed on a form available from the commissioner of revenue. At the time of filing the report, the plan shall pay the fee required by Minnesota Statutes, section 62H.07, to the commissioner of revenue in the amount of two percent of the total amount of claims paid during the fund year, with no deduction for claims wholly or partially reimbursed through stop–loss insurance.

Statutory Authority: *MS s 62H.06*

History: *9 SR 989*