CHAPTER 446—S.F.No. 1980

An act relating to insurance; regulating coverages; regulating premium taxes; modifying agent cancellations or terminations; providing certain filing requirements for domestic insurers; regulating disclosures and policy and contract provisions; providing for the operation and administration of the medical malpractice joint underwriting association and the Minnesota joint underwriting association; regulating policy cancellations or terminations and claims practices; regulating information handling practices; establishing solvency requirements; making technical changes; regulating the provision of certain insured services; requiring a study and a report; amending Minnesota Statutes 1994, sections 60A.07, subdivision 8; 60A.08, subdivision 14; 60A.09, subdivision 4a; 60A.11, subdivision 21; 60A.171, subdivision 7, and by adding a subdivision; 60A.36, subdivision 1; 60C.09, subdivision 2; 60C.11, by adding a subdivision; 61A.02, subdivision 2, and by adding a subdivision; 61A.072, subdivision 4; 61A.32; 61B.20, subdivision 15; 61B.28, subdivision 7; 62A.02, by adding a subdivision; 62A.31, subdivisions 1p, 1r, 1s, and 3; 62A.315; 62A.318; 62A.39; 62A.44, subdivision 2; 62A.49, subdivision 1; 62A.60; 62F.03, subdivision 6; 62F.04, subdivision 1a; 62I.02, subdivisions 2, 5, and by adding a subdivision; 62I.07; 62L.09, subdivision 3; 65A.01, subdivision 3; 65A.10, subdivision 1; 65A.295; 65B.14, by adding a subdivision; 65B.15, subdivision 1; 65B.64, subdivision 3; 70A.07; 72A.20, subdivisions 17, 23, 26, 30, and by adding a subdivision; 148.235, subdivisions 2 and 4; 471.617, subdivision 2, as amended; and 471.98, subdivision 3, as amended; Minnesota Statutes 1995 Supplement, sections 60A.07, subdivision 10; 60A.15, subdivision 1; 60A.67, subdivision 2; 60K.03, subdivision 7; 61A.09, subdivision 1; 62A.042; 62A.135, subdivision 1; 62A.31, subdivision 1h; 62A.46, subdivision 2; 62A.48, subdivision 1; 62C.14, subdivision 14; 62E.05, subdivision 1; 62F.02, subdivision 2; 62L.045; and 65B.47, subdivision 1a; proposing coding for new law in Minnesota Statutes, chapters 60A; 61A; 62A; 62Q; and 72A; repealing Minnesota Statutes 1994, sections 60A.13, subdivision 8; 60A.40; 60B.27; 62I.20; 65A.25; and 72A.205; Laws 1995, chapter 140, section 1.

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

ARTICLE 1

Section 1. Minnesota Statutes 1994, section 60A.08, subdivision 14, is amended to read:

Subd. 14. **AGREEMENT TO RESCIND POLICY OR RELEASE BAD FAITH CLAIM.** (a) If the insurer has knowledge of any claims against the insured that would remain unsatisfied due to the financial condition of the insured, the insurer and the insured may not agree to:

(1) rescind the policy; or

(2) directly or indirectly transfer to, or release to, the insurer the insured's claim or potential claim against the insurer based upon the insurer's refusal to settle a claim against the insured.

(b) Before entering into an agreement ~~to rescind a policy~~ described in paragraph (a), an insurer must make a good faith effort to ascertain: (1) the existence and identity of all claims against the policy; and (2) the financial condition of the insured.

(c) The insured must provide reasonable financial information upon request of the insurer.

(d) An agreement made in violation of this section is void and unenforceable.

Sec. 2. Minnesota Statutes 1994, section 60A.09, subdivision 4a, is amended to read:

Subd. 4a. **ASSUMPTION TRANSACTIONS REGULATED.** No ~~life~~ company, whether domestic, foreign, or alien, shall perform an assumption transaction, including an assumption reinsurance agreement, with respect to a policy issued to a Minnesota resident, unless:

(1) the assumption agreement has been filed with the commissioner;

(2) the assumption agreement specifically provides that the original insurer remains liable to the insured in the event the assuming insurer is unable to fulfill its obligations or the original insurer acknowledges in writing to the commissioner that it remains liable to the insured in the event the assuming insurer is unable to fulfill its obligations;

(3) the proposed certificate of assumption to be provided to the policyholder has been filed with the commissioner for review and approval as provided in section 61A.02; and

(4) the proposed certificate of assumption contains, in bold face type, the following language:

"Policyholder: Please be advised that you retain all rights with respect to your policy against your original insurer in the event the assuming insurer is unable to fulfill its obligations. In such event, your original insurer remains liable to you notwithstanding the terms of its assumption agreement."

With respect to residents of Minnesota, the notice to policyholders shall also include a statement as to the effect on guaranty fund coverage, if any, that will result from the transfer.

Clauses (2) and (4) above do not apply if the policyholder consents in a signed writing to a release of the original insurer from liability and to a waiver of the protections provided in clauses (2) and (4) after being informed in writing by the insurer of the circumstances relating to and the effect of the assumption, provided that the consent form signed by the policyholder has been filed with and approved by the commissioner.

If a company is deemed by the commissioner to be in a hazardous condition or is under a court ordered supervision, rehabilitation, liquidation, conservation or receivership, and the transfer of policies is in the best interest of the policyholders, as determined by the commissioner, a transfer may be effected notwithstanding the provisions in this subdivision by using a different form of consent by policyholders. This may include a form of implied consent and adequate notification to the policyholder of the circumstances requiring the transfer as approved by the commissioner. This paragraph does not apply when a policy is transferred to the Minnesota life and health guaranty association or to the Minnesota insurance guaranty association.

Sec. 3. Minnesota Statutes 1995 Supplement, section 60A.15, subdivision 1, is amended to read:

Subdivision 1. **DOMESTIC AND FOREIGN COMPANIES.** (a) On or before April 1, June 1, and December 1 of each year, every domestic and foreign company, including town and farmers' mutual insurance companies, domestic mutual insurance companies, marine insurance companies, health maintenance organizations, integrated service networks, community integrated service networks, and nonprofit health service plan corporations, shall pay to the commissioner of revenue installments equal to one–third of the insurer's total estimated tax for the current year. Except as provided in paragraphs (d) and (e), installments must be based on a sum equal to two percent of the premiums described in paragraph (b).

(b) Installments under paragraph (a), (d), or (e) are percentages of gross premiums less return premiums on all direct business received by the insurer in this state, or by its agents for it, in cash or otherwise, during such year.

(c) Failure of a company to make payments of at least one–third of either (1) the total tax paid during the previous calendar year or (2) 80 percent of the actual tax for the current calendar year shall subject the company to the penalty and interest provided in this section, unless the total tax for the current tax year is $500 or less.

(d) For health maintenance organizations, nonprofit health services plan corporations, integrated service networks, and community integrated service networks, the installments must be based on an amount equal to one percent of premiums described in paragraph (b) that are paid after December 31, 1995.

(e) For purposes of computing installments for town and farmers' mutual insurance companies and for mutual property casualty companies with total assets on December 31, 1989, of $1,600,000,000 or less, the following rates apply:

(1) for all life insurance, two percent;

(2) for town and farmers' mutual insurance companies and for mutual property and casualty companies with total assets of $5,000,000 or less, on all other coverages, one percent; and

(3) for mutual property and casualty companies with total assets on December 31, 1989, of $1,600,000,000 or less, on all other coverages, 1.26 percent.

(f) Premiums under medical assistance, general assistance medical care, the MinnesotaCare program, and the Minnesota comprehensive health insurance plan are not subject to tax under this section.

Sec. 4. Minnesota Statutes 1994, section 60A.171, subdivision 7, is amended to read:

Subd. 7. The provisions of this section do not apply to the termination of an agent's contract for insolvency, abandonment, gross and willful misconduct, or failure to pay over to the company money due to the company after receipt by the agent of a written demand therefor, or after revocation of the agent's license by the commissioner of commerce~~; nor to the termination of agents who write insurance business exclusively for one company or agents in the direct employ of the company~~. This section does not apply to the termination of an agent's contract if the agent is directly employed by the company or if the agent writes 80 percent or more of the agent's gross annual insurance business for one company or any or all of its subsidiaries.

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

Sec. 5. Minnesota Statutes 1994, section 60A.171, is amended by adding a subdivision to read:

Subd. 12. For purposes of this section, a cancellation or termination of an agent's contract is considered to have occurred if the company cancels a line of insurance business or a volume of insurance business that equals or exceeds 75 percent of the insurance business placed by that agent with the company.

Sec. 6. **[60A.179] LIFE OR HEALTH INSURANCE POLICY QUOTAS FOR EXCLUSIVE AGENTS.**

Subdivision 1. **APPLICATION.** This section applies to licensed insurance agents as defined by section 60A.176.

Subd. 2. **PROHIBITED PRACTICE.** No insurer shall require an agent who has been licensed as an agent three years or more to sell a specified number of life or health insurance policies or a specified dollar amount of life and health insurance in relation to the sale of other insurance products. No insurer may terminate an agent's contract or reduce or restrict an agent's underwriting authority on property and casualty insurance policies based upon the sale of life or health insurance.

Sec. 7. Minnesota Statutes 1994, section 60A.36, subdivision 1, is amended to read:

Subdivision 1. **REASON FOR CANCELLATION.** No insurer may cancel a policy of commercial liability and/or property insurance during the term of the policy, except for one or more of the following reasons:

(1) nonpayment of premium;

(2) misrepresentation or fraud made by or with the knowledge of the insured in obtaining the policy or in pursuing a claim under the policy;

(3) actions by the insured that have substantially increased or substantially changed the risk insured;

(4) refusal of the insured to eliminate known conditions that increase the potential for loss after notification by the insurer that the condition must be removed;

(5) substantial change in the risk assumed, except to the extent that the insurer should reasonably have foreseen the change or contemplated the risk in writing the contract;

(6) loss of reinsurance by the insurer which provided coverage to the insurer for a significant amount of the underlying risk insured. A notice of cancellation under this clause shall advise the policyholder that the policyholder has ten days from the date of receipt of the notice to appeal the cancellation to the commissioner of commerce and that the commissioner will render a decision as to whether the cancellation is justified because of the loss of reinsurance within ~~five~~ 30 business days after receipt of the appeal;

(7) a determination by the commissioner that the continuation of the policy could place the insurer in violation of the insurance laws of this state; or

(8) nonpayment of dues to an association or organization, other than an insurance association or organization, where payment of dues is a prerequisite to obtaining or continuing the insurance. This provision for cancellation for failure to pay dues does not ap-

ply to persons who are retired at 62 years of age or older or who are disabled according to social security standards.

Sec. 8. Minnesota Statutes 1995 Supplement, section 60K.03, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

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

(9) representatives of prepaid legal service plans in connection with the sale and marketing of these plans.

Sec. 9. Minnesota Statutes 1994, section 61A.02, subdivision 2, is amended to read:

Subd. 2. **APPROVAL REQUIRED.** No policy or certificate of life insurance or annuity contract, issued to an individual, group, or multiple employer trust, nor any rider of any kind or description which is made a part thereof shall be issued or delivered in this state, or be issued by a life insurance company organized under the laws of this state, until the form of the same has been approved by the commissioner. In making a determination under this section, the commissioner may require the insurer to provide rates and advertising materials related to policies or contracts, certificates, or similar evidence of coverage issued or delivered in this state.

~~This section applies~~ Subdivisions 1 to 5 apply to a policy, certificate of insurance, or similar evidence of coverage issued to a Minnesota resident or issued to provide coverage to a Minnesota resident. ~~This section does~~ Subdivisions 1 to 5 do not apply to a certificate of insurance or similar evidence of coverage that meets the conditions of section 61A.093, subdivision 2.

Sec. 10. Minnesota Statutes 1994, section 61A.02, is amended by adding a subdivision to read:

Subd. 6. **FILING BY DOMESTIC INSURERS FOR PURPOSES OF COMPLYING WITH ANOTHER STATE'S FILING REQUIREMENTS.** A domestic insurer may file with the commissioner for informational purposes only a policy, certificate of insurance, or annuity contract that is not intended to be offered or sold within this state. This subdivision only applies to the filing in Minnesota of a policy, certificate of insurance, or annuity contract issued to an insured, certificate holder, or annuitant located outside of this state when the filing is for the express purpose of complying with the law of the state in which the insured, certificate holder, or annuitant resides. In no event may a policy, certificate of insurance, or annuity contract filed under this subdivision for out–of–state use be issued or delivered in Minnesota unless and until the policy, certificate of insurance, or annuity contract is approved under subdivision 2.

Sec. 11. Minnesota Statutes 1994, section 61A.072, subdivision 4, is amended to read:

Subd. 4. **LONG–TERM CARE EXPENSES.** If the right to receive accelerated benefits is contingent upon the insured receiving long–term care services, the contract or supplemental contract shall include the following provisions:

(1) the minimum accelerated benefit shall be $1,200 per month if the insured is receiving nursing facility services and $750 per month if the insured is receiving home services with a minimum lifetime benefit limit of $50,000;

(2) coverage is effective immediately and benefits shall commence with the receipt of services as defined in section 62A.46, subdivision 3, 4, or 5, but may include a waiting period of not more than 90 days, provided that no more than one waiting period may be required per benefit period as defined in section 62A.46, subdivision 11;

(3) premium shall be waived during any period in which benefits are being paid to the insured during confinement to a nursing home facility;

(4) coverage may not be canceled or renewal refused except on the grounds of nonpayment of premium;

(5) coverage must include preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage;

(6) ~~the contract or supplemental contract shall contain the following disclosure:~~

~~"THE ACCELERATED LIFE INSURANCE BENEFITS PROVIDED UNDER THIS CONTRACT MAY NOT COVER ALL NURSING HOME, HOME CARE, OR ADULT DAY CARE EXPENSES. BENEFITS ARE NOT PAYABLE UPON RECEIPT OF RESIDENTIAL CARE. READ YOUR POLICY CAREFULLY TO DETERMINE YOUR BENEFIT AMOUNT.";~~

~~(7)~~ coverage must include mental or nervous disorders which have a demonstrable organic cause such as Alzheimer's and related dementias;

~~(8)~~ (7) no prior hospitalization requirement shall be allowed unless a similar requirement is allowed by section 62A.48, subdivision 1; and

~~(9)~~ (8) the contract shall include a cancellation provision that meets the requirements of section 62A.50, subdivision 2.

Sec. 12. Minnesota Statutes 1995 Supplement, section 61A.09, subdivision 1, is amended to read:

Subdivision 1. No group life insurance policy or group annuity shall be issued for delivery in this state until the form thereof and the form of any certificates issued thereunder have been filed in accordance with and subject to the provisions of section 61A.02. Each person insured under such a group life insurance policy (excepting policies which insure the lives of debtors of a creditor or vendor to secure payment of indebtedness) shall be furnished a certificate of insurance issued by the insurer and containing the following:

(a) Name and location of the insurance company;

(b) A statement as to the insurance protection to which the certificate holder is entitled, including any changes in such protection depending on the age of the person whose life is insured;

(c) Any and all provisions regarding the termination or reduction of the certificate holder's insurance protection;

(d) A statement that the master group policy may be examined at a reasonably accessible place;

(e) The maximum rate of contribution to be paid by the certificate holder;

(f) Beneficiary and method required to change such beneficiary;

(g) A statement that alternative methods for the payment of group life policy proceeds of $15,000 or more must be offered to beneficiaries in lieu of a lump sum distribution, at their request. Alternative payment methods which must be offered at the request of the beneficiaries must include, but are not limited to, a life income option, an income option for fixed amounts or fixed time periods, and the option to select an interest–bearing account with the company with the right to select another option at a later date;

(h) In the case of a group term insurance policy if the policy provides that insurance of the certificate holder will terminate, in case of a policy issued to an employer, by reason of termination of the certificate holder's employment, or in case of a policy issued to an organization of which the certificate holder is a member, by reason of termination of membership, a provision to the effect that in case of termination of employment or membership, or in case of termination of the group policy, the certificate holder shall be entitled to have issued by the insurer, without evidence of insurability, upon application made to the insurer within 31 days after the termination, and upon payment of the premium applicable to the class of risk to which that person belongs and to the form and amount of the policy at that person's then attained age, a policy of life insurance only, in any one of the forms customarily issued by the insurer except term insurance, in an amount equal to the amount of the life insurance protection under such group insurance

policy at the time of such termination; and shall contain a further provision to the effect that upon the death of the certificate holder during such 31–day period and before any such individual policy has become effective, the amount of insurance for which the certificate holder was entitled to make application shall be payable as a death benefit by the insurer.

This section applies to a policy, certificate of insurance, or similar evidence of coverage issued to a Minnesota resident or issued to provide coverage to a Minnesota resident. This section does not apply to a certificate of insurance or similar evidence of coverage that meets the conditions of section 61A.093, subdivision 2.

Sec. 13. **[61A.53] DEFINITIONS.**

Subdivision 1. **APPLICABILITY.** For purposes of sections 61A.53 to 61A.60, the terms defined in this section have the meanings given.

Subd. 2. **REPLACEMENT.** "Replacement" means any transaction in which new life insurance or a new annuity is to be purchased, and it is known or should be known to the proposing agent or broker or to the proposing insurer if there is no agent, that by reason of the transaction, existing life insurance or annuity has been or is to be:

(1) lapsed, forfeited, surrendered, or otherwise terminated;

(2) converted to reduced paid–up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) reissued with any reduction in cash value; or

(5) pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding 25 percent of the loan value set forth in the policy.

Subd. 3. **CONSERVATION.** "Conservation" means any attempt by the existing insurer or its agent or broker to dissuade a policy owner or contract holder from the replacement of existing life insurance or annuity. Conservation does not include routine administrative procedures such as late payment reminders, late payment offers, or reinstatement offers.

Subd. 4. **DIRECT–RESPONSE SALE.** "Direct–response sale" means any sale of life insurance or annuity where the insurer does not use an agent in the sale or delivery of the policy or contract.

Subd. 5. **EXISTING INSURER.** "Existing insurer" means the insurance company whose policy or contract is or will be changed or terminated in such a manner as described within the definition of "replacement."

Subd. 6. **EXISTING LIFE INSURANCE OR ANNUITY.** "Existing life insurance or annuity" means any life insurance or annuity in force, including life insurance under a binding or conditional receipt or a life insurance policy or annuity contract that is within an unconditional refund period.

Subd. 7. **REPLACING INSURER.** "Replacing insurer" means the insurance company that issues or proposes to issue a new policy or contract which is a replacement of existing life insurance or annuity.

Sec. 14. **[61A.54] EXEMPTIONS.**

Unless otherwise specifically included, sections 61A.53 to 61A.60 do not apply to transactions involving:

(1) credit life insurance;

(2) group life insurance or group annuities;

(3) an application to the existing insurer that issued the existing life insurance or annuity, where a contractual change or a conversion privilege is being exercised;

(4) proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company; or

(5) transactions where the replacing insurer and the existing insurer are the same, or are subsidiaries or affiliates under common ownership or control; provided, however, that agents or brokers proposing replacement shall comply with section 61A.55, subdivision 1.

Sec. 15. **[61A.55] DUTIES OF AGENTS AND BROKERS.**

Subdivision 1. **SUBMISSION TO INSURER.** Each agent or broker who initiates the application shall submit to the insurer to which an application for life insurance or annuity is presented, with or as part of each application:

(1) a statement signed by the applicant as to whether replacement of existing life insurance or annuity is involved in the transaction; and

(2) a signed statement as to whether the agent or broker knows replacement is or may be involved in the transaction.

Subd. 2. **REPLACEMENT INFORMATION.** Where a replacement is involved, the agent or broker shall:

(1) present to the applicant, not later than at the time of taking the application, a "notice regarding replacement" in the form as described in section 61A.60, subdivision 1, or other substantially similar form approved by the commissioner. The notice shall be fully completed and signed by both the applicant and the agent or broker and left with the applicant. The completed notice must list all existing life insurance and annuity to be replaced, properly identified by name of insurer, the insured, and contract number. If a contract number has not been assigned by the existing insurer, alternative identification, such as an application or receipt number, shall be listed;

(2) leave with the applicant the original or a copy of any written or printed communications used for presentation to the applicant; and

(3) submit to the replacing insurer with the application a copy of the fully completed and signed replacement notice provided under this subdivision.

Subd. 3. **MATERIALS USED TO DISSUADE REPLACEMENT.** Each agent or broker who uses written or printed communications in a conservation shall leave with the applicant the original or a copy of the communications.

Sec. 16. **[61A.56] DUTIES OF ALL INSURERS.**

Each insurer shall:

(1) inform its field representatives or other personnel responsible for compliance with sections 61A.53 to 61A.60 of the requirements of those sections; and

(2) require with or as a part of each completed application for life insurance or annuity a statement signed by the applicant as to whether the proposed insurance or annuity will replace existing life insurance or annuity.

Sec. 17. **[61A.57] DUTIES OF INSURERS THAT USE AGENTS OR BROKERS.**

Each insurer that uses an agent or broker in a life insurance or annuity sale shall:

(a) require with or as part of each completed application for life insurance or annuity, a statement signed by the agent or broker as to whether the agent or broker knows replacement is or may be involved in the transaction;

(b) where a replacement is involved:

(1) require from the agent or broker with the application for life insurance or annuity, a copy of the fully completed and signed replacement notice provided the applicant under section 61A.55. The existing life insurance or annuity must be identified by name of insurer, insured, and contract number. If a number has not been assigned by the existing insurer, alternative identification, such as an application or receipt number, must be listed; and

(2) send to each existing insurer a written communication advising of the replacement or proposed replacement and the identification information obtained under this section. This written communication must be made within five working days of the date that the application is received in the replacing insurer's home or regional office, or the date the proposed policy or contract is issued, whichever is sooner.

(c) The replacing insurer shall maintain evidence of the "notice regarding replacement" and a replacement register, cross–indexed, by replacing agent and existing insurer to be replaced. Evidence that all requirements were met shall be maintained for at least six years.

(d) The replacing insurer shall provide in its policy or contract, or in a separate written notice that is delivered with the policy or contract, that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within a period of 20 days beginning from the date of delivery of the policy.

Sec. 18. **[61A.58] DUTIES OF INSURERS WITH RESPECT TO DIRECT RESPONSE SALES.**

(a) If in the solicitation of a direct response sale, the insurer did not propose the replacement, and a replacement is involved, the insurer shall send to the applicant with the policy or contract a replacement notice as described in section 61A.60, subdivision 2, or other substantially similar form approved by the commissioner.

(b) If the insurer proposed the replacement, it shall:

(1) provide to applicants or prospective applicants with or as a part of the application a replacement notice as described in section 61A.60, subdivision 2, or other substantially similar form approved by the commissioner;

(2) request from the applicant with or as part of the application, a list of all existing life insurance policies or annuity contracts to be replaced and properly identified by name of insurer and insured; and

(3) comply with the requirements of section 61A.57, paragraph (b), clause (2), if the applicant furnishes the names of the existing insurers, and the requirements of section 61A.57, paragraphs (c) and (d), except that it need not index the replacement register by replacing agent.

Sec. 19. **[61A.59] ENFORCEMENT; EFFECT OF COMPLIANCE.**

(a) An agent, broker or insurer shall not recommend the replacement or conservation of an existing policy or contract by use of a substantially inaccurate presentation or comparison of an existing policy's or contract's premiums and benefits or dividends and values, if any. An insurer, agent, representative, officer, or employee of the insurer failing to comply with the requirements of sections 61A.53 to 61A.60 is subject to such penalties as may be appropriate under this chapter.

(b) Patterns of action by policyholders or contract holders who purchase replacing policies or contracts from the same agent or broker, after indicating on applications that replacement is not involved, are prima facie evidence of the agent's or broker's knowledge that replacement was intended in connection with the sale of those policies, and the patterns of action are prima facie evidence of the agent's or broker's intent to violate sections 61A.53 to 61A.60.

(c) Sections 61A.53 to 61A.60 do not prohibit the use of additional material other than that which is required that does not violate those sections or any other statute or rule.

(d) Compliance by an insurer, agent, or broker with sections 61A.53 to 61A.60 does not limit any cause of action or other remedies that the insured may otherwise have against an insurer, agent, or broker. In a proceeding in which the insured's knowledge or understanding is an issue, compliance with those sections may be admitted as evidence on that issue, but shall not be conclusive.

Sec. 20. **[61A.60] REQUIRED REPLACEMENT NOTICE AND FORM.**

Subdivision 1. **NOTICE FORM; AGENT SALES.** The notice required where sections 61A.53 to 61A.60 refer to this subdivision is as follows:

IMPORTANT NOTICE

DEFINITION: REPLACEMENT IS any transaction where, in connection with the purchase of New Insurance or a New Annuity, you LAPSE, SURRENDER, CONVERT to Paid-up Insurance, Place on Extended Term, or BORROW all or part of the policy loan values on an existing insurance policy or an

annuity. (See reverse side for DEFINITIONS.)

IF YOU INTEND TO REPLACE COVERAGE

In connection with the purchase of this insurance or annuity, if you have REPLACED or intend to REPLACE your present life insurance coverage or annuity(ies), you should be certain that you understand all the relevant factors involved.

You should BE AWARE that you may be required to provide **EVIDENCE OF INSURABILITY** and

1) If your HEALTH condition has CHANGED since the application was taken on your present policies, you may be required to pay ADDITIONAL PREMIUMS under the NEW POLICY, or be DENIED coverage.

2) Your present occupation or activities **may not be covered or could require additional premiums.**

3) The INCONTESTABLE and SUICIDE CLAUSE will begin anew in a new policy. This could RESULT in a **CLAIM under the new policy BEING DENIED** that would otherwise have been paid.

4) Current law DOES NOT REQUIRE your present insurer(s) to REFUND any premiums.

5) It is to your advantage to OBTAIN INFORMATION regarding your existing policies or annuity contracts **from the insurer or agent from whom you purchased the policy or annuity contract.**

(If you are purchasing an annuity, clauses (1), (2), and (3) above would not apply to the new annuity contract.)

THE INSURANCE OR ANNUITY I INTEND TO PURCHASE FROM _____ INSURANCE CO. MAY REPLACE OR ALTER EXISTING LIFE INSURANCE POLICY(IES) OR ANNUITY CONTRACT(S).

The following policy(ies) or annuity contract(s) may be replaced as a result of this transaction:

Insurer as it appears on the policy or contract	**Insured as it appears on the policy or contract**
Policy or Contract Number	**Insured Birthdate**

The proposed policy or contract is:

type of policy– or contract–generic name $ face amount

signature of applicant date

address of applicant city state

I certify that this form was given to and completed by

(applicant–please print or type)

prior to taking an application and that I am leaving a signed copy for the applicant.

agent's signature date

address

city state

NOTE IMPORTANT STATEMENT ON REVERSE SIDE

Subd. 2. **NOTICE FORM; DIRECT RESPONSE SALES.** The notice required where sections 61A.53 to 61A.60 refer to this subdivision is as follows:

IMPORTANT NOTICE REQUIRED BY MINNESOTA INSURANCE LAW

DEFINITION: REPLACEMENT is any transaction where, in connection with the purchase of New Insurance or a New Annuity, you LAPSE, SURRENDER, CONVERT to Paid–up Insurance, Place on Extended Term, or BORROW all or part of the policy loan values on an existing insurance policy or an annuity. (See reverse side for DEFINITIONS.)

IF YOU INTEND TO REPLACE COVERAGE

In connection with the purchase of this insurance or annuity, if you have REPLACED or intend to REPLACE your present life insurance coverage or annuity(ies), you should be certain that you understand all the relevant factors involved.

You should BE AWARE that you may be required to provide **Evidence of insurability** and

(1) If your HEALTH condition has CHANGED since the application was taken on your present policies, you may be required to pay ADDITIONAL PREMIUMS under the NEW POLICY, or be DENIED coverage.

(2) Your present occupation or activities **may not be covered or could require additional premiums.**

(3) The INCONTESTABLE and SUICIDE CLAUSE will begin anew in a new policy. This could RESULT in a **CLAIM under the new policy BEING DENIED** that would otherwise have been paid.

(4) Current law DOES NOT REQUIRE your present insurer(s) to REFUND any premiums.

(5) It may be to your advantage to OBTAIN INFORMATION regarding your existing policies or annuity contracts **from the insurer or agent from whom you purchased the policy or annuity contract.**

(If an annuity is being purchased, Items 1, 2 and 3 above would not apply to the new contract.)

CAUTION If after studying the information made available to you, you decide to replace your existing life insurance or annuity with our policy or annuity contract, you are urged not to take action to terminate or alter your existing coverage or annuity(ies) until after you have been issued the new policy or annuity contract, examined it and found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage or annuity(ies) and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or be able to purchase it only at substantially higher rates.

INSURER'S MAILING DATE: .....

Subd. 3. **DEFINITIONS.** The following definitions must appear on the back of the notice forms provided in subdivisions 1 and 2:

DEFINITIONS

PREMIUMS: Premiums are the payments you make in exchange for an insurance policy or annuity contract. They are unlike deposits in a savings or investment program, because if you drop the policy or contract, you might get back less than you paid in.

CASH SURRENDER VALUE: This is the amount of money you can get in cash if you surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender value is the difference between the cash value printed in the policy and the loan value. Not all policies have cash surrender values.

LAPSE: A life insurance policy may lapse when you do not pay the premiums within the grace period. If you had a cash surrender value, the insurer might change your policy to as much extended term insurance or paid–up insurance as the cash surrender value will buy. Sometimes the policy lets the insurer borrow from the cash surrender value to pay the premiums.

SURRENDER: You surrender a life insurance policy when you either let it lapse or tell the company you want to drop it. Whenever a policy has a cash surrender value, you can get it in cash if you return the policy to the company with a written request. Most insurers will also let you exchange the cash value of the policy for paid–up or extended term insurance.

CONVERT TO PAID–UP INSURANCE: This means you use your cash surrender value to change your insurance to a paid–up policy with the same insurer. The death benefit generally will be lower than under the old policy, but you will not have to pay any more premiums.

PLACE ON EXTENDED TERM: This means you use your cash surrender value to change your insurance to term insurance with the same insurer. In this case, the net death benefit will be the same as before. However, you will only be covered for a specified period of time stated in the policy.

BORROW POLICY LOAN VALUES: If your life insurance policy has a cash surrender value, you can almost always borrow all or part of it from the insurer. Interest will be charged according to the terms of the policy, and if the loan with unpaid interest ever exceeds the cash surrender value, your policy will be surrendered. If you die, the amount of the loan and any unpaid interest due will be subtracted from the death benefits.

EVIDENCE OF INSURABILITY: This means proof that you are an acceptable risk. You have to meet the insurer's standards regarding age, health, occupation, etc., to be eligible for coverage.

INCONTESTABLE CLAUSE: This says that after two years, depending on the policy or insurer, the life insurer will not resist a claim because you made a false or incomplete statement when you applied for the policy. For the early years, though, if there are wrong answers on the application and the insurer finds out about them, the insurer can deny a claim as if the policy had never existed.

SUICIDE CLAUSE: This says that if you commit suicide after being insured for less than two years, depending on the policy and insurer, your beneficiaries will receive only a refund of the premiums that were paid.

Subd. 4. **PRINTING OF NOTICES.** The notices in subdivisions 1 and 2 must be reproduced in their entirety on one side of an 8–1/2 by 11 inch sheet of plain paper. The definitions contained in subdivision 3 must be printed on the reverse side. The insurer may print its legal name in the space provided.

Sec. 21. Minnesota Statutes 1994, section 61B.28, subdivision 7, is amended to read:

Subd. 7. **NOTICE CONCERNING LIMITATIONS AND EXCLUSIONS.** (a) No person, including an insurer, agent, or affiliate of an insurer or agent, shall offer for sale in this state a covered life insurance, annuity, or health insurance policy or contract without delivering at the time of application for that policy or contract a notice in the form specified in subdivision 8, or in a form approved by the commissioner under paragraph (b), relating to coverage provided by the Minnesota life and health insurance guaranty association. The notice may be part of the application. A copy of the notice must be given to the applicant. The notice must be delivered to the applicant at the time of application for the policy or contract, except that if the application is not taken from the applicant in person, the notice must be sent to the applicant within 72 hours after the application is taken. The person offering the policy or contract shall document the fact that the notice was given at the time of application or was sent within the specified time. This does not require that the receipt of the notice be acknowledged by the applicant.

(b) The association may prepare, and file with the commissioner for approval, a form of notice as an alternative to the form of notice specified in subdivision 8 describing the general purposes and limitations of this chapter. The form of notice shall:

(1) state the name, address, and telephone number of the Minnesota life and health insurance guaranty association;

(2) prominently warn the policy or contract holder that the Minnesota life and health insurance guaranty association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(3) state that the insurer and its agents are prohibited by law from using the existence of the Minnesota life and health insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(4) emphasize that the policy or contract holder should not rely on coverage under the Minnesota life and health insurance guaranty association when selecting an insurer;

(5) provide other information as directed by the commissioner. The commissioner may approve any form of notice proposed by the association and, as to the approved form of notice, the association may notify all member insurers by mail that the form of notice is available as an alternative to the notice specified in subdivision 8.

(c) A policy or contract not covered by the Minnesota Life and Health Insurance Guaranty Association or the Minnesota Insurance Guaranty Association must contain the following notice in ten–point type, stamped in red ink or contrasting type on the policy or contract and the application:

"THIS POLICY OR CONTRACT IS NOT PROTECTED BY THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE MINNESOTA INSURANCE GUARANTY ASSOCIATION. IN THE CASE OF INSOLVENCY, PAYMENT OF CLAIMS IS NOT GUARANTEED. ONLY THE ASSETS OF THIS INSURER WILL BE AVAILABLE TO PAY YOUR CLAIM."

This section does not apply to fraternal benefit societies regulated under chapter 64B.

Sec. 22. Minnesota Statutes 1994, section 62A.02, is amended by adding a subdivision to read:

Subd. 7. **FILING BY DOMESTIC INSURERS FOR PURPOSES OF COMPLYING WITH ANOTHER STATE'S FILING REQUIREMENTS.** A domestic insurer may file with the commissioner for informational purposes only a policy or certificate of insurance that is not intended to be offered or sold within this state. This subdivision only applies to the filing in Minnesota of a policy or certificate of insurance issued to an insured or certificate holder located outside of this state when the filing is for the express purpose of complying with the law of the state in which the insured or certificate holder resides. In no event may a policy or certificate of insurance filed under this subdivision for out–of–state use be issued or delivered in Minnesota unless and until the policy or certificate of insurance is approved under subdivision 2.

Sec. 23. Minnesota Statutes 1995 Supplement, section 62A.042, is amended to read:

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

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

birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth. For purposes of this paragraph, "newborn infants" includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. 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 shall be 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.

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

Subd. 2. **GROUP POLICIES; ~~RENEWALS~~.** (a) No group accident and sickness insurance policy and no group health maintenance contract which provide for coverage of family members or other dependents of an employee or other member of the covered group shall be renewed to cover members of a group located in this state or delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered family members or dependents any newborn infants~~, including dependent grandchildren who reside with a covered grandparent,~~ immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth. For purposes of this paragraph, "newborn infants" includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. 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 shall be entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may reduce the health benefits owed to the insured, certificate holder, member, or subscriber by the amount of past due premiums applicable to the additional dependent.

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

Sec. 24. **[62A.3091] NONDISCRIMINATE COVERAGE OF TESTS.**

Subdivision 1. **SCOPE OF REQUIREMENT.** This section applies to any of the following if issued or renewed to a Minnesota resident or to cover a Minnesota resident:

(1) a health plan, as defined in section 62A.011;

(2) coverage described in section 62A.011, subdivision 3, clauses (2), (3), or (6) to (12); and

(3) a policy, contract, or certificate issued by a community integrated service network or an integrated service network licensed under chapter 62N.

Subd. 2. **REQUIREMENT.** Coverage described in subdivision 1 that covers laboratory tests, diagnostic tests, and X–rays must provide the same coverage, without requiring additional signatures, for all such tests ordered by an advanced practice nurse operating pursuant to chapter 148. Nothing in this section shall be construed to interfere with any written agreement between a physician and an advanced practice nurse.

Sec. 25. **[62A.3092] EQUAL TREATMENT OF SURGICAL FIRST ASSISTING SERVICES.**

Subdivision 1. **SCOPE OF REQUIREMENT.** This section applies to any of the following if issued or renewed to a Minnesota resident or to cover a Minnesota resident:

(1) a health plan, as defined in section 62A.011;

(2) coverage described in section 62A.011, subdivision 3, clauses (2), (3), or (6) to (12); and

(3) a policy, contract, or certificate issued by a community integrated service network or an integrated service network licensed under chapter 62N.

Subd. 2. **REQUIREMENT.** Coverage described in subdivision 1 that provides for payment for surgical first assisting benefits or services shall be construed as providing for payment for a registered nurse who performs first assistant functions and services that are within the scope of practice of a registered nurse.

Sec. 26. Minnesota Statutes 1995 Supplement, section 62A.135, subdivision 1, is amended to read:

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

(a) "fixed indemnity policy" is a policy form, other than an accidental death and dismemberment policy, a disability income policy, or a long–term care policy as defined in section 62A.46, subdivision 2, that pays a predetermined, specified, fixed benefit for services provided. Claim costs under these forms are generally not subject to inflation, although they may be subject to changes in the utilization of health care services. For policy forms providing both expense–incurred and fixed benefits, the policy form is a fixed indemnity policy if 50 percent or more of the total claims are for predetermined, specified, fixed benefits;

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

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

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

Sec. 27. Minnesota Statutes 1995 Supplement, section 62A.31, subdivision 1h, is amended to read:

Subd. 1h. **LIMITATIONS ON DENIALS, CONDITIONS, AND PRICING OF COVERAGE.** No ~~issuer of Medicare supplement policies, including policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq.,~~ health carrier issuing Medicare–related coverage in this state may impose preexisting condition limitations or otherwise deny or condition the issuance or effectiveness of any ~~Medicare supplement insurance policy form~~ such coverage available for sale in this state, nor may it discriminate in the pricing of such ~~a policy~~ coverage, because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant where an application for such ~~insurance~~ coverage is submitted prior to or during the six–month period beginning with the first day of the month in which an individual first enrolled for benefits under Medicare Part B. This ~~paragraph~~ subdivision applies to each Medicare–related coverage offered by a health carrier regardless of whether the individual has attained the age of 65 years. If an individual who is enrolled in Medicare Part B due to disability status is involuntarily disenrolled due to loss of disability status, the individual is eligible for ~~the~~ another six–month enrollment period provided under this subdivision ~~if~~ beginning the first day of the month in which the individual later becomes eligible for and enrolls again in Medicare Part B. An individual who is or was previously enrolled in Medicare Part B due to disability status is eligible for another six–month enrollment period under this subdivision beginning the first day of the month in which the individual has attained the age of 65 years and either maintains enrollment in, or enrolls again in, Medicare Part B.

Sec. 28. Minnesota Statutes 1994, section 62A.31, subdivision 1p, is amended to read:

Subd. 1p. **RENEWAL OR CONTINUATION PROVISIONS.** Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy or certificate, and shall include any reservation by the issuer of the right to change premiums. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy or certificate, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy or certificate after the date of issue or at reinstatement or renewal that

reduce or eliminate benefits or coverage in the policy or certificate shall require a signed acceptance by the insured. After the date of policy or certificate issue, a rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy or certificate term shall be agreed to in writing and signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, declaration page, or certificate. If a Medicare supplement policy or certificate contains limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "preexisting condition limitations."

Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis~~, other than incidentally,~~ to a ~~person~~ persons eligible for Medicare ~~by reason of age~~ shall provide to ~~such~~ those applicants a ~~Medicare Supplement Buyer's~~ " Guide to Health Insurance for People with Medicare" in the form developed by the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the ~~Buyer's~~ guide must be made whether or not such policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this section. Except in the case of direct response issuers, delivery of the ~~Buyer's~~ guide must be made to the applicant at the time of application, and acknowledgment of receipt of the ~~Buyer's~~ guide must be obtained by the issuer. Direct response issuers shall deliver the ~~Buyer's~~ guide to the applicant upon request, but no later than the time at which the policy is delivered.

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

Subd. 1r. **COMMUNITY RATE.** Each health maintenance organization, health service plan corporation, insurer, or fraternal benefit society that sells ~~coverage that supplements~~ Medicare-related coverage shall establish a separate community rate for that coverage. Beginning January 1, 1993, no Medicare-related coverage ~~that supplements Medicare or that is governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq.,~~ may be offered, issued, sold, or renewed to a Minnesota resident, except at the community rate required by this subdivision. The same community rate must apply to newly issued coverage and to renewal coverage.

For coverage that supplements Medicare and for the Part A rate calculation for plans governed by section 1833 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., the community rate may take into account only the following factors:

(1) actuarially valid differences in benefit designs or provider networks;

(2) geographic variations in rates if preapproved by the commissioner of commerce; and

(3) premium reductions in recognition of healthy lifestyle behaviors, including but not limited to, refraining from the use of tobacco. Premium reductions must be actuarially valid and must relate only to those healthy lifestyle behaviors that have a proven posi-

tive impact on health. Factors used by the health carrier making this premium reduction must be filed with and approved by the commissioner of commerce.

For insureds not residing in Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, or Washington county, a health plan may, at the option of the health carrier, phase in compliance under the following timetable:

(i) a premium adjustment as of March 1, 1993, that consists of one–half of the difference between the community rate that would be applicable to the person as of March 1, 1993, and the premium rate that would be applicable to the person as of March 1, 1993, under the rate schedule permitted on December 31, 1992. A health plan may, at the option of the health carrier, implement the entire premium difference described in this clause for any person as of March 1, 1993, if the premium difference would be 15 percent or less of the premium rate that would be applicable to the person as of March 1, 1993, under the rate schedule permitted on December 31, 1992, if the health plan does so uniformly regardless of whether the premium difference causes premiums to rise or to fall. The premium difference described in this clause is in addition to any premium adjustment attributable to medical cost inflation or any other lawful factor and is intended to describe only the premium difference attributable to the transition to the community rate; and

(ii) with respect to any person whose premium adjustment was constrained under clause (i), a premium adjustment as of January 1, 1994, that consists of the remaining one–half of the premium difference attributable to the transition to the community rate, as described in clause (i).

A health plan that initially follows the phase–in timetable may at any subsequent time comply on a more rapid timetable. A health plan that is in full compliance as of January 1, 1993, may not use the phase–in timetable and must remain in full compliance. Health plans that follow the phase–in timetable must charge the same premium rate for newly issued coverage that they charge for renewal coverage. A health plan whose premiums are constrained by clause (i) may take the constraint into account in establishing its community rate.

From January 1, 1993 to February 28, 1993, a health plan may, at the health carrier's option, charge the community rate under this paragraph or may instead charge premiums permitted as of December 31, 1992.

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

Subd. 1s. **PRESCRIPTION DRUG COVERAGE.** Beginning January 1, 1993, a health maintenance organization that issues Medicare–related coverage ~~that supplements Medicare or that issues coverage governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq.,~~ must offer, to each person to whom it offers any contract described in this subdivision, at least one contract that either:

(1) covers 80 percent of the reasonable and customary charge for prescription drugs or the copayment equivalency; or

(2) offers the coverage described in clause (1) as an optional rider that may be purchased separately from other optional coverages.

Sec. 31. Minnesota Statutes 1994, section 62A.31, subdivision 3, is amended to read:

Subd. 3. **DEFINITIONS.** (a) "Accident," "accidental injury," or "accidental means" means to employ "result" language and does not include words that establish an accidental means test or use words such as "external," "violent," "visible wounds," or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under a workers' compensation, employer's liability or similar law, or motor vehicle no–fault plan, unless prohibited by law.

(b) "Applicant" means:

(1) in the case of an individual Medicare supplement policy or certificate, the person who seeks to contract for insurance benefits; and

(2) in the case of a group Medicare supplement policy or certificate, the proposed certificate holder.

(c) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

(d) "Certificate" means a certificate delivered or issued for delivery in this state or offered to a resident of this state under a group Medicare supplement policy or certificate.

(e) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(f) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

(g) "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers. The expenses shall not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; and

(7) claims processing costs.

(h) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in the Medicare program.

(i) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery Medicare supplement policies or certificates in this state or offering these policies or certificates to residents of this state.

(j) "Medicare" shall be defined in the policy and certificate. Medicare may be defined as the Health Insurance for the Aged Act, title XVIII of the Social Security Amendments of 1965, as amended, or title I, part I, of Public Law Number 89--97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as amended.

(k) "Medicare eligible expenses" means health care expenses covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

(l) "Medicare–related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.31 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by section 1833 (known as "cost" or "HCPP" contracts) or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

(m) "Medicare supplement policy or certificate" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, ~~other than a policy or certificate issued under a contract under~~ or those policies or certificates covered by section 1833 ~~or 1876~~ of the federal Social Security Act, United States Code, title 42, section 1395, et seq., or an issued policy under a demonstration project ~~authorized~~ specified under amendments to the federal Social Security Act, which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.

~~(m)~~ (n) "Physician" shall not be defined more restrictively than as defined in the Medicare program or section 62A.04, subdivision 1, or 62A.15, subdivision 3a.

~~(n)~~ (o) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

~~(o)~~ (p) "Sickness" shall not be defined more restrictively than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under a workers' compensation, occupational disease, employer's liability, or similar law.

Sec. 32. Minnesota Statutes 1994, section 62A.315, is amended to read:

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

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

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

(2) coverage for the daily copayment amount of Medicare part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the copayment amount of Medicare eligible expenses under Medicare part B regardless of hospital confinement, and the Medicare part B deductible amount;

(4) 80 percent of the usual and customary hospital and medical expenses and supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation established by the Medicare program or state law, the usual and customary hospital and medical expenses and supplies, described in section 62E.06, subdivision 1, while in a foreign country, and prescription drug expenses, not covered by ~~Medicare's eligible expenses~~ Medicare;

(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 and routine screening procedures for cancer, including mammograms and pap smears;

(7) preventive medical care benefit: coverage for the following preventive health services:

(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) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) fecal occult blood test and/or digital rectal examination;

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(C) pure tone (air only) hearing screening test administered or ordered by a physician;

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

(iii) any other tests or preventive measures determined appropriate by the attending physician.

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

(8) at–home recovery benefit: 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 shall 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 aide, 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 medically necessary by the insured's attending physician. The total number of at–home recovery visits shall not exceed the number of Medicare–approved home health 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.

Sec. 33. Minnesota Statutes 1994, section 62A.318, is amended to read:

62A.318 **MEDICARE SELECT POLICIES AND CERTIFICATES.**

(a) This section applies to Medicare select policies and certificates, as defined in this section, including those issued by health maintenance organizations. No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

(b) For the purposes of this section:

(1) "complaint" means any dissatisfaction expressed by an individual concerning a Medicare select issuer or its network providers;

(2) "grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare select issuer or its network providers;

(3) "Medicare select issuer" means an issuer offering, or seeking to offer, a Medicare select policy or certificate;

(4) "Medicare select policy" or "Medicare select certificate" means a Medicare supplement policy or certificate that contains restricted network provisions;

(5) "network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy or certificate;

(6) "restricted network provision" means a provision that conditions the payment of benefits, in whole or in part, on the use of network providers; and

(7) "service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare select policy or certificate.

(c) The commissioner may authorize an issuer to offer a Medicare select policy or certificate pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, Public Law Number 101–508, if the commissioner finds that the issuer has satisfied all of the requirements of Minnesota Statutes.

(d) A Medicare select issuer shall not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(e) A Medicare select issuer shall file a proposed plan of operation with the commissioner, in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(i) the services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

(ii) the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(A) to deliver adequately all services that are subject to a restricted network provision; or

(B) to make appropriate referrals;

(iii) there are written agreements with network providers describing specific responsibilities;

(iv) emergency care is available 24 hours per day and seven days per week; and

(v) in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against an individual insured under a Medicare select policy or certificate. This section does not apply to supplemental charges or coinsurance amounts as stated in the Medicare select policy or certificate;

(2) a statement or map providing a clear description of the service area;

(3) a description of the grievance procedure to be used;

(4) a description of the quality assurance program, including:

(i) the formal organizational structure;

(ii) the written criteria for selection, retention, and removal of network providers; and

(iii) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted;

(5) a list and description, by specialty, of the network providers;

(6) copies of the written information proposed to be used by the issuer to comply with paragraph (i); and

(7) any other information requested by the commissioner.

(f) A Medicare select issuer shall file proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner before implementing the changes. The changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

An updated list of network providers shall be filed with the commissioner at least quarterly.

(g) A Medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or condition; and

(2) it is not reasonable to obtain the services through a network provider.

(h) A Medicare select policy or certificate shall provide payment for full coverage under the policy or certificate for covered services that are not available through network providers.

(i) A Medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare select policy or certificate to each applicant. This disclosure must include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate with:

(i) other Medicare supplement policies or certificates offered by the issuer; and

(ii) other Medicare select policies or certificates;

(2) a description, including address, phone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are used;

(4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

(7) a description of the Medicare select issuer's quality assurance program and grievance procedure.

(j) Before the sale of a Medicare select policy or certificate, a Medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to paragraph (i) and that the applicant understands the restrictions of the Medicare select policy or certificate.

(k) A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure must be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances must be considered in a timely manner and must be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action must be taken promptly.

(5) All concerned parties must be notified about the results of a grievance.

(6) The issuer shall report no later than March 31 of each year to the commissioner regarding the grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of the grievances.

(l) At the time of initial purchase, a Medicare select issuer shall make available to each applicant for a Medicare select policy or certificate the opportunity to purchase a Medicare supplement policy or certificate otherwise offered by the issuer.

(m)(1) At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare supplement policy or certificate has been in force for six months. If the issuer does not have available for sale a policy or certificate without restrictive network provisions, the issuer shall provide enrollment information for the Minnesota comprehensive health association Medicare supplement plans.

(2) For the purposes of this paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare part A deductible, coverage for prescription drugs, coverage for at–home recovery services, or coverage for part B excess charges.

(n) Medicare select policies and certificates shall provide for continuation of coverage if the secretary of health and human services determines that Medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare select program to be reauthorized under law or its substantial amendment.

(1) Each Medicare select issuer shall make available to each individual insured under a Medicare select policy or certificate the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare part A deductible, coverage for prescription drugs, coverage for at–home recovery services, or coverage for part B excess charges.

(o) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare select program.

(p) Medicare select policies and certificates under this section shall be regulated and approved by the department of commerce.

(q) Medicare select policies and certificates must be either a basic plan or an extended basic plan. Before a Medicare select policy or certificate is sold or issued in this state, the applicant must be provided with an explanation of coverage for both a Medicare select basic and a Medicare select extended basic policy or certificate and must be provided with the opportunity of purchasing either a Medicare select basic or a Medicare select extended basic policy. The basic plan may also include any of the optional benefit riders authorized by section 62A.316. Preventive care provided by Medicare select policies or certificates must be provided as set forth in section 62A.315 or 62A.316, except that the benefits are as defined in chapter 62D.

(r) Medicare select policies and certificates are exempt from the requirements of section 62A.31, subdivision 1, paragraph (d). This paragraph expires January 1, 1994.

Sec. 34. Minnesota Statutes 1994, section 62A.39, is amended to read:

62A.39 **DISCLOSURE.**

No individual Medicare supplement plan shall be delivered or issued in this state and no certificate shall be delivered under a group Medicare supplement plan delivered or issued in this state unless the plan is shown on the cover page and an outline containing at least the following information in no less than 12–point type is delivered to the applicant at the time the application is made:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the exceptions, reductions, and limitations contained in the policy including the following language, as applicable, in bold print: "THIS POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THIS POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.";

(c) A statement of the renewal provisions including any reservations by the insurer of a right to change premiums. The premium and manner of payment shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated;

(d) **READ YOUR POLICY OR CERTIFICATE VERY CAREFULLY.** A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions. Additionally, it does not give all the details of Medicare coverage. Contact your local Social Security office or consult the Medicare handbook for more details;

(e) A statement of the policy's loss ratio as follows: "This policy provides an anticipated loss ratio of (..%). This means that, on the average, policyholders may expect that ($....) of every $100.00 in premium will be returned as benefits to policyholders over the life of the contract.";

(f) When the outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the

outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12–point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.";

(g) **RIGHT TO RETURN POLICY OR CERTIFICATE.** "If you find that you are not satisfied with your policy or certificate for any reason, you may return it to (insert issuer's address). If you send the policy or certificate back to us within 30 days after you receive it, we will treat the policy or certificate as if it had never been issued and return all of your payments within ten days.";

(h) **POLICY OR CERTIFICATE REPLACEMENT.** "If you are replacing another health insurance policy or certificate, do NOT cancel it until you have actually received your new policy or certificate and are sure you want to keep it.";

(i) **NOTICE.** "This policy or certificate may not fully cover all of your medical costs."

A. (for agents:)

"Neither (insert company's name) nor its agents are connected with Medicare."

B. (for direct response:)

"(insert company's name) is not connected with Medicare."

(j) Notice regarding policies or certificates which are not Medicare supplement policies.

Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, or a policy or certificate issued pursuant to a contract under the federal Social Security Act, section 1833 or 1876 (United States Code, title 42, section 1395, et seq.), disability income policy; ~~basic, catastrophic, or major medical expense policy; single premium nonrenewable policy;~~ or other policy, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12–point type and shall contain the following language:

"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the ~~Medicare supplement buyer's~~ "Guide to Health Insurance for People with Medicare" available from the company."

(k) **COMPLETE ANSWERS ARE VERY IMPORTANT.** "When you fill out the application for the new policy or certificate, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy or certificate and refuse to pay any claims if you leave out or falsify important medical information." If the policy or certificate is guaranteed issue, this paragraph need not appear.

"Review the application carefully before you sign it. Be certain that all information has been properly recorded."

Include for each plan, prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments, and insured payments for each plan, using the same language, in the same order, using uniform layout and format.

The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the insurer.

Sec. 35. Minnesota Statutes 1994, section 62A.44, subdivision 2, is amended to read:

Subd. 2. **QUESTIONS.** (a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing the questions and statements may be used.

"(1) You do not need more than one Medicare supplement policy or certificate.

(2) If you ~~are 65 or older,~~ purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy or certificate.

~~(3)~~ (4) The benefits and premiums under your Medicare supplement policy or certificate ~~will~~ can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy or certificate will be reinstated if requested within 90 days of losing Medicaid eligibility.

(5) Counseling services may be available in Minnesota to provide advice concerning medical assistance through state Medicaid, Qualified Medicare Beneficiaries (QMBs), and Specified Low-Income Medicare Beneficiaries (SLMBs).

To the best of your knowledge:

(1) Do you have another Medicare supplement policy or certificate in force~~, including health care service contract or health maintenance organization contract~~?

(a) If so, with which company?

(b) If so, do you intend to replace your current Medicare supplement policy with this policy or certificate?

(2) Do you have any other health insurance policies that provide benefits ~~that~~ which this Medicare supplement policy or certificate would duplicate?

(a) If ~~you do~~ so, please name the company ~~and the~~.

(b) What kind of policy~~.~~?

(3) ~~If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy or certificate?~~

~~(4)~~ Are you covered ~~by~~ for medical assistance through the state Medicaid program? If so, which of the following programs provides coverage for you?

a. Specified Low–Income Medicare Beneficiary (SLMB),

b. Qualified Medicare Beneficiary (QMB), or

c. full Medicaid Beneficiary?"

(b) Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold that are still in force.

(2) List policies sold in the past five years that are no longer in force.

(c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer on delivery of the policy or certificate.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, before issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy or certificate the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by paragraph (d) for an issuer shall be provided in substantially the following form in no less than 12–point type:

"NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT 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 terminate existing Medicare supplement insurance and replace it with a policy or certificate to be issued by (Company Name) Insurance Company. Your new policy or certificate will provide 30 days within which you may decide without cost whether you desire to keep the policy or certificate.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. ~~Terminate your present policy only~~ If, after due consid-

eration, you find that purchase of this Medicare supplement coverage is a wise decision you should terminate your present Medicare supplement policy. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, (BROKER OR OTHER REPRESENTATIVE): I have reviewed your current medical or health insurance coverage. ~~The replacement of insurance involved in this transaction does not duplicate coverage.~~ To the best of my knowledge this Medicare supplement policy will not duplicate your existing Medicare supplement policy because you intend to terminate the existing Medicare supplement policy. The replacement policy or certificate is being purchased for the following reason(s) (check one):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ Other (please specify)

_____

_____

_____

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

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

(3) If you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and 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 or certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Do not cancel your present policy or certificate until you have received your new policy or certificate and you are sure that you want to keep it.

_____

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

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

_____

(Typed Name and Address of Issuer, Agent, or Broker)

_____

(Date)

_____

(Applicant's Signature)

_____

(Date)*

*Signature not required for direct response sales."

(f) Paragraph (e), clauses (1) and (2), of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

Sec. 36. Minnesota Statutes 1995 Supplement, section 62A.46, subdivision 2, is amended to read:

Subd. 2. **LONG–TERM CARE POLICY.** "Long–term care policy" means an individual or group policy, certificate, subscriber contract, or other evidence of coverage that provides benefits for prescribed long–term care, including nursing facility services ~~and~~ or home care services, or both nursing facility services and home care services, pursuant to the requirements of sections 62A.46 to 62A.56.

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

Sec. 37. Minnesota Statutes 1995 Supplement, section 62A.48, subdivision 1, is amended to read:

Subdivision 1. **POLICY REQUIREMENTS.** No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long–term care services shall be offered, issued, delivered, or renewed in this state, whether or not the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long–term care policy must cover prescribed long–term care

in nursing facilities ~~and at least~~ or the prescribed long–term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. A long–term care policy may cover both prescribed long–term care in nursing facilities and the prescribed long–term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long–term care policy, other than one that covers only nursing facility services, must include: a minimum lifetime benefit limit of at least $25,000 for services, ~~and~~. A long–term care policy that covers only nursing facility services must include a minimum lifetime benefit limit of not less than one year of nursing facility services. Nursing facility and home care coverages under a long–term care policy must not be subject to separate lifetime maximums for policies that cover both nursing facility and home health care. Prior hospitalization may not be required under a long–term care policy.

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

No individual long–term care policy shall be offered or delivered in this state until the insurer has received from the insured a written designation of at least one person, in addition to the insured, who is to receive notice of cancellation of the policy for nonpayment of premium. The insured has the right to designate up to a total of three persons who are to receive the notice of cancellation, in addition to the insured. The form used for the written designation must inform the insured that designation of one person is required and that designation of up to two additional persons is optional and must provide space clearly designated for listing between one and three persons. The designation shall include each person's full name, home address, and telephone number. Each time an individual policy is renewed or continued, the insurer shall notify the insured of the right to change this written designation.

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

Sec. 38. Minnesota Statutes 1994, section 62A.49, subdivision 1, is amended to read:

Subdivision 1. **GENERALLY.** Section 62A.48 does not prohibit the sale of policies, certificates, subscriber contracts, or other evidences of coverage that provide home care services only. ~~This does not, however, remove the requirement that home care service benefits must be provided as part of a long-term care policy pursuant to that section.~~ Home care services only policies may be sold, provided that they meet the requirements set forth in sections 62A.46 to 62A.56, except that they do not have to meet those conditions that relate to long-term care in nursing facilities. Disclosures and representations regarding these policies must be adjusted accordingly to remove references to coverage for nursing home care.

Sec. 39. Minnesota Statutes 1994, section 62A.60, is amended to read:

62A.60 **RETROACTIVE DENIAL OF EXPENSES.**

In cases where the subscriber or insured is liable for costs beyond applicable copayments or deductibles, no insurer may retroactively deny payment to a person who is covered when the services are provided for health care services that are otherwise covered, if the insurer or its representative failed to provide prior or concurrent review or authorization for the expenses when required to do so under the policy, plan, or certificate. If prior or concurrent review or authorization was provided by the insurer or its representative, and the preexisting condition limitation provision, the general exclusion provision and any other coinsurance, or other policy requirements have been met, the insurer may not deny payment for the authorized service or time period except in cases where fraud or substantive misrepresentation occurred.

Sec. 40. Minnesota Statutes 1995 Supplement, section 62C.14, subdivision 14, is amended to read:

Subd. 14. No subscriber's individual contract or any group contract which provides for coverage of family members or other dependents of a subscriber or of an employee or other group member of a group subscriber, shall be renewed, delivered, or issued for delivery in this state unless such contract includes as covered family members or dependents any newborn infants~~, including dependent grandchildren,~~ immediately from the moment of birth and thereafter which insurance shall provide coverage for illness, injury, congenital malformation or premature birth. For purposes of this paragraph, "newborn infants" includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. No policy, contract, or agreement covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy, contract, or agreement mandates an additional premium for each dependent, the health carrier shall be 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. 41. Minnesota Statutes 1995 Supplement, section 62E.05, subdivision 1, is amended to read:

Subdivision 1. **CERTIFICATION.** Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified medicare supplement plan for the purposes of sections 62E.01 to 62E.16, the commissioner shall make a determination within 90 days as to whether the plan is qualified. All

plans of health coverage, except Medicare supplement policies, shall be labeled as "qualified" or "nonqualified" on the front of the policy or ~~evidence of insurance~~ contract, or on the schedule page. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

Sec. 42. Minnesota Statutes 1995 Supplement, section 62F.02, subdivision 2, is amended to read:

Subd. 2. **DIRECTORS.** The association shall have a board of directors composed of 11 persons chosen for a term of four years as follows: five persons elected by members of the association at a meeting called by the commissioner; three members who are health care providers appointed by the commissioner prior to the election by the association; and three public members, as defined in section 214.02, appointed by the governor prior to the election by the association. If the commissioner determines that it is no longer cost-effective or efficient to operate a separate board of directors to administer the medical malpractice joint underwriting association, the commissioner shall deactivate the board and assign all of the board's authority and responsibilities under this chapter to the Minnesota joint underwriting association board of directors established under section 62I.02.

Sec. 43. Minnesota Statutes 1994, section 62F.03, subdivision 6, is amended to read:

Subd. 6. "Net direct premiums" means gross direct premiums written on personal injury liability insurance, including the liability component of multiple peril package policies as computed by the commissioner, less return premiums for the unused or unabsorbed portions of premium deposits. Net direct premiums do not include policyholder dividends.

Sec. 44. Minnesota Statutes 1994, section 62F.04, subdivision 1a, is amended to read:

Subd. 1a. **REAUTHORIZATION.** The authorization to issue insurance is valid for a period of two years from the date it was made. The commissioner may reauthorize the issuance of insurance for additional two-year periods ~~under the terms of subdivision 1~~ according to the procedures set forth in sections 62I.21 and 62I.22. This subdivision is not a limitation on the number of times the commissioner may reauthorize the issuance of insurance.

Sec. 45. Minnesota Statutes 1994, section 62I.02, subdivision 2, is amended to read:

Subd. 2. ~~**DIRECTOR**~~ **BOARD OF DIRECTORS.** The association shall have a board of directors composed of 11 persons chosen as follows: five persons elected by members of the association at a meeting called by the commissioner; three public members, as defined in section 214.02, appointed by the commissioner; and three members, appointed by the commissioner representing groups to whom coverage has been extended by the association. The terms of the members shall be four years. Terms may be staggered so that no more than six members are appointed or elected every two years. Members may serve until their successors are appointed or elected. If at any time no coverage is currently extended by the association, then either additional public members may be appointed to fill these three positions or, at the option of the commissioner, representatives from groups who had previously been covered by the association may serve as directors. In the event that the commissioner assigns the responsibility for administering chapter 62F to the Minnesota joint underwriting association, the board of directors must be increased by four additional members. The commissioner shall appoint two of the

additional members, one of whom must be a licensed health care provider, and one of whom must be a public member. Association members shall elect the other two members, one of whom must be a representative of medical malpractice insurers, and one of whom must be a representative of personal injury liability insurers.

Sec. 46. Minnesota Statutes 1994, section 62I.02, subdivision 5, is amended to read:

Subd. 5. **ACCOUNTS.** (a) For the purposes of administration and assessment, and except as otherwise authorized under paragraph (b), the association shall be divided into two separate accounts:

(1) the property and casualty insurance account; and

(2) the personal injury liability insurance ~~account~~ account–liquor.

(b) If the association is authorized by the commissioner to issue medical malpractice insurance, the association shall establish a third account for purposes of administration and assessment. This account must be identified as the personal injury liability insurance account–medical malpractice.

Sec. 47. Minnesota Statutes 1994, section 62I.02, is amended by adding a subdivision to read:

Subd. 6. **MEDICAL MALPRACTICE.** If the association is authorized by the commissioner to issue medical malpractice insurance, it shall administer the medical malpractice insurance program according to chapter 62F.

Sec. 48. Minnesota Statutes 1994, section 62I.07, is amended to read:

62I.07 **MEMBERSHIP ASSESSMENTS.**

Subdivision 1. **GENERAL ASSESSMENT.** Each member of the association that is authorized to write property and casualty insurance in the state shall participate in its losses and expenses in the proportion that the direct written premiums of the member on the kinds of insurance in that account bears to the total aggregate direct written premiums written in this state by all members on the kinds of insurance in that account. The members' participation in the association shall be determined annually on the direct written premiums written during the preceding calendar year as reported on the annual statements and other reports filed by the member with the commissioner. Direct written premiums mean that amount at page 14, column (2), lines 5, 8, 9, 17, 21.2, 22, 23, 24, 25, 26, and 27 of the annual statement filed annually with the department of commerce under section 60A.13.

Subd. 2. **PERSONAL INJURY LIABILITY INSURANCE ASSESSMENT; LIQUOR LIABILITY.** A member of the association shall participate in its writings, expenses, servicing allowance, management fees, and losses in the proportion that the net direct premiums of the member, excluding that portion of premiums attributable to the operation of the association, written during the preceding calendar year on the kinds of insurance in that account bears to the aggregate net direct premiums written in this state by all members on the kinds of insurance in that account. The member's participation in the association shall be determined annually on the basis of net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the member with the commissioner. Net direct premiums mean gross direct pre-

miums written on personal injury liability insurance, including the liability component of multiple peril package policies as computed by the commissioner, less return premiums for the unused or unabsorbed portions of premium deposits. The net direct premiums are calculated using lines 5.2 CMP, and 17–other liability from page 14, column (2) of the annual statement filed annually with the department of commerce pursuant to section 60A.13.

Subd. 3. **PERSONAL INJURY LIABILITY INSURANCE ASSESSMENT; MEDICAL MALPRACTICE.** If an assessment is needed for medical malpractice, the assessment is made using the following lines from page 14, column (2) of the annual statement filed annually with the department of commerce pursuant to section 60A.13 using the following lines: 5.2 commercial multiperil liability, 11 medical malpractice, 17–other liability, 19.1 PIP–private passenger, 19.3 PIP–commercial.

Sec. 49. Minnesota Statutes 1994, section 62L.09, subdivision 3, is amended to read:

Subd. 3. **REENTRY PROHIBITION.** (a) Except as otherwise provided in paragraph (b), a health carrier that ceases to do business in the small employer market after July 1, 1993, is prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the commissioner. This subdivision applies to any health maintenance organization that ceases to do business in the small employer market in one service area with respect to that service area only. Nothing in this subdivision prohibits an affiliated health maintenance organization from continuing to do business in the small employer market in that same service area.

(b) The commissioner of commerce or the commissioner of health may permit a health carrier that ceases to do business in the small employer market in this state after July 1, 1993, to begin writing new business in the small employer market if:

(1) since the carrier ceased doing business in the small employer market, legislative action has occurred that has significantly changed the effect on the carrier of its decision to cease doing business in the small employer market; and

(2) the commissioner deems it appropriate.

Sec. 50. **[62Q.49] ENROLLEE COST SHARING; NEGOTIATED PROVIDER PAYMENTS.**

Subdivision 1. **APPLICABILITY.** This section applies to all health plans, as defined in section 62Q.01, subdivision 3, that provide coverage for health care to be provided entirely or partially:

(1) through contracts in which health care providers agree to accept discounted charges, negotiated charges, or other limits on health care provider charges;

(2) by employees of, or facilities or entities owned by, the issuer of the health plan; or

(3) through contracts with health care providers that provide for payment to the providers on a fully or partially capitated basis or on any other non–fee–for–service basis.

Subd. 2. **DISCLOSURE REQUIRED.** (a) All health plans included in subdivision 1 must clearly specify how the cost of health care used to calculate any copayments, coinsurance, or lifetime benefits will be affected by the arrangements described in subdivision 1.

(b) Any summary or other marketing material used in connection with marketing of a health plan that is subject to this section must prominently disclose and clearly explain the provisions required under paragraph (a), if the summary or other marketing material refers to copayments, coinsurance, or maximum lifetime benefits.

(c) A health plan that is subject to paragraph (a) must not be used in this state if the commissioner of commerce or health, as appropriate, has determined that it does not comply with this section.

Sec. 51. **[62Q.50] PROSTATE CANCER SCREENING.**

A health plan must cover prostate cancer screening for men 40 years of age or over who are symptomatic or in a high–risk category and for all men 50 years of age or older.

The screening must consist at a minimum of a prostate–specific antigen blood test and a digital rectal examination.

This coverage is subject to any deductible, coinsurance, copayment, or other limitation on coverage applicable to other coverages under the plan.

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

Sec. 52. **[62Q.51] POINT–OF–SERVICE OPTION.**

Subdivision 1. **DEFINITION.** For purposes for this section, "point–of–service option" means a health plan under which the health plan company will reimburse an appropriately licensed or registered provider for providing covered services to an enrollee, without regard to whether the provider belongs to a particular network and without regard to whether the enrollee was referred to the provider by another provider.

Subd. 2. **REQUIRED POINT–OF–SERVICE OPTION.** Each health plan company operating in the small group or large group market shall offer at least one point–of–service option in each such market in which it operates.

Subd. 3. **RATE APPROVAL.** The premium rates and cost sharing requirements for each option must be submitted to the commissioner of health or the commissioner of commerce as required by law. A health plan that includes lower enrollee cost sharing for services provided by network providers than for services provided by out–of–network providers, or lower enrollee cost sharing for services provided with prior authorization or second opinion than for services provided without prior authorization or second opinion, qualifies as a point–of–service option.

Subd. 4. **EXEMPTION.** This section does not apply to a health plan company with fewer than 50,000 enrollees.

Sec. 53. Minnesota Statutes 1994, section 65A.01, subdivision 3, is amended to read:

Subd. 3. **POLICY PROVISIONS.** On said policy following such matter as provided in subdivisions 1 and 2, printed in the English language in type of such size or sizes and arranged in such manner, as is approved by the commissioner of commerce, the following provisions and subject matter shall be stated in the following words and in the following sequence, but with the convenient placing, if desired, of such matter as will act

as a cover or back for such policy when folded, with the blanks below indicated being left to be filled in at the time of the issuing of the policy, to wit:

(Space for listing the amounts of insurance, rates and premiums for the basic coverages provided under the standard form of policy and for additional coverages or perils provided under endorsements attached. The description and location of the property covered and the insurable value(s) of any building(s) or structure(s) covered by the policy or its attached endorsements; also in the above space may be stated whether other insurance is limited and if limited the total amount permitted.)

In consideration of the provisions and stipulations herein or added hereto and of the premium above specified this company, for a term of ..... from ..... (At 12:01 a.m. Standard Time) to ..... (At 12:01 a.m. Standard Time) at location of property involved, to an amount not exceeding the amount(s) above specified does insure ..... and legal representatives .....

(In above space may be stated whether other insurance is limited.) (And if limited the total amount permitted.)

Subject to form No.(s) ..... attached hereto.

This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which are hereby made a part of this policy, together with such provisions, stipulations and agreements as may be added hereto as provided in this policy.

The insurance effected above is granted against all loss or damage by fire originating from any cause, except as hereinafter provided, also any damage by lightning and by removal from premises endangered by the perils insured against in this policy, to the property described hereinafter while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere. The amount of said loss or damage, except in case of total loss on buildings, to be estimated according to the actual value of the insured property at the time when such loss or damage happens.

If the insured property shall be exposed to loss or damage from the perils insured against, the insured shall make all reasonable exertions to save and protect same.

This entire policy shall be void if, whether before a loss, the insured has willfully, or after a loss, the insured has willfully and with intent to defraud, concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interests of the insured therein.

This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money or securities; nor, unless specifically named hereon in writing, bullion, or manuscripts.

This company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly by: (a) enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order of any civil authority except acts of destruction at the time of

and for the purpose of preventing the spread of fire, providing that such fire did not originate from any of the perils excluded by this policy.

Other insurance may be prohibited or the amount of insurance may be limited by so providing in the policy or an endorsement, rider or form attached thereto.

Unless otherwise provided in writing added hereto this company shall not be liable for loss occurring:

(a) while the hazard is increased by any means within the control or knowledge of the insured; or

(b) while the described premises, whether intended for occupancy by owner or tenant, are vacant or unoccupied beyond a period of 60 consecutive days; or

(c) as a result of explosion or riot, unless fire ensue, and in that event for loss by fire only.

Any other peril to be insured against or subject of insurance to be covered in this policy shall be by endorsement in writing hereon or added hereto.

The extent of the application of insurance under this policy and the contributions to be made by this company in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provision may be waived except such as by the terms of this policy is subject to change.

No permission affecting this insurance shall exist, or waiver of any provision be valid, unless granted herein or expressed in writing added hereto. No provision, stipulation or forfeiture shall be held to be waived by any requirements or proceeding on the part of this company relating to appraisal or to any examination provided for herein.

This policy shall be canceled at any time at the request of the insured, in which case this company shall, upon demand and surrender of this policy, refund the excess of paid premium above the customary short rates for the expired time. This policy may be canceled at any time by this company by giving to the insured ~~a ten~~ 30 days' written notice of cancellation with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not tendered, shall be refunded on demand. Notice of cancellation shall state that said excess premium (if not tendered) will be refunded on demand.

If loss hereunder is made payable, in whole or in part, to a designated mortgagee or contract for deed vendor not named herein as insured, such interest in this policy may be canceled by giving to such mortgagee or vendor a ten days' written notice of cancellation.

Notwithstanding any other provisions of this policy, if this policy shall be made payable to a mortgagee or contract for deed vendor of the covered real estate, no act or default of any person other than such mortgagee or vendor or the mortgagee's or vendor's agent or those claiming under the mortgagee or vendor, whether the same occurs before or during the term of this policy, shall render this policy void as to such mortgagee or vendor nor affect such mortgagee's or vendor's right to recover in case of loss on such real estate; provided, that the mortgagee or vendor shall on demand pay according to the established scale of rates for any increase of risks not paid for by the insured; and whenever this com-

pany shall be liable to a mortgagee or vendor for any sum for loss under this policy for which no liability exists as to the mortgagor, vendee, or owner, and this company shall elect by itself, or with others, to pay the mortgagee or vendor the full amount secured by such mortgage or contract for deed, then the mortgagee or vendor shall assign and transfer to the company the mortgagee's or vendor's interest, upon such payment, in the said mortgage or contract for deed together with the note and debts thereby secured.

This company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved.

In case of any loss under this policy the insured shall give immediate written notice to this company of any loss, protect the property from further damage, and a statement in writing, signed and sworn to by the insured, shall within 60 days be rendered to the company, setting forth the value of the property insured, except in case of total loss on buildings the value of said buildings need not be stated, the interest of the insured therein, all other insurance thereon, in detail, the purposes for which and the persons by whom the building insured, or containing the property insured, was used, and the time at which and manner in which the fire originated, so far as known to the insured.

The insured, as often as may be reasonably required, shall exhibit to any person designated by this company all that remains of any property herein described, and, after being informed of the right to counsel and that any answers may be used against the insured in later civil or criminal proceedings, the insured shall, within a reasonable period after demand by this company, submit to examinations under oath by any person named by this company, and subscribe the oath. The insured, as often as may be reasonably required, shall produce for examination all records and documents reasonably related to the loss, or certified copies thereof if originals are lost, at a reasonable time and place designated by this company or its representatives, and shall permit extracts and copies thereof to be made.

In case the insured and this company, except in case of total loss on buildings, shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within 20 days of such demand. In case either fails to select an appraiser within the time provided, then a presiding judge of the district court of the county wherein the loss occurs may appoint such appraiser for such party upon application of the other party in writing by giving five days' notice thereof in writing to the party failing to appoint. The appraisers shall first select a competent and disinterested umpire; and failing for 15 days to agree upon such umpire, then a presiding judge of the above mentioned court may appoint such an umpire upon application of party in writing by giving five days' notice thereof in writing to the other party. The appraisers shall then appraise the loss, stating separately actual value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this company shall determine the amount of actual value and loss. Each appraiser shall be paid by the selecting party, or the party for whom selected, and the expense of the appraisal and umpire shall be paid by the parties equally.

It shall be optional with this company to take all of the property at the agreed or appraised value, and also to repair, rebuild or replace the property destroyed or damaged

with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within 30 days after the receipt of the proof of loss herein required.

There can be no abandonment to this company of any property.

The amount of loss for which this company may be liable shall be payable 60 days after proof of loss, as herein provided, is received by this company and ascertainment of the loss is made either by agreement between the insured and this company expressed in writing or by the filing with this company of an award as herein provided. It is moreover understood that there can be no abandonment of the property insured to the company, and that the company will not in any case be liable for more than the sum insured, with interest thereon from the time when the loss shall become payable, as above provided.

No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy have been complied with, and unless commenced within two years after inception of the loss.

This company is subrogated to, and may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefor is made by this company; and the insurer may prosecute therefor in the name of the insured retaining such amount as the insurer has paid.

Assignment of this policy shall not be valid except with the written consent of this company.

IN WITNESS WHEREOF, this company has executed and attested these presents.

.....	.....
(Signature)	(Signature)
.....	.....
(Name of office)	(Name of office)

Sec. 54. Minnesota Statutes 1994, section 65A.10, subdivision 1, is amended to read:

Subdivision 1. **BUILDINGS.** Nothing contained in sections 65A.08 and 65A.09 shall be construed to preclude insurance against the cost, in excess of actual cash value at the time any loss or damage occurs, of actually repairing, rebuilding or replacing the insured property. Subject to any applicable policy limits, where an insurer offers replacement cost insurance~~,~~: (i) the insurance must cover the cost of replacing, rebuilding, or repairing any loss or damaged property in accordance with the minimum code as required by state or local authorities; and (ii) the insurance coverage may not be conditioned on replacing or rebuilding the damaged property at its original location on the owner's property if the structure must be relocated because of zoning or land use regulations of state or local government. In the case of a partial loss, unless more extensive coverage is otherwise specified in the policy, this coverage applies only to the damaged portion of the property.

Sec. 55. Minnesota Statutes 1994, section 65A.295, is amended to read:

65A.295 **HOMEOWNER'S INSURANCE COVERAGE.**

(a) Every insurer writing homeowner's insurance in this state shall make available at least one form of homeowner's policy for each level of peril coverage offered by the insurer in which the insured has the option to specify the dollar amount of coverage provided for structures other than the dwelling and for personal property. The premium must be reduced to reflect the reduced risk of lesser coverage.

(b) ~~A written notice must be provided to all applicants for homeowner's insurance at the time of application informing them of the options provided in paragraph (a).~~

~~(c)~~ Coverage for structures other than the dwelling is the coverage provided under "Coverage B, Other Structures" in the standard homeowner's policy. Coverage for personal property is the coverage provided under "Coverage C, Personal Property" in the standard homeowner's package policy.

~~(d)~~ (c) "Level of peril" refers to basic, broad, and all risk levels of coverage.

Sec. 56. Minnesota Statutes 1994, section 65B.14, is amended by adding a subdivision to read:

Subd. 5. **VIOLATIONS.** "Violations" means all moving traffic violations that are recorded by the department of public safety on a household member's motor vehicle record, and violations reported by a similar authority in another state or moving traffic violations reported by the insured.

Sec. 57. Minnesota Statutes 1994, section 65B.15, subdivision 1, is amended to read:

Subdivision 1. No cancellation or reduction in the limits of liability of coverage during the policy period of any policy shall be effective unless notice thereof is given and unless based on one or more reasons stated in the policy which shall be limited to the following:

1. Nonpayment of premium; or

2. The policy was obtained through a material misrepresentation; or

3. Any insured made a false or fraudulent claim or knowingly aided or abetted another in the presentation of such a claim; or

4. The named insured failed to disclose fully motor vehicle accidents and moving traffic violations of the named insured for the preceding 36 months if called for in the written application; or

5. The named insured failed to disclose in the written application any requested information necessary for the acceptance or proper rating of the risk; or

6. The named insured knowingly failed to give any required written notice of loss or notice of lawsuit commenced against the named insured, or, when requested, refused to cooperate in the investigation of a claim or defense of a lawsuit; or

7. The named insured or any other operator who either resides in the same household, or customarily operates an automobile insured under such policy, unless the other operator is identified as a named insured in another policy as an insured;

(a) has, within the 36 months prior to the notice of cancellation, had that person's driver's license under suspension or revocation because the person committed a moving traffic violation or because the person refused to be tested under section 169.121, subdivision 1, paragraph (a); or

(b) is or becomes subject to epilepsy or heart attacks, and such individual does not produce a written opinion from a physician testifying to that person's medical ability to operate a motor vehicle safely, such opinion to be based upon a reasonable medical probability; or

(c) has an accident record, conviction record (criminal or traffic), physical condition or mental condition, any one or all of which are such that the person's operation of an automobile might endanger the public safety; or

(d) has been convicted, or forfeited bail, during the 24 months immediately preceding the notice of cancellation for criminal negligence in the use or operation of an automobile, or assault arising out of the operation of a motor vehicle, or operating a motor vehicle while in an intoxicated condition or while under the influence of drugs; or leaving the scene of an accident without stopping to report; or making false statements in an application for a driver's license, or theft or unlawful taking of a motor vehicle; or

(e) has been convicted of, or forfeited bail for, one or more violations within the 18 months immediately preceding the notice of cancellation, of any law, ordinance, or rule which justify a revocation of a driver's license.

8. The insured automobile is:

(1) so mechanically defective that its operation might endanger public safety; or

(2) used in carrying passengers for hire or compensation, provided however that the use of an automobile for a car pool shall not be considered use of an automobile for hire or compensation; or

(3) used in the business of transportation of flammables or explosives; or

(4) an authorized emergency vehicle; or

(5) subject to an inspection law and has not been inspected or, if inspected, has failed to qualify within the period specified under such inspection law; or

(6) substantially changed in type or condition during the policy period, increasing the risk substantially, such as conversion to a commercial type vehicle, a dragster, sports car or so as to give clear evidence of a use other than the original use.

Sec. 58. Minnesota Statutes 1995 Supplement, section 65B.47, subdivision 1a, is amended to read:

Subd. 1a. **EXEMPTIONS.** Subdivision 1 does not apply to:

(1) a commuter van;

(2) a vehicle being used to transport children as part of a family or group family day care program;

(3) a vehicle being used to transport children to school or to a school–sponsored activity;

(4) a bus while it is in operation within the state of Minnesota as to any Minnesota resident who is an insured as defined in section 65B.43, subdivision 5;

(5) a passenger in a taxi; or

(6) a taxi driver, provided that this clause applies only to policies issued or renewed on or after September 1, 1996, and prior to September 1, 1997.

Sec. 59. Minnesota Statutes 1994, section 65B.64, subdivision 3, is amended to read:

Subd. 3. A person shall not be entitled to basic economic loss benefits through the assigned claims plan with respect to injury which was sustained if at the time of such injury the injured person was the owner of a private passenger motor vehicle for which security is required under sections 65B.41 to 65B.71 and that person failed to have such security in effect.

For purposes of determining whether security is required under section 65B.48, an owner of any vehicle is deemed to have contemplated the operation or use of the vehicle at all times unless the owner demonstrates to the contrary by clear and convincing objective evidence.

Persons, whether or not related by blood or marriage, who dwell and function together with the owner as a family, other than adults who have been adjudicated as incompetent and minor children, shall also be disqualified from benefits through the assigned claims plan.

Sec. 60. Minnesota Statutes 1994, section 70A.07, is amended to read:

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

All rates and supplementary rate information, furnished to the commissioner under this chapter shall, as soon as the rates are ~~effective~~ reviewed by the commissioner, be open to public inspection at any reasonable time.

Sec. 61. Minnesota Statutes 1994, section 72A.20, subdivision 17, is amended to read:

Subd. 17. **RETURN OF PREMIUMS.** (a) Refusing, upon surrender of an individual policy of life insurance in the case of the insured's death, or in the case of a surrender prior to death, of an individual insurance policy not covered by the standard nonforfeiture laws under section 61A.24, to refund to the owner all unearned premiums paid on the policy covering the insured as of the time of the insured's death or surrender if the unearned premium is for a period of more than one month.

(b) Refusing, upon termination or cancellation of a policy of automobile insurance under section 65B.14, subdivision 2, or a policy of homeowner's insurance under section 65A.27, subdivision 4, or a policy of accident and sickness insurance under section 62A.01, or a policy of comprehensive health insurance under chapter 62E, to refund to the insured all unearned premiums paid on the policy covering the insured as of the time of the termination or cancellation if the unearned premium is for a period of more than one month. The return of unearned premium must be delivered to the insured within 30 days following receipt by the insurer of the insured's request for cancellation.

(c) This subdivision does not apply to policies of insurance providing coverage only for motorcycles or other seasonally rated or limited use vehicles where the rate is reduced to reflect seasonal or limited use.

(d) For purposes of this section, a premium is unearned during the period of time the insurer has not been exposed to any risk of loss. Except for premiums for motorcycle coverage or other seasonally rated or limited use vehicles where the rate is reduced to reflect seasonal or limited use, the unearned premium is determined by multiplying the premium by the fraction that results from dividing the period of time from the date of termination to the date the next scheduled premium is due by the period of time for which the premium was paid.

(e) The owner may cancel a policy referred to in this section at any time during the policy period. This provision supersedes any inconsistent provision of law or any inconsistent policy provision.

Sec. 62. Minnesota Statutes 1994, section 72A.20, subdivision 23, is amended to read:

Subd. 23. **DISCRIMINATION IN AUTOMOBILE INSURANCE POLICIES.** (a) No insurer that offers an automobile insurance policy in this state shall:

(1) use the employment status of the applicant as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason.

(b) No insurer that offers an automobile insurance policy in this state shall:

(1) use the applicant's status as a tenant, as the term is defined in section 566.18, subdivision 2, as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason; or

(3) make any discrimination in offering or establishing rates, premiums, dividends, or benefits of any kind, or by way of rebate, for the same reason.

(c) No insurer that offers an automobile insurance policy in this state shall:

(1) use the failure of the applicant to have an automobile policy in force during any period of time before the application is made as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason.

This provision does not apply if the applicant was required by law to maintain automobile insurance coverage and failed to do so.

An insurer may require reasonable proof that the applicant did not fail to maintain this coverage. The insurer is not required to accept the mere lack of a conviction or citation for failure to maintain this coverage as proof of failure to maintain coverage. The insurer must provide the applicant with information identifying the documentation that is required to establish reasonable proof that the applicant did not fail to maintain the coverage.

(d) No insurer that offers an automobile insurance policy in this state shall use an applicant's prior claims for benefits paid under section 65B.44 as an underwriting stan-

dard or guideline if the applicant was 50 percent or less negligent in the accident or accidents causing the claims.

Sec. 63. Minnesota Statutes 1994, section 72A.20, subdivision 26, is amended to read:

Subd. 26. **LOSS EXPERIENCE.** An insurer shall without cost to the insured provide an insured with the loss or claims experience of that insured for the current policy period and for the two policy periods preceding the current one for which the insurer has provided coverage, within 30 days of a request for the information by the policyholder. Claims experience data must be provided to the insured in accordance with state and federal requirements regarding the confidentiality of medical data. The insurer shall not be responsible for providing information without cost more often than once in a 12–month period. The insurer is not required to provide the information if the policy covers the employee of more than one employer and the information is not maintained separately for each employer and not all employers request the data.

An insurer, health maintenance organization, or a third–party administrator may not request more than three years of loss or claims experience as a condition of submitting an application or providing coverage.

This subdivision ~~does not apply to individual life and health insurance policies or personal automobile or homeowner's insurance~~ only applies to group life policies and group health policies.

Sec. 64. Minnesota Statutes 1994, section 72A.20, subdivision 30, is amended to read:

Subd. 30. **RECORDS RETENTION.** An insurer shall retain copies of all underwriting documents, policy forms, and applications for three years from the effective date of the policy. An insurer shall retain all claim files and documentation related to a claim for three years from the date the claim was paid or denied. This subdivision does not relieve the insurer of its obligation to produce these documents to the department after the retention period has expired in connection with an enforcement action or administrative proceeding against the insurer from whom the documents are requested, if the insurer has retained the documents. Records required to be retained by this section may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process which accurately reproduces or forms a durable medium for the reproduction of a record.

Sec. 65. Minnesota Statutes 1994, section 72A.20, is amended by adding a subdivision to read:

Subd. 35. **DETERMINATION OF HEALTH PLAN POLICY LIMITS.** Any health plan that includes a specific policy limit within its insurance policy, certificate, or subscriber agreement shall calculate the policy limit by using the amount actually paid on behalf of the insured, subscriber, or dependents for services covered under the policy, subscriber agreement, or certificate unless the amount paid is greater than the billed charge.

Sec. 66. **[72A.207] GRADED DEATH BENEFITS.**

For the purpose of this section, a graded death benefit is a provision within a life insurance policy in which the death benefit, in the early years of the policy, is less than the face amount of the policy, but which increases with the passage of time.

No policy of life insurance paying a graded death benefit may be issued in this state unless the graded death benefit is equal to at least four times the first year premium. This section does not prohibit the return of premiums or premiums plus interest in connection with the voluntary or judicially ordered rescission of the policy, or according to the terms of the exclusions from coverage for suicide, aviation, or war risk.

Sec. 67. Minnesota Statutes 1994, section 148.235, subdivision 2, is amended to read:

Subd. 2. **NURSE PRACTITIONERS.** A registered nurse who (1) has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners, (2) is certified through a national professional nursing organization which certifies nurse practitioners and is included in the list of professional nursing organizations adopted by the board under section 62A.15, subdivision 3a, and (3) has a written agreement with a physician based on standards established by the Minnesota nurses association and the Minnesota medical association that defines the delegated responsibilities related to the prescription of drugs and therapeutic devices, may prescribe and administer drugs and therapeutic devices within the scope of the written agreement and within practice as a nurse practitioner. The written agreement required under this subdivision shall be based on standards established by the Minnesota nurses association and the Minnesota medical association as of January 1, 1996, unless both associations agree to revisions. The written agreement shall be maintained at the certified nurse practitioner's place of employment and does not need to be filed with the board of nursing.

Sec. 68. Minnesota Statutes 1994, section 148.235, subdivision 4, is amended to read:

Subd. 4. **CLINICAL NURSE SPECIALISTS IN PSYCHIATRIC AND MENTAL HEALTH NURSING.** A registered nurse who (1) has a masters degree, (2) is certified through a national professional nursing organization which certifies clinical specialists in psychiatric and mental health nursing and is included in the list of professional nursing organizations adopted by the board under section 62A.15, subdivision 3a, (3) has successfully completed no less than 30 hours of formal study in the prescribing of psychotropic medications and medications to treat their side effects which included instruction in health assessment, psychotropic classifications, psychopharmacology, indications, dosages, contraindications, side effects, and evidence of application, and (4) has a verbal agreement or a written agreement with a psychiatrist based on standards established by the Minnesota nurses association and the Minnesota psychiatric association that specifies and defines the delegated responsibilities related to the prescription of drugs in relationship to the diagnosis, may prescribe and administer drugs used to treat psychiatric and behavioral disorders and the side effects of those drugs within the scope of the written agreement and within practice as a clinical specialist in psychiatric and mental health nursing. The written agreement required under this subdivision shall be based on standards established by the Minnesota nurses association and the Minnesota medical association as of January 1, 1996, unless both associations agree to revisions. The written agreement shall be maintained at the certified clinical nurse specialist's place of employment and does not need to be filed with the board of nursing.

Nothing in this subdivision removes or limits the legal professional liability of the treating psychiatrist, clinical nurse specialist, mental health clinic or hospital for the prescription and administration of drugs by a clinical specialist in accordance with this subdivision.

Sec. 69. **MEDICAL MALPRACTICE INSURANCE COVERAGE; REAUTHORIZATION.**

Any authorization to issue insurance according to Minnesota Statutes, section 62F.04, valid on the effective date of this section remains valid for an additional two-year period at the end of the initial two-year authorization. The additional authorization period granted by this section applies only to the types of coverages authorized as of the effective date of this section.

Sec. 70. **COMMITTEE STUDY; DISCLOSURE OF FINANCIAL INCENTIVES.**

The house committee on financial institutions and insurance shall study how best to disclose to consumers any financial arrangements between health plan companies and health care providers that may provide financial incentives for providers to restrict care provided to consumers.

Sec. 71. **TAXI INSURANCE REVIEW; REPORT**

The commissioner of commerce shall review the impact that Laws of Minnesota 1995, chapter 227, has on the following:

(1) any increase in the cost of individual policies of personal automobile insurance that is attributable to coverage of taxi drivers as reported by insurers providing the majority of coverage in the state;

(2) the number and dollar amount of claims for injuries attributable to taxi drivers who carry individual policies of insurance as reported by insurers providing the majority of coverage in the state;

(3) the number and dollar amount of claims filed by drivers of taxis insured under policies issued to owners of taxis leased to drivers, to the extent that the data is available;

(4) the entry of insurers providing coverage for owners of vehicles used as taxis;

(5) changes in the cost of coverage carried by owners of vehicles used as taxis.

The commissioner shall provide a written report to the chair of the committee on financial institutions and insurance of the house of representatives and the chair of the committee on commerce of the senate by March 1, 1997.

Sec. 72. **REPEALER.**

(a) Minnesota Statutes 1994, sections 60A.40; 60B.27; 62I.20; 65A.25; and 72A.205, are repealed.

(b) Laws 1995, chapter 140, section 1, is repealed.

(c) Section 51 is repealed effective August 1, 1998.

Sec. 73. **EFFECTIVE DATES.**

Sections 2, 5, 9, 10, 12, 21, 22, 26 to 31, 36 to 38, 41 to 48, 61, 64, 66, and 69 are effective the day following final enactment.

Section 3 is effective retroactive to January 1, 1996.

Sections 51 and 52 are effective August 1, 1996, and applies to all health plans issued or renewed to provide coverage to Minnesota residents on or after that date.

Section 49 is effective retroactive to July 1, 1995.

Sections 1 and 13 to 20 are effective January 1, 1997.

Section 50 is effective June 30, 1997, and applies to health plans issued or renewed on or after that date.

ARTICLE 2

Section 1. Minnesota Statutes 1994, section 60A.07, subdivision 8, is amended to read:

Subd. 8. **SPECIAL PROVISIONS AS TO MUTUAL COMPANIES.** (1) **AMENDMENT OF ARTICLES OR CERTIFICATE OF INCORPORATION.** The certificate of incorporation or articles of association of any domestic insurance company without capital stock, now or hereafter organized and existing under the laws of this state, may be amended in respect to any matter which an original certificate of incorporation or articles of association of a corporation of the same kind might lawfully have contained by the adoption of a resolution specifying the proposed amendment, at a regular meeting of the members thereof or at a special meeting called for that expressly stated purpose, by the affirmative vote of a majority of the members present, in person or by proxy, at the meeting, and by causing the resolution to be embraced in a certificate duly executed by its president and secretary or other presiding and recording officers, under its corporate seal, and approved, filed, recorded, and published in the manner prescribed by law for the execution, approval, filing, recording, and publishing of a like original certificate of incorporation or articles of association.

(2) **RENEWAL OF CORPORATE EXISTENCE.** Any domestic insurance company or corporation having no capital stock, heretofore or hereafter organized and existing under the laws of this state, whose period of duration has expired or is about to expire, may, on or before the date of the expiration, or within six months after the date of expiration, renew its corporate existence from the date of such expiration for any period permitted by the laws of this state, by the adoption of a resolution to that effect by the affirmative vote of three–fourths of the members present, in person or by proxy, at a regular meeting of the members, or at any special meeting called for that expressly stated purpose, and by causing the resolution to be embraced in a certificate duly executed by its president and secretary or other presiding and recording officers, under its corporate seal, and approved, filed, recorded, and published in the manner prescribed by law for the execution, approval, filing, recording, and publishing of an original certificate of incorporation or articles of association.

(3) **BYLAWS.** The bylaws of any domestic insurance corporation without capital stock, in cases where the bylaws must be adopted or approved by the members thereof, may be adopted, altered, or amended at a regular meeting of the members thereof, or at a special meeting called for that expressly stated purpose, by the affirmative vote of a majority of the members present, in person or by proxy, at the meeting.

~~(4) **CONVERSION OF A DOMESTIC MUTUAL INTO A STOCK INSURANCE CORPORATION.** A domestic mutual corporation may be converted into a stock insurance corporation as follows:~~

~~(a) **ACTION BY BOARD OF DIRECTORS.** The board of directors shall adopt a plan of conversion.~~

~~(b) **PLAN OF CONVERSION.** (i) The plan of conversion shall provide that, upon consummation of the conversion, each policyholder at the date of the passage of the resolution by the board of directors shall be entitled to such shares of stock of the new company as the policyholder's equitable share of the surplus of the company will purchase. This equitable share shall be determined by independent certified auditors or consulting actuaries and shall be subject to approval by the commissioner. If a policyholder's equitable share of the surplus of the company produces a fractional share, the policyholder shall be given the option of either receiving the value of the fractional share in cash or of purchasing the fractional part of a share that will entitle the policyholder to a full share.~~

~~(ii) No shares of the corporation being organized shall be issued or subscribed for, formally or informally, directly or indirectly during the conversion except as authorized under subparagraph (i).~~

~~(iii) The corporation shall not pay compensation or remuneration of any kind to any person in connection with the proposed conversion, except at reasonable rates for printing costs, and for legal and other professional fees for services actually rendered.~~

~~(iv) The plan of conversion shall include a copy of the proposed articles of incorporation which shall comply with the requirements of chapter 300. Except as otherwise specifically provided, the corporation resulting from conversion under this section shall be deemed to have been organized as of the date of issuance of the initial certificate of authority to the mutual corporation being converted.~~

~~(c) **APPROVAL BY POLICYHOLDERS.** Within 30 days after its adoption by the board of directors, the plan of conversion shall be submitted to the policyholders for approval by the affirmative vote of a majority of the policyholders entitled to vote, in the manner prescribed by subparagraph (1). Every policyholder as of the date of the adoption under subparagraph (a) shall be entitled to one vote for each policy held. Only such policyholders shall be entitled to vote.~~

~~(d) **APPROVAL BY THE COMMISSIONER.** (i) Within 30 days after its adoption by the policyholders, the plan of conversion shall be submitted to the commissioner with an application for approval.~~

~~(ii) The commissioner shall not approve if the value of single shares is set at a figure that substantially burdens policyholders who wish to purchase a fractional share under subparagraph (b)(i).~~

~~(iii) If the commissioner finds that the plan of conversion has been duly approved by the policyholders, that the conversion would not violate any law and would not be con-~~

~~trary to the interests of the policyholders, the commissioner shall approve the plan of conversion and shall issue a new certificate of authority to the corporation.~~

~~(e) **CONVERSION.** After filing an amendment of the articles of incorporation as provided by chapter 300, the corporation shall become a stock corporation and shall no longer be a mutual corporation, and the board of directors shall execute the plan of conversion.~~

~~(f) **SECURITIES REGULATION.** The filing with the commissioner of commerce of a certified copy of the plan of conversion as adopted by the policyholders and approved by the commissioner shall constitute registration under chapter 80A, of the securities authorized to be issued to policyholders thereunder.~~

Sec. 2. Minnesota Statutes 1995 Supplement, section 60A.07, subdivision 10, is amended to read:

Subd. 10. **SPECIAL PROVISIONS AS TO LIFE COMPANIES.** (1) **PREREQUISITES OF LIFE COMPANIES.** No mutual life company shall be qualified to issue any policy until applications for at least $200,000 of insurance, upon lives of at least 200 separate residents, have been actually and in good faith made, accepted, and entered upon its books and at least one full annual premium thereunder, based upon the authorized table of mortality, received in cash or in absolutely payable and collectible notes. A duplicate receipt for each premium, conditioned for the return thereof unless the policy be issued within one year thereafter, shall be issued, and one copy delivered to the applicant and the other filed with the commissioner, together with the certificate of a solvent authorized bank in the state, of the deposit therein of such cash and notes, aggregating the amount aforesaid, specifying the maker, payee, date, maturity, and amount of each. Such cash and notes shall be held by it not longer than one year, and at or before the expiration thereof to be by it paid or delivered, upon the written order of the commissioner, to such company or applicants, respectively.

(2) ~~**FOREIGN COMPANIES MAY BECOME DOMESTIC.** Any company organized under the laws of any other state or country, which might have been originally incorporated under the laws of this state, and which has been admitted to do business therein for either or both the purpose of life or accident insurance, upon complying with all the requirements of law relative to the execution, filing, recording and publishing of original certificates and payment of incorporation fees by like domestic corporations, therein designating its principal place of business at a place in this state, may become a domestic corporation, and be entitled to like certificates of its corporate existence and license to transact business in this state, and be subject in all respects to the authority and jurisdiction thereof.~~

(3) **TEMPORARY CAPITAL STOCK OF MUTUAL LIFE COMPANIES.** A new mutual life insurance company which has complied with the provisions of clause (1) or an existing mutual life insurance company may establish, a temporary capital of, such amount not less than $100,000, as may be approved by the commissioner. Such temporary capital shall be invested by the company in the same manner as is provided for the investment of its other funds. Out of the net surplus of the company the holders of the temporary capital stock may receive a dividend which may be cumulative. This capital stock shall not be a liability of the company but shall be retired within a reasonable time and according to terms approved by the commissioner. At the time for the retirement of

this capital stock, the holders shall be entitled to receive from the company the par value thereof and any dividends thereon due and unpaid, and thereupon the stock shall be surrendered and canceled. In the event of the liquidation of the company, the holders of temporary capital stock shall have the same preference in the assets of the company as shareholders have in a stock insurance company. Dividends on this stock are subject to section 60D.20, subdivision 2.

Temporary capital stock may be issued with or without voting rights. If issued with voting rights, the holders shall, at all meetings, be entitled to one vote for each $10 of temporary capital stock held.

Sec. 3. **[60A.075] MUTUAL COMPANY CONVERSION TO STOCK COMPANY.**

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

(a) "Eligible member" means a policyholder whose policy is in force as of the record date, which is the date that the mutual company's board of directors adopts a plan of conversion or some other date specified as the record date in the plan of conversion and approved by the commissioner. Unless otherwise provided in the plan, a person insured under a group policy is not an eligible member, unless on the record date:

(1) the person is insured or covered under a group life policy or group annuity contract under which funds are accumulated and allocated to the respective covered persons;

(2) the person has the right to direct the application of the funds so allocated;

(3) the group policyholder makes no contribution to the premiums or deposits for the policy or contract; and

(4) the converting mutual company has the names and addresses of the persons covered under the group life policy or group annuity contract.

(b) "Reorganized company" means a Minnesota domestic stock insurance company that has converted from a Minnesota domestic mutual insurance company according to this section.

(c) "Plan of conversion" or "plan" means a plan adopted by a Minnesota domestic mutual insurance company's board of directors under this section to convert the mutual company into a Minnesota domestic stock insurance company.

(d) "Policy" means a policy or contract of insurance issued by a converting mutual company, including an annuity contract.

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

(f) "Converting mutual company" means a Minnesota domestic mutual insurance company seeking to convert to a Minnesota domestic stock insurance company according to this section.

(g) "Effective date of a conversion" means the date determined according to subdivision 6.

(h) "Membership interests" means all policyholders' rights as members of the converting mutual company, including but not limited to, rights to vote and to participate in any distributions of surplus, whether or not incident to the company's liquidation.

(i) "Equitable surplus" means the converting mutual company's surplus as regards policyholders as of the effective date of the conversion determined in a manner that is not unfair or inequitable to policyholders.

(j) "Permitted issuer" means: (1) a corporation organized and owned by the converting mutual company or by any other insurance company or insurance holding company for the purpose of purchasing and holding all of the stock of the reorganized company; (2) a stock insurance company owned by the converting mutual company or by any other insurance company or insurance holding company into which the converting mutual company will be merged; or (3) any other corporation approved by the commissioner.

Subd. 2. **AUTHORIZATION.** A mutual insurance company may become a stock insurance company according to a plan of conversion established and approved in the manner provided by this section.

Subd. 3. **ADOPTION OF A PLAN OF CONVERSION BY THE BOARD OF DIRECTORS.** (a) A converting mutual company shall, by the affirmative vote of a majority of its board of directors, adopt a plan of conversion consistent with the requirements of this section.

(b) At any time before approval of a plan by the commissioner, the converting mutual company, by the affirmative vote of a majority of its board of directors, may amend or withdraw the plan.

Subd. 4. **APPROVAL OF THE PLAN OF CONVERSION BY THE COMMISSIONER.** (a) **DOCUMENTS TO BE FILED.** After adoption of the plan by the converting mutual company's board of directors, but before the members' approval of the plan, the converting mutual company shall file the following documents with the commissioner for review and approval:

(1) the plan of conversion, including an independent evaluation of the pro forma market value and of the equitable surplus of the company and of the estimated value of any shares to be issued and an independent actuarial opinion, if required;

(2) the form of notice of meeting for eligible members to vote on the plan;

(3) the form of any proxies to be solicited from eligible members;

(4) the proposed articles of incorporation and bylaws of the converted stock company;

(5) information required under chapter 60D if the plan results in a change of control of the converting mutual company; and

(6) other information or documentation requested by the commissioner or required by rule.

(b) **REQUIRED FINDINGS.** The commissioner shall approve or conditionally approve the plan upon finding that:

(1) the provisions of this section have been fully met; and

(2) the plan will not be unfair or inequitable to policyholders.

(c) **TIME.** The plan of conversion shall, by order, be approved, conditionally approved, or disapproved by the commissioner within the later of 30 days from the commis-

sioner's receipt of all required information from the converting mutual company or 30 days after the conclusion of a public hearing held according to paragraph (e). An approval or conditional approval of a plan expires if the reorganization is not completed within 180 days after the approval or conditional approval unless this time period is extended by the commissioner for good cause shown.

(d) **CONSULTANTS.** The commissioner may retain, at the converting mutual company's expense, qualified experts not otherwise a part of the commissioner's staff to assist in reviewing the plan and supplemental materials and valuations.

(e) **HEARING.** The commissioner may, but need not, conduct a public hearing regarding the proposed plan of conversion. The hearing must begin no later than 30 days after submission to the commissioner of a plan of conversion and all required information. The commissioner shall give the converting mutual company at least 20 days' notice of the hearing. At the hearing, the converting mutual company, its policyholders, and any other person whose interest may be affected by the proposed conversion may present evidence, examine and cross-examine witnesses, and offer oral and written arguments or comments according to the procedure for contested cases under chapter 14. The persons participating may conduct discovery proceedings in the same manner as prescribed for the district courts of this state. All discovery proceedings must be concluded no later than three days before the scheduled commencement date of the public hearing.

Subd. 5. **APPROVAL OF THE PLAN BY THE ELIGIBLE MEMBERS.** (a) **NOTICE.** Following approval or conditional approval of the plan by the commissioner, all eligible members shall be given notice of a regular or special meeting of the policyholders called for the purpose of considering the plan and any corporate actions that are a part of, or are reasonably attendant to, the accomplishment of the plan.

(b) **NOTICE REQUIRED.** A copy of the plan or a summary of the plan must accompany the notice. The notice must be mailed to each eligible member's last known address, as shown on the converting mutual company's records, within 45 days of the commissioner's approval of the plan, unless the commissioner directs an earlier date for mailing. The meeting to vote upon the plan must be set for a date no less than 45 days after the date when the notice of the meeting is mailed by the converting mutual company unless the commissioner directs an earlier date for the meeting. If the meeting to vote upon the plan is held coincident with the converting mutual company's annual meeting of policyholders, only one combined notice of meeting is required.

(c) **FAILURE TO GIVE NOTICE.** If the converting mutual company complies substantially and in good faith with the notice requirements of this section, the converting mutual company's failure to give any member or members any required notice does not impair the validity of any action taken under this section.

(d) **VOTING.** (1) The plan must be adopted upon receiving the affirmative vote of a majority of the votes cast by eligible members.

(2) Eligible members may vote in person or by proxy. The form of any proxy must be filed with and approved by the commissioner.

(3) The number of votes each eligible member may cast shall be determined by the converting mutual company's bylaws. If the bylaws are silent, or if the commissioner determines that the voting requirements under the bylaws would be unfair or would prejudice the rights of the eligible members, each eligible member may cast one vote.

Subd. 6. **CONVERSION.** (a) **FILING.** Following approval by the members, the converting mutual company shall file a copy of the company's amended or restated articles of incorporation with the commissioner, together with a certified copy of the minutes of the meeting at which the plan was adopted and a certified copy of the plan. The commissioner shall review and, if appropriate, approve the amended or restated articles. After approval by the commissioner, the converting mutual company shall file the articles with the secretary of state as provided by chapter 300.

(b) **EFFECTIVE DATE.** Effective on the date of filing an amendment or restatement of the articles of incorporation with the secretary of state as provided by chapter 300, or on a later date if the plan so specifies, the converting mutual corporation shall become a stock corporation and shall no longer be a mutual corporation.

Subd. 7. **PLAN NOT UNFAIR OR INEQUITABLE.** A plan of conversion shall not be unfair or inequitable to policyholders. A plan of conversion is not unfair or inequitable if it satisfies the conditions of subdivision 8, 9, or 10. The commissioner may determine that any other plan proposed by a converting mutual company is not unfair or inequitable to policyholders.

Subd. 8. **SHARE CONVERSION.** A plan of conversion under this subdivision shall provide for exchange of policyholders' membership interests in return for shares in the reorganized company, according to paragraphs (a) to (c).

(a) The policyholders' membership interests shall be exchanged, in a manner that takes into account the estimated proportionate contribution of equitable surplus of each class of participating policies and contracts, for all of the common shares of the reorganized company or its parent company or a permitted issuer, or for a combination of the common shares of the reorganized company or its parent company or a permitted issuer.

(b) Unless the anticipated issuance within a shorter period is disclosed in the plan of conversion, the issuer of common shares shall not, within two years after the effective date of reorganization, issue either of the following:

(1) any of its common shares or any securities convertible with or without consideration into the common shares or carrying any warrant to subscribe to or purchase common shares; and

(2) any warrant, right, or option to subscribe to or purchase the common shares or other securities described in paragraph (a), except for the issue of common shares to or for the benefit of policyholders according to the plan of conversion and the issue of options for the purchase of common shares being granted to officers, directors, or employees of the reorganized company or its parent company, if any, according to this section.

(c) Unless the common shares have a public market when issued, the issuer shall use its best efforts to encourage and assist in the establishment of a public market for the common shares within two years of the effective date of the conversion or a longer period as disclosed in the plan of conversion. Within one year after any offering of stock other than the initial distribution, but no later than six years after the effective date of the conversion, the reorganized company shall offer to make available to policyholders who received and retained shares of common stock or securities described in paragraph (b), clause (1), a procedure to dispose of those shares of stock at market value without brokerage commissions or similar fees.

Subd. 9. **SURPLUS DISTRIBUTION.** A plan of conversion under this subdivision shall provide for the exchange of the policyholders' membership interests in return for the operation of the converting mutual company's participating policies as a closed block of business and for the distribution of the company's equitable surplus to policyholders, and shall provide for the issuance of new shares of the reorganized company or its parent corporation, each according to paragraphs (a) to (i).

(a) The converting mutual company's participating business, comprised of its participating policies and contracts in force on the effective date of the conversion or other reasonable date as provided in the plan, shall be operated by the reorganized company as a closed block of participating business. However, at the option of the converting mutual company, group policies and group contracts may be omitted from the closed block.

(b) Assets of the converting mutual company must be allocated to the closed block of participating business in an amount equal to the reserves and liabilities for the converting mutual life insurer's participating policies and contracts in force on the effective date of the conversion. The plan must be accompanied by an opinion of an independent qualified actuary who meets the standards set forth in the insurance laws or regulations for the submission of actuarial opinions as to the adequacy of reserves or assets. The opinion must relate to the adequacy of the assets allocated to support the closed block of business. The actuarial opinion must be based on methods of analysis considered appropriate for those purposes by the Actuarial Standards Board.

(c) The reorganized company shall keep a separate accounting for the closed block and shall make and include in the annual statement to be filed with the commissioner each year a separate statement showing the gains, losses, and expenses properly attributable to the closed block.

(d) Notwithstanding the establishment of a closed block, the entire assets of the reorganized company shall be available for the payment of benefits to policyholders. Payment must first be made from the assets supporting the closed block until exhausted, and then from the general assets of the reorganized company.

(e) The converting mutual company's equitable surplus shall be distributed to eligible participating policyholders in a form or forms selected by the converting mutual company. The form of distribution may consist of cash, securities of the reorganized company, securities of another institution, a certificate of contribution, additional life insurance, annuity benefits, increased dividends, reduced premiums, or other equitable consideration or any combination of forms of consideration. The consideration, if any, given to a class or category of policyholders may differ from the consideration given to another class or category of policyholders. A certificate of contribution must be repayable in ten years, be equal to 100 percent of the value of the policyholders' membership interest, and bear interest at the highest rate charged by the reorganized company for policy loans on the effective date of the conversion.

(f) The consideration must be allocated among the policyholders in a manner that is fair and equitable to the policyholders.

(g) The reorganized company or its parent corporation shall issue and sell shares of one or more classes having a total price equal to the estimated value in the market of the shares on the initial offering date. The estimated value must take into account all of the following:

(1) the pro forma market value of the reorganized company;

(2) the consideration to be given to policyholders according to paragraph (e);

(3) the proceeds of the sale of the shares; and

(4) any additional value attributable to the shares as a result of a purchaser or a group of purchasers who acted in concert to obtain shares in the initial offering, attaining, through such purchase, control of the reorganized company or its parent corporation.

(h) If a purchaser or a group of purchasers acting in concert is to attain control in the initial offering, the mutual company shall not, directly or indirectly, pay for any of the costs or expenses of conversion of the mutual company, whether or not the conversion is effected.

(i) Periodically, with the commissioner's approval, the reorganized company may share in the profits of the closed block of participating business for the benefit of stockholders if the assets allocated to the closed block are in excess of those necessary to support the closed block.

Subd. 10. **SUBSCRIPTION RIGHTS.** A plan of conversion under this subdivision shall provide for exchange of the policyholders' membership interests in return for the operation of the converting mutual company's participating policies as a closed block of business, for the creation of a liquidation account to protect the interests of policyholders, and for the issuance of subscription rights to eligible policyholders, and shall provide for the issuance of shares by the reorganized company, each according to paragraphs (a) to (j).

(a) The converting mutual company's participating business, comprised of its participating policies and contracts in force on the effective date of the conversion, or such other reasonable date specified in the plan, and excluding at the converting mutual company's option any group policies or group contracts, shall be operated by the reorganized company as a closed block of participating business according to subdivision 9, paragraphs (a) to (d).

(b) The reorganized company or its parent corporation or a permitted issuer shall issue and sell shares of one or more classes having a total price equal to the estimated value of the shares in the market on the initial offering date taking into account the proceeds of the sale of shares and the consideration given to policyholders.

(c) The policyholders shall receive nontransferable preemptive subscription rights to purchase all of the common shares of the issuer according to paragraph (b).

(d) The preemptive subscription rights to purchase the common shares must be allocated among the participating policyholders in whole shares in a manner provided in the plan that takes into account the estimated contribution of each class of participating policies and contracts to the total amount of the policyholders' consideration. The plan must provide a fair and equitable means for the allocation of shares in the event of an oversubscription. The plan must further provide that any shares of capital stock not subscribed by eligible members must be sold in a public offering through an underwriter, unless the number of shares unsubscribed is so small in number so as not to warrant the expense of a public offering, in which case the plan may provide for the purchase of the unsubscribed shares by private placement or through any fair and equitable alternative means approved by the commissioner.

(e) The number of the common shares that a person, together with any affiliates or group of persons acting in concert, may subscribe or purchase in the reorganization, must be limited to not more than five percent of the common shares. For this purpose, neither the members of the board of directors of the reorganized company nor its parent corporation, if any, is considered to be affiliates or a group of persons acting in concert solely by reason of their board membership.

(f) Unless the common shares have a public market when issued, officers and directors of the issuer and their affiliates shall not, for at least three years after the date of conversion, purchase common shares of the issuer, except with the approval of the commissioner.

(g) Unless the common shares have a public market when issued, the issuer shall use its best efforts to encourage and assist in the establishment of a public market for the common shares.

(h) The issuer shall not, for at least three years following the conversion, repurchase any of its common shares except according to a pro rata tender offer to all shareholders, or with the approval of the commissioner.

(i) A liquidation account must be established for the benefit of policyholders in the event of a complete liquidation of the reorganized company. The liquidation account must be equal to the equitable surplus of the converting mutual company as of the effective date of the conversion. The function of the liquidation account is solely to establish a priority on liquidation and its existence does not restrict the use or application of the surplus of the reorganized company except as specified in paragraph (j). The liquidation account must be allocated equitably as of the effective date of conversion among the then participating policyholders. The amount allocated to a policy or contract must not increase and must be reduced to zero when the policy or contract terminates. In the event of a complete liquidation of the reorganized company, the policyholders among which the liquidation account is allocated are entitled to receive a liquidation distribution in the amount of the liquidation account before any liquidation distribution is made with respect to shares.

(j) Until the liquidation account has been reduced to zero, the issuer shall not declare or pay a cash dividend on, or repurchase any of, its common shares in an amount in excess of its cumulative earned surplus generated after the conversion determined according to statutory accounting principles, if the effect would be to cause the amount of the statutory surplus of the reorganized company to be reduced below the then amount of the liquidation account.

Subd. 11. **OPTIONAL PROVISIONS.** A plan under subdivision 8, 9, or 10 may include, with the approval of the commissioner, any of the provisions in paragraphs (a) and (b).

(a) A plan may provide that any shares of the stock of the reorganized company or its parent corporation or a permitted issuer included in the policyholders' consideration must be placed on the effective date of the conversion in a trust or other entity existing for the exclusive benefit of the participating policyholders and established solely for the purposes of effecting the reorganization. Under this option, the shares placed in trust must be sold over a period of not more than ten years and the proceeds of the shares must be distributed using the distribution priorities prescribed in the plan.

(b) A plan may provide that the directors and officers of the converting mutual company shall receive, without payment, nontransferable subscription rights to purchase capital stock of the reorganized company, its parent, or a permitted issuer. Those subscription rights must be allocated among the directors and officers by a fair and equitable formula.

(1) The total number of shares that may be purchased under this clause, may not exceed 35 percent of the total number of shares to be issued in the case of a converting mutual company with total assets of less than $50,000,000 or 25 percent of the total shares to be issued in the case of a converting mutual company with total assets of more than $500,000,000. For converting mutual companies with total assets between $50,000,000 and $500,000,000, the total number of shares that may be purchased may not exceed an interpolated percentage between 25 and 35 percent.

(2) Stock purchased by a director or officer under clause (1) may not be sold within one year following the effective date of the conversion.

(3) The plan may also provide that a director or officer, or person acting in concert with a director or officer of the converting mutual company, may not acquire any capital stock of the reorganized company for three years after the effective date of the conversion, except through a licensed securities broker or dealer, without the permission of the commissioner. That provision may not apply to prohibit the directors and officers from purchasing stock through subscription rights received in the plan under clause (1).

(c) A plan may allocate to a tax–qualified employee benefit plan nontransferable subscription rights to purchase up to ten percent of the capital stock of the reorganized company, its parent, or a permitted issuer. The employee benefit plan must be entitled to exercise its subscription rights regardless of the amount of shares purchased by other persons.

Subd. 12. **ALTERNATIVE PLAN OF CONVERSION.** In lieu of selecting a plan of conversion provided for in this section, the converting mutual company may convert according to a plan approved by the commissioner if the commissioner finds that the plan does not prejudice the interests of the members, is fair and equitable, and is based upon an independent appraisal of the market value of the mutual company by a qualified person, and is a fair and equitable allocation of any consideration to be given eligible members. The commissioner may retain, at the converting mutual company's expense, any qualified expert not otherwise a part of the commissioner's staff to assist in reviewing whether the alternative plan may be approved and the valuation of the company.

Subd. 13. **EFFECT OF CONVERSION.** (a) Upon the conversion of a converting mutual company to a reorganized company according to this section, the corporate existence of the converting mutual company must be continued in the reorganized company. All the rights, franchises, and interests of the converting mutual company in and to all property and things in action belonging to this property, is considered transferred to and vested in the reorganized company without any deed or transfer. Simultaneously, the reorganized company is considered to have assumed all the obligations and liabilities of the converting mutual company.

(b) The directors and officers of the converting mutual company, unless otherwise specified in the plan of conversion, shall serve as directors and officers of the reorganized

company until new directors and officers of the reorganized company are duly elected according to the articles of incorporation and bylaws of the reorganized company.

(c) All policies in force on the effective date of the conversion continue to remain in force under the terms of those policies, except that any voting rights of the policyholders provided for under the policies are extinguished on the effective date of the conversion.

Subd. 14. **CONFLICT OF INTEREST.** No director, officer, agent, employee of the converting mutual company, or any other person shall receive a fee, commission, or other valuable consideration, other than the person's usual regular salary and compensation, for in any manner aiding, promoting, or assisting in the conversion except as set forth in the plan approved by the commissioner. This provision does not prohibit the payment of reasonable fees and compensation to attorneys, accountants, investment bankers, and actuaries for services performed in the independent practice of their professions.

Subd. 15. **COSTS AND EXPENSES.** All the costs and expenses connected with a plan of conversion must be paid for or reimbursed by the converting mutual company or the reorganized company except where the plan provides otherwise.

Subd. 16. **LIMITATION OF ACTIONS.** (a) An action challenging the validity of or arising out of acts taken or proposed to be taken according to this section must be commenced within 180 days after the effective date of the conversion.

(b) The converting mutual company, the reorganized company, or any defendant in an action described in paragraph (a), may petition the court in the action to order a party to give security for the reasonable attorney fees that may be incurred by a party to the action. The amount of security may be increased or decreased in the discretion of the court having jurisdiction if a showing is made that the security provided is or may become inadequate or excessive.

Subd. 17. **SUPERVISORY CONVERSIONS.** The commissioner may waive or alter any of the requirements of this section to protect the interests of policyholders if the converting mutual company is subject to the commissioner's administrative supervision under chapter 60G or rehabilitation under chapter 60B.

Sec. 4. **[60A.077] MUTUAL INSURANCE HOLDING COMPANIES.**

Subdivision 1. **FORMATION.** (a) A domestic mutual insurance company, upon approval of the commissioner, may reorganize by forming an insurance holding company based upon a mutual plan and continuing the corporate existence of the reorganizing insurance company as a stock insurance company. The commissioner, if satisfied that the interests of the policyholders are properly protected and that the plan of reorganization is fair and equitable to the policyholders, may approve the proposed plan of reorganization and may require as a condition of approval the modifications of the proposed plan of reorganization as the commissioner finds necessary for the protection of the policyholders' interests. The commissioner shall retain jurisdiction over the mutual insurance holding company according to this section and chapter 60D to assure that policyholder interests are protected.

(b) All of the initial shares of the capital stock of the reorganized insurance company must be issued to the mutual insurance holding company or to an intermediate stock holding company that is wholly owned by the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company become

membership interests in the mutual insurance holding company. "Membership interests" means those interests described in section 60A.075, subdivision 1, paragraph (h). Policyholders of the reorganized insurance company shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall, at all times, directly or through an intermediate stock holding company, control a majority of the voting shares of the capital stock of the reorganized insurance company.

Subd. 2. **MERGER.** (a) A domestic mutual insurance company, upon the approval of the commissioner, may reorganize by merging its policyholders' membership interests into a mutual insurance holding company formed according to subdivision 1 and continuing the corporate existence of the reorganizing insurance company as a stock insurance company subsidiary of the mutual insurance holding company. "Membership interests" means those interests described in section 60A.075, subdivision 1, paragraph (h). The commissioner, if satisfied that the interests of the policyholder are properly protected and that the merger is fair and equitable to the policyholders, may approve the proposed merger and may require as a condition of approval the modifications of the proposed merger as the commissioner finds necessary for the protection of the policyholders' interests. The commissioner shall retain jurisdiction over the mutual insurance holding company organized according to this section to assure that policyholder interests are protected.

(b) All of the initial shares of the capital stock of the reorganized insurance company must be issued to the mutual insurance holding company, or to an intermediate stock holding company that is wholly owned by the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company become membership interests in the mutual insurance holding company. Policyholders of the reorganized insurance company shall be members of the mutual insurance holding company according to the articles of incorporation and bylaws of the mutual insurance holding company.

Subd. 3. **PLAN OF REORGANIZATION; APPROVAL BY COMMISSIONER.** (a) The reorganizing or merging insurer shall file a plan of reorganization, approved by the affirmative vote of a majority of its board of directors, for review and approval by the commissioner. The plan must provide for the following:

(1) establishing a mutual insurance holding company with at least one stock insurance company subsidiary, the majority of shares of which must be owned, either directly or through an intermediate stock holding company, by the mutual insurance holding company;

(2) analyzing the benefits and risks attendant to the proposed reorganization, including the rationale for the reorganization and analysis of the comparative benefits and risks of a demutualization under section 60A.075;

(3) protecting the immediate and long–term interests of existing policyholders;

(4) ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic insurance company;

(5) describing a plan providing for membership interests of future policyholders;

(6) describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders;

(7) ensuring that, in the event of proceedings under chapter 60B involving a stock insurance company subsidiary of the mutual insurance holding company that resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company;

(8) for periodic distribution of accumulated holding company earnings to members;

(9) describing the nature and content of the annual report and financial statement to be sent to each member;

(10) a copy of the proposed mutual insurance holding company's articles of incorporation and bylaws specifying all membership rights;

(11) the names, addresses, and occupational information of all corporate officers and members of the proposed mutual insurance holding company board of directors;

(12) information sufficient to demonstrate that the financial condition of the reorganizing or merging company will not be diminished upon reorganization;

(13) a copy of the articles of incorporation and bylaws for any proposed insurance company subsidiary or intermediate holding company subsidiary;

(14) describing any plans for the initial sale of stock for the reorganized insurance company; and

(15) any other information requested by the commissioner or required by rule.

(b) The commissioner may approve the plan upon finding that the requirements of this section have been fully met and the plan will protect the immediate and long-term interests of policyholders.

(c) The commissioner may retain, at the reorganizing or merging mutual company's expense, any qualified experts not otherwise a part of the commissioner's staff to assist in reviewing the plan.

(d) The commissioner may, but need not, conduct a public hearing regarding the proposed plan. The hearing must be held within 30 days after submission of a completed plan of reorganization to the commissioner. The commissioner shall give the reorganizing mutual company at least 20 days' notice of the hearing. At the hearing, the reorganizing mutual company, its policyholders, and any other person whose interest may be affected by the proposed reorganization, may present evidence, examine and cross-examine witnesses, and offer oral and written arguments or comments according to the procedure for contested cases under chapter 14. The persons participating may conduct discovery proceedings in the same manner as prescribed for the district courts of this state. All discovery proceedings must be concluded no later than three days before the scheduled commencement of the public hearing.

Subd. 4. **APPROVAL BY COMMISSIONER.** The plan by order shall be approved, conditionally approved, or disapproved within the later of 30 days from the date of the commissioner's receipt of all required information or 30 days after the conclusion of the public hearing. An approval or conditional approval of a plan of reorganization expires if the reorganization is not completed within 180 days after the approval or conditional approval unless the time period is extended by the commissioner upon a showing of good cause.

Subd. 5. **APPROVAL BY MEMBERS.** The plan shall be approved by the members as provided in section 60A.075, subdivision 5.

Subd. 6. **INCORPORATION.** A mutual insurance holding company resulting from the reorganization of a domestic mutual insurance company organized under chapter 300 shall be incorporated pursuant to chapter 300. The articles of incorporation and any amendments to the articles of the mutual insurance holding company are subject to approval of the commissioner in the same manner as those of an insurance company.

Subd. 7. **APPLICABILITY OF CERTAIN PROVISIONS.** (a) A mutual insurance holding company is considered to be an insurer subject to chapter 60B and shall automatically be a party to any proceeding under chapter 60B involving an insurance company that, as a result of a reorganization according to subdivision 1 or 2, is a subsidiary of the mutual insurance holding company. In any proceeding under chapter 60B involving the reorganized insurance company, the assets of the mutual insurance holding company are considered to be assets of the estate of the reorganized insurance company for purposes of satisfying the claims of the reorganized insurance company's policyholders. A mutual insurance holding company shall not dissolve or liquidate without the approval of the commissioner or as ordered by the district court according to chapter 60B.

(b) A mutual insurance holding company is subject to chapter 60D to the extent consistent with this section.

(c) As a condition to approval of the plan, the commissioner may require the mutual insurance holding company to comply with any provision of the insurance laws necessary to protect the interests of the policyholders as if the mutual insurance holding company were a domestic mutual insurance company.

Subd. 8. **APPLICABILITY OF DEMUTUALIZATION PROVISIONS.** (a) Except as otherwise provided, section 60A.075 is not applicable to a reorganization or merger according to this section, and except for section 60A.075, subdivisions 14 to 16.

(b) Section 60A.075 is applicable to demutualization of a mutual insurance holding company that resulted from the reorganization of a domestic mutual insurance company organized under chapter 300 as if it were a mutual insurance company.

Subd. 9. **MEMBERSHIP INTERESTS.** A membership interest in a domestic mutual insurance holding company does not constitute a security as defined in section 80A.14, subdivision 18.

Subd. 10. **FINANCIAL STATEMENT REQUIREMENTS.** (a) In addition to any items required under chapter 60D, each mutual insurance holding company shall file with the commissioner, by April 1 of each year, an annual statement consisting of the following:

(1) an income statement, balance sheet, and cashflow statement prepared in accordance with generally accepted accounting principles;

(2) complete information on the status of any closed block formed as part of a plan of reorganization;

(3) an investment plan covering all assets; and

(4) a statement disclosing any intention to pledge, borrow against, alienate, hypothecate, or in any way encumber the assets of the mutual insurance holding company. Ac-

tion taken according to the statement is subject to the commissioner's prior written approval.

(b) The aggregate pledges and encumbrances of a mutual holding company's assets shall not affect more than 49 percent of the company's stock in any subsidiary insurance holding company or subsidiary insurance company that resulted from a reorganization or merger.

(c) At least 50 percent of the generally accepted accounting principles (GAAP) net worth of a mutual insurance holding company must be invested in insurance company subsidiaries.

Subd. 11. **SALE OF STOCK AND PAYMENT OF DIVIDENDS.** No solicitation for the sale of the stock of the reorganized insurance company, or of an intermediate stock holding company of the mutual insurance holding company, may be made without the commissioner's prior written approval. Dividends and other distributions to the shareholders of the reorganized stock insurance company or of an intermediate stock holding company shall not be made except in compliance with section 60D.20.

Sec. 5. Minnesota Statutes 1994, section 60A.11, subdivision 21, is amended to read:

Subd. 21. **FOREIGN INVESTMENTS.** Obligations of and investments in foreign countries, on the following conditions:

(a) a company may acquire and hold any foreign investments which are required as a condition of doing business in the foreign country or necessary for the convenient accommodation of its foreign business. An investment is considered necessary for the convenient accommodation of the insurance company's foreign business only if it is demonstrably and directly related in size and purpose to the company's foreign insurance operations; and

(b) a company may ~~not~~ also invest not more than five percent of its total admitted assets in any combination of:

(1) the obligations of foreign governments, corporations, or business trusts;

(2) obligations of federal, provincial, or other political subdivisions backed by the full faith and credit of the foreign governmental unit;

(3) or in the stocks or stock equivalents or obligations of foreign corporations or business trusts not qualifying for investment under subdivision 12, if the obligations, stocks or stock equivalents are listed or regularly traded on the London, Paris, Zurich, or Tokyo stock exchange or any similar regular securities exchange not disapproved by the commissioner within 30 days following notice from the company of its intention to invest in these securities.

Sec. 6. Minnesota Statutes 1995 Supplement, section 60A.67, subdivision 2, is amended to read:

Subd. 2. **PROHIBITION ON ANNOUNCEMENTS.** The comparison of an insurer's total adjusted capital to any of its risk–based capital levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer and is not intended as a means to rank insurers generally. Except as otherwise required under sec-

tions 60A.60 to 60A.696, the making, publishing, dissemination, circulating, or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk–based capital levels of an insurer, or of any component derived in the calculation, by an insurer, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is prohibited. However, if a materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its risk–based capital levels, or any of them, or an inappropriate comparison of any other amount to the insurer's risk–based capital levels is published in a written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement. This subdivision does not prohibit an insurance company or its holding company from disclosing information about its risk–based capital levels in the notes to its financial statements if required by pronouncements of the American Institute of Certified Public Accountants or the Financial Accounting Standards Board, or making this disclosure as required by other governmental regulatory agencies.

Sec. 7. Minnesota Statutes 1994, section 60C.09, subdivision 2, is amended to read:

Subd. 2. **FURTHER DEFINITION.** In addition to subdivision 1, a covered claim does not include:

(1) claims by an affiliate of the insurer; ~~and~~

(2) claims due a reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise. This clause does not prevent a person from presenting the excluded claim to the insolvent insurer or its liquidator, but the claims shall not be asserted against another person, including the person to whom the benefits were paid or the insured of the insolvent insurer, except to the extent that the claim is outside the coverage of the policy issued by the insolvent insurer; and

(3) any first–party claims, resulting from insolvencies which occur after July 31, 1996, by an insured whose net worth exceeds $25,000,000 on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis.

Sec. 8. Minnesota Statutes 1994, section 60C.11, is amended by adding a subdivision to read:

Subd. 7. The association may recover the amount of any covered claim paid, resulting from insolvencies which occur after July 31, 1996, on behalf of an insured who has a net worth of $25,000,000 as provided in section 60C.09, subdivision 2, clause (3), on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter.

Sec. 9. Minnesota Statutes 1994, section 61A.32, is amended to read:

61A.32 **DOMESTIC MUTUAL AND STOCK AND MUTUAL COMPANIES; VOTING RIGHTS OF MEMBERS.**

Every person insured by a domestic mutual life insurance company, and every participating policyholder of a domestic stock and mutual life insurance company as defined in sections 61A.33 to 61A.36, shall be a member, entitled to one vote and one vote additional for each $1,000 of insurance in excess of the first $1,000; provided, that no member shall be entitled to more than 100 votes; and, provided, further, that in the case of group insurance on employees such group shall be deemed to be a single member and the employer shall be deemed to be such member for the purpose of voting, having not to exceed 100 votes, provided, that in cases where the employees pay all or any part of the premium, either directly or by payroll deductions, the employees shall be allowed to choose their representative, who shall exercise a voting power in proportion to the percentage of premium paid by such employees. Every member shall be notified of its annual meetings by a written notice mailed to the member's address, or by an imprint on the back of the policy, premium notice, receipt or certificate of renewal, as follows:

"The insured is hereby notified that by virtue of this policy the insured is a member of the ..... Insurance Company, and that the annual meetings of said company are held at its home office on the ..... day of ..... in each year, at ..... o'clock."

The blanks shall be duly filled in print. Any such member may vote by proxy by filing written proxy appointment with the secretary of the company at its home office at least five days before the first meeting at which it is to be used. Such proxy appointment may be for a specified period of time ~~or may provide that it will be in effect until revoked~~ not to exceed one year. A proxy may be revoked by a member at any time by written notice to the secretary of the company or by executing a new proxy appointment and filing it as required herein: provided, however, that any member may always appear personally and exercise rights as a member at any meeting of the company.

A domestic mutual life insurance company may by its articles of incorporation or bylaws provide for a representative system of voting in any meeting of members. The articles or bylaws may provide for the selection of representatives from districts as therein specified, such representatives to represent approximately equal numbers of members with power to exercise all the voting powers, rights and privileges of the members they represent with the same force and effect as might be exercised by the members themselves. In such a representative system the votes cast by the representative shall be one vote for each member, notwithstanding the amount of insurance carried, and proxy voting shall not be permitted; provided, however, that any member may always appear personally and exercise rights as a member of the company at any meeting of the membership.

Sec. 10. Minnesota Statutes 1994, section 61B.20, subdivision 15, is amended to read:

Subd. 15. **PREMIUMS.** "Premiums" means amounts received on covered policies or contracts less premiums, considerations, and deposits returned, and less dividends and experience credits on those covered policies or contracts to the extent not guaranteed in advance. The term does not include amounts received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under section 61B.19, subdivision 3, except that assessable premium shall not be reduced on account of section

61B.19, subdivision 4, relating to limitations with respect to any one life, any one individual, and any one contract holder~~,~~. Premiums subject to assessment under section 61B.24, include all amounts received on any unallocated annuity contract issued to a contract holder resident in this state if the contract is not otherwise excluded from coverage under section 61B.19, subdivision 3; provided that "premiums" shall not include any premiums in excess of the liability limit on any unallocated annuity contract specified in section 61B.19, subdivision 4.

Sec. 11. **REPEALER.**

Minnesota Statutes 1994, section 60A.13, subdivision 8, is repealed.

ARTICLE 3

Section 1. Minnesota Statutes 1995 Supplement, section 62L.045, is amended to read:

62L.045 **ASSOCIATIONS.**

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

(a) "Association" means:

(1) an association as defined in section 60A.02;

(2) a group or organization of political subdivisions;

(3) ~~an educational cooperative service unit~~ a service cooperative created under section ~~123.58~~ 123.582; or

(4) a joint self–insurance pool authorized under section 471.617, subdivision 2.

(b) "Qualified association" means an association, as defined in this subdivision, that:

(1) is registered with the commissioner of commerce;

(2) provides health plan coverage through a health carrier that participates in the small employer market in this state, other than through associations, to the extent that the association purchases health plan coverage rather than self–insures;

(3) has and adheres to membership and participation criteria and health ~~plan~~ coverage eligibility criteria that are not designed to disproportionately include or attract small employers that are likely to have low costs of health coverage or to disproportionately exclude or repel small employers that are likely to have high costs of health coverage; and

(4) permits any small employer that meets its membership, participation, and eligibility criteria to become a member and to obtain health ~~plan~~ coverage through the association.

(c) "Health coverage" means a health benefit plan as defined in section 62L.02, subdivision 15; or similar self-insured coverage offered, sold, issued, or renewed by an association as defined in paragraph (a) to a small employer.

Subd. 2. **QUALIFIED ASSOCIATIONS.** (a) A qualified association, as defined in this section, and health ~~benefit plans~~ coverage offered by it, to it, or through it, to a small employer in this state must comply with the requirements of this chapter regarding guaranteed issue, guaranteed renewal, preexisting condition limitations, credit against preexisting condition limitations for continuous coverage, treatment of MCHA enrollees, and the definition of dependent, and with section 62A.65, subdivision 5, paragraph (b). They must also comply with all other requirements of this chapter not specifically exempted in paragraph (b) or (c).

(b) A qualified association and a health carrier offering, selling, issuing, or renewing a health ~~benefit plan~~ coverage to, or to cover, a small employer in this state through the qualified association, may, but are not, in connection with that health ~~benefit plan~~ coverage, required to:

(1) offer the two small employer plans described in section 62L.05; and

(2) offer to small employers that are not members of the association, health ~~benefit plans~~ coverage offered to, by, or through the qualified association.

(c) A qualified association, and a health carrier offering, selling, issuing, and renewing a health ~~benefit plan~~ coverage to, or to cover, a small employer in this state must comply with section 62L.08, except that:

(1) a separate index rate may be applied by a health carrier to each qualified association, provided that:

~~(1)~~ (i) the premium rate applied to participating small employer members of the qualified association is no more than 25 percent above and no more than 25 percent below the index rate applied to the qualified association, irrespective of when members applied for health coverage; and

~~(2)~~ (ii) the index rate applied by a health carrier to a qualified association is no more than 20 percent above and no more than 20 percent below the index rate applied by the health carrier to any other qualified association or to any small employer. In comparing index rates for purposes of this clause, the 20 percent shall be calculated as a percent of the larger index rate; and

(2) a qualified association described in subdivision 1, paragraph (a), clauses (2) to (4), providing health coverage through a health carrier, or on a self-insured basis in compliance with section 471.617 and the rules adopted under that section, may cover small employers and other employers within the same pool and may charge premiums to small employer members on the same basis as it charges premiums to members that are not small employers, if the premium rates charged to small employers do not have greater variation than permitted under section 62L.08. A qualified association operating under this clause shall annually prove to the commissioner of commerce that it complies with this clause through a sampling procedure acceptable to the commissioner. If the qualified association fails to prove compliance to the satisfaction of the commissioner, the association shall agree to a written plan of correction acceptable to the commissioner. The qualified association is considered to be in compliance under this clause if there is a premium

rate that would, if used as an index rate, result in all premium rates in the sample being in compliance with section 62L.08. This clause does not exempt a qualified association or a health carrier providing coverage through the qualified association from the loss ratio requirement of section 62L.08, subdivision 11.

Subd. 3. **OTHER ASSOCIATIONS.** Associations as defined in this section that are not qualified associations; health ~~benefit plans~~ coverage offered, sold, issued, or renewed by or through them; and the health carriers doing so, must fully comply with this chapter with respect to small employers that are members of the association.

Subd. 4. **PRINCIPLES; ASSOCIATION COVERAGE.** (a) This subdivision applies to associations as defined in this section, whether qualified associations or not, and is intended to clarify subdivisions 1 to 3.

(b) This section applies only to associations that provide health coverage to small employers.

(c) ~~The requirements of guaranteed issue and guaranteed renewal apply to coverage issued to cover small employers and persons covered through them, within the context of an arrangement between an association and a health carrier.~~ A health carrier is not required under this chapter to comply with guaranteed issue and guaranteed renewal with respect to its relationship with the association itself. An arrangement between the health carrier and the association, once entered into, must comply with guaranteed issue and guaranteed renewal with respect to members of the association that are small employers and persons covered through them.

(d) When an arrangement between a health carrier and an association has validly terminated, the health carrier has no continuing obligation to small employers and persons covered through them, except as otherwise provided in:

(1) section 62A.65, subdivision 5, paragraph (b);

(2) any other continuation or conversion rights applicable under state or federal law; and

(3) section 60A.082, relating to group replacement coverage, and rules adopted under that section.

(e) When an association's arrangement with a health carrier has terminated and the association has entered into a new arrangement with that health carrier or a different health carrier, the new arrangement is subject to section 60A.082 and rules adopted under it, with respect to members of the association that are small employers and persons covered through them.

(f) An association that offers its members more than one ~~health~~ plan of health coverage may have uniform rules restricting movement between the ~~health~~ plans of health coverage, if the rules do not discriminate against small employers.

(g) This chapter does not require or prohibit separation of an association's members into one group consisting only of small employers and another group or other groups consisting of all other members. The association must comply with this section with respect to the small employer group.

(h) For purposes of this section, "member" of an association includes an employer participant in the association.

(i) For purposes of this section, health coverage issued to, or to cover, a small employer includes a certificate of coverage issued directly to the employer's employees and dependents, rather than to the small employer.

Subd. 5. **REGISTRATION.** The commissioner may require all associations that are subject to this section to register with the commissioner prior to an initial purchase of health coverage under this section.

Sec. 2. Minnesota Statutes 1994, section 471.617, subdivision 2, as amended by Laws 1995, chapter 233, article 2, section 56, is amended to read:

Subd. 2. Any two or more statutory or home rule charter cities, counties, school districts, or instrumentalities thereof which together have more than 100 employees may jointly self–insure for any employee health benefits including long–term disability, but not for employee life benefits, subject to the same requirements as an individual self–insurer under subdivision 1. Self–insurance pools under this section are subject to section 62L.045. A self–insurance pool established and operated by one or more service cooperatives governed by section 123.582 to provide coverage described in this subdivision qualifies under this subdivision. The commissioner of commerce may adopt rules pursuant to chapter 14, providing standards or guidelines for the operation and administration of self–insurance pools.

Sec. 3. Minnesota Statutes 1994, section 471.98, subdivision 3, as amended by Laws 1995, chapter 256, section 19, is amended to read:

Subd. 3. **POOL.** "Pool" means any self–insurance fund or agreement for the reciprocal assumption of risk established by or among two or more political subdivisions for coverage of their respective risks including, but not limited to, the pools described in section 471.982, subdivision 3. Except in connection with provisions in sections 471.981 and 471.982 that relate to bonding, "pool" does not include a self–insurance pool for employee health benefits under section 471.617.

Sec. 4. **SMALL SELF–INSURED POLITICAL SUBDIVISION POOLS.**

Self–insurance pools under Minnesota Statutes, section 471.617, subdivision 2, having fewer than 1,500 enrollees as of March 1, 1996, shall become subject to Minnesota Statutes, chapter 62L, effective January 1, 1998.

Sec. 5. **EFFECTIVE DATE.**

Sections 1 to 3 are effective January 1, 1997, and apply to coverage issued; renewed; or continued as defined in Minnesota Statutes, section 60A.02, subdivision 2a; on or after that date.

Presented to the governor April 4, 1996

Signed by the governor April 11, 1996, 11:58 a.m.