

A bill for an act
relating to health; modifying health care provisions; changing health plan
premium rate restrictions; establishing the Minnesota Health Insurance
Exchange; requiring certain employers to offer Section 125 Plans; requiring
language interpreter services for certain enrollees; amending Minnesota Statutes
2006, sections 62A.65, subdivision 3; 62E.141; 62L.12, subdivision 2; proposing
coding for new law in Minnesota Statutes, chapters 62A; 62Q.

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

ARTICLE 1
HEALTH INSURANCE EXCHANGE; SECTION 125 PLANS

Section 1. Minnesota Statutes 2006, section 62A.65, subdivision 3, is amended to read:

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

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

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age for adults aged 19 and above of up to plus or minus 50 percent of the index rate. Premium rates for children under the age of 19 may not vary based on age, regardless of whether the child is covered as a dependent or as a primary insured.

(c) A health carrier may request approval by the commissioner to establish separate geographic regions determined by the health carrier and to establish separate index rates for each such region. The commissioner shall grant approval if the following conditions are met:

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

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

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

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

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

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

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

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

(h) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes

in risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

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

Sec. 2. [62A.67] MINNESOTA HEALTH INSURANCE EXCHANGE.

Subdivision 1. Title; citation. This section may be cited as the "Minnesota Health Insurance Exchange."

Subd. 2. Creation; tax exemption. The Minnesota Health Insurance Exchange is created for the limited purpose of providing individuals with greater access, choice, portability, and affordability of health insurance products. The Minnesota Health Insurance Exchange is a not-for-profit corporation under chapter 317A and section 501(c) of the Internal Revenue Code.

Subd. 3. Definitions. The following terms have the meanings given them unless otherwise provided in text.

(a) "Board" means the board of directors of the Minnesota Health Insurance Exchange under subdivision 13.

(b) "Commissioner" means:

(1) the commissioner of commerce for health insurers subject to the jurisdiction of the Department of Commerce;

(2) the commissioner of health for health insurers subject to the jurisdiction of the Department of Health; or

(3) either commissioner's designated representative.

(c) "Exchange" means the Minnesota Health Insurance Exchange.

(d) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

(e) "Individual market health plans," unless otherwise specified, means individual market health plans defined in section 62A.011 and MinnesotaCare II products as defined in chapter 256L.

(f) "Section 125 Plan" means a cafeteria or Premium Only Plan under section 125 of the Internal Revenue Code that allows employees to pay for health insurance premiums with pretax dollars.

Subd. 4. **Insurer and health plan participation.** All health plans as defined in section 62A.011, subdivision 3, issued or renewed in the individual market shall participate in the exchange. No health plans in the individual market may be issued or renewed outside of the exchange. Group health plans as defined in section 62A.10 shall not be offered through the exchange. Health plans offered through the Minnesota Comprehensive Health Association as defined in section 62E.10 are offered through the exchange to eligible enrollees as determined by the Minnesota Comprehensive Health Association. Health plans offered through MinnesotaCare and MinnesotaCare II under chapter 256L are offered through the exchange to eligible enrollees as determined by the commissioner of human services.

Subd. 5. **Approval of health plans.** No health plan may be offered through the exchange unless the commissioner has first certified that:

(1) the insurer seeking to offer the health plan is licensed to issue health insurance in the state; and

(2) the health plan meets the requirements of this section, and the health plan and the insurer are in compliance with all other applicable health insurance laws.

Subd. 6. **Individual market health plans.** Individual market health plans offered through the exchange continue to be regulated by the commissioner as specified in chapters 62A, 62C, 62D, 62E, 62Q, and 72A, and must include the following provisions that apply to all health plans issued or renewed through the exchange:

(1) premiums for children under the age of 19 shall not vary by age in the exchange; and

(2) premiums for children under the age of 19 must be excluded from rating factors under section 62A.65, subdivision 3, paragraph (b).

Subd. 7. **MinnesotaCare II health plans.** Health plans approved for MinnesotaCare II under section 256L.075 shall be offered by participating insurers to exchange participants not enrolled in MinnesotaCare II.

Subd. 8. **Individual participation and eligibility.** Individuals are eligible to purchase health plans directly through the exchange or through an employer Section 125 Plan under section 62A.68. Nothing in this section requires guaranteed issue of

individual market health plans offered through the exchange. Individuals are eligible to purchase individual market health plans through the exchange by meeting one or more of the following qualifications:

(1) the individual is a Minnesota resident, meaning the individual is physically residing on a permanent basis in a place that is the person's principal residence and from which the person is absent only for temporary purposes;

(2) the individual is a student attending an institution outside of Minnesota and maintains Minnesota residency;

(3) the individual is not a Minnesota resident but is employed by an employer physically located within the state and the individual's employer is required to offer a Section 125 Plan under section 62A.68;

(4) the individual is not a Minnesota resident but is self-employed and the individual's principal place of business is in the state; or

(5) the individual is a dependent as defined in section 62L.02, of another individual who is eligible to participate in the exchange.

Subd. 9. **Continuation of coverage.** Enrollment in a health plan may be canceled for nonpayment of premiums, fraud, or changes in eligibility for MinnesotaCare under chapter 256L. Enrollment in an individual market health plan may not be canceled or nonrenewed because of any change in employer or employment status, marital status, health status, age, residence, or any other change that does not affect eligibility as defined in this section.

Subd. 10. **Responsibilities of the exchange.** The exchange shall serve as the sole entity for enrollment and collection and transfer of premium payments for health plans sold to individuals through the exchange. The exchange shall be responsible for the following functions:

(1) publicize the exchange, including but not limited to its functions, eligibility rules, and enrollment procedures;

(2) provide assistance to employers to establish Section 125 Plans under section 62A.68;

(3) provide education and assistance to employers to help them understand the requirements of Section 125 Plans and compliance with applicable regulations;

(4) create a system to allow individuals to compare and enroll in health plans offered through the exchange;

(5) create a system to collect and transmit to the applicable plans all premium payments made by individuals, including developing mechanisms to receive and process

6.1 automatic payroll deductions for individuals who purchase coverage through employer

6.2 Section 125 Plans;

6.3 (6) refer individuals interested in MinnesotaCare or MinnesotaCare II under chapter
6.4 256L to the Department of Human Services to determine eligibility;

6.5 (7) establish a mechanism with the Department of Human Services to transfer
6.6 premiums and subsidies for MinnesotaCare and MinnesotaCare II to qualify for federal
6.7 matching payments;

6.8 (8) administer bonus accounts as defined in chapter 256L to reimburse
6.9 MinnesotaCare II enrollees for qualified medical expenses under section 213(d) of the
6.10 Internal Revenue Code;

6.11 (9) collect and assess information for eligibility for bonus accounts and premium
6.12 incentives under chapter 256L;

6.13 (10) upon request, issue certificates of previous coverage according to the provisions
6.14 of HIPAA and as referenced in section 62Q.181 to all such individuals who cease to be
6.15 covered by a participating health plan through the exchange;

6.16 (11) establish procedures to account for all funds received and disbursed by the
6.17 exchange for individual participants of the exchange; and

6.18 (12) make available to the public, at the end of each calendar year, a report of an
6.19 independent audit of the exchange's accounts. The exchange shall not accept premium
6.20 payments for individual market health plans from an employer Section 125 Plan if the
6.21 employer offers a group health plan as defined in section 62A.10 or if the employer is a
6.22 self-insurer as defined in section 62E.02.

6.23 Subd. 11. **Powers of the exchange.** The exchange shall have the power to:

6.24 (1) contract with insurance producers licensed in accident and health insurance
6.25 under chapter 60K and vendors to perform one or more of the functions specified in
6.26 subdivision 10;

6.27 (2) contract with employers to collect premiums through a Section 125 Plan for
6.28 eligible individuals who purchase an individual market health plan through the exchange;

6.29 (3) establish and assess fees on health plan premiums of health plans purchased
6.30 through the exchange to fund the cost of administering the exchange;

6.31 (4) seek and directly receive grant funding from government agencies or private
6.32 philanthropic organizations to defray the costs of operating the exchange;

6.33 (5) establish and administer rules and procedures governing the operations of the
6.34 exchange;

6.35 (6) establish one or more service centers within Minnesota;

6.36 (7) sue or be sued or otherwise take any necessary or proper legal action;

(8) establish bank accounts and borrow money; and
(9) enter into agreements with the commissioners of commerce, health, human services, revenue, employment and economic development, and other state agencies as necessary for the exchange to implement the provisions of this section.

Subd. 12. **Dispute resolution.** The exchange shall establish procedures for resolving disputes with respect to the eligibility of an individual to participate in the exchange. The exchange does not have the authority or responsibility to intervene in or resolve disputes between an individual and a health plan or health insurer. The exchange shall refer complaints from individuals participating in the exchange to the commissioner to be resolved according to sections 62Q.68 to 62Q.73.

Subd. 13. **Governance.** The exchange shall be governed by a board of directors with 11 members. The board shall convene on or before July 1, 2007, after the initial board members have been selected. The initial board membership consists of the following:

- (1) the commissioner of commerce;
- (2) the commissioner of human services;
- (3) the commissioner of health;
- (4) four members appointed by a joint committee of the Minnesota senate and the Minnesota house of representatives to serve three-year terms; and
- (5) four members appointed by the governor to serve three-year terms.

Subd. 14. **Subsequent board membership.** Ongoing membership of the exchange consists of the following effective July 1, 2010:

- (1) the commissioner of commerce;
- (2) the commissioner of human services;
- (3) the commissioner of health;
- (4) four members appointed by the governor with the approval of a joint committee of the senate and house of representatives to serve two- or three-year terms. Appointed members may serve more than one term; and
- (5) four members elected by the membership of the exchange of which two are elected to serve a two-year term and two are elected to serve a three-year term. Elected members may serve more than one term.

Subd. 15. **Operations of the board.** Officers of the board of directors are elected by members of the board and serve one-year terms. Six members of the board constitutes a quorum, and the affirmative vote of six members of the board is necessary and sufficient for any action taken by the board. Board members serve without pay, but are reimbursed for actual expenses incurred in the performance of their duties.

8.1 Subd. 16. **Operations of the exchange.** The board of directors shall appoint an
8.2 exchange director who shall:

8.3 (1) be a full-time employee of the exchange;

8.4 (2) administer all of the activities and contracts of the exchange; and

8.5 (3) hire and supervise the staff of the exchange.

8.6 Subd. 17. **Insurance producers.** When a producer licensed in accident and health
8.7 insurance under chapter 60K enrolls an eligible individual in the exchange, the health plan
8.8 chosen by an individual may pay the producer a commission.

8.9 Subd. 18. **Implementation.** Health plan coverage through the exchange begins on
8.10 January 1, 2009. The exchange must be operational to assist employers and individuals
8.11 by September 1, 2008, and be prepared for enrollment by December 1, 2008. Enrollees
8.12 of individual market health plans, MinnesotaCare, and the Minnesota Comprehensive
8.13 Health Association as of December 2, 2008, are automatically enrolled in the exchange
8.14 on January 1, 2009, in the same health plan and at the same premium that they were
8.15 enrolled as of December 2, 2008, subject to the provisions of this section. As of January 1,
8.16 2009, all enrollees of individual market health plans, MinnesotaCare, and the Minnesota
8.17 Comprehensive Health Association shall make premium payments to the exchange.

8.18 Sec. 3. **[62A.68] SECTION 125 PLANS.**

8.19 Subdivision 1. **Definitions.** The following terms have the meanings given unless
8.20 otherwise provided in text:

8.21 (a) "Current employee" means an employee currently on an employer's payroll other
8.22 than a retiree or disabled former employee.

8.23 (b) "Employer" means a person, firm, corporation, partnership, association, business
8.24 trust, or other entity employing one or more persons, including a political subdivision of
8.25 the state, filing payroll tax information on such employed person or persons.

8.26 (c) "Section 125 Plan" means a cafeteria or Premium Only Plan under section 125
8.27 of the Internal Revenue Code that allows employees to purchase health insurance with
8.28 pretax dollars.

8.29 (d) "Exchange" means the Minnesota Health Insurance Exchange under section
8.30 62A.67.

8.31 (e) "Exchange director" means the appointed director under section 62A.67,
8.32 subdivision 16.

8.33 Subd. 2. **Section 125 Plan requirement.** (a) Effective January 1, 2009, all
8.34 employers with 11 or more current employees shall establish a Section 125 Plan to allow

their employees to purchase individual market health plan coverage with pretax dollars.

The following employers are exempt from the Section 125 Plan requirement:

(1) employers that offer a group health insurance plan as defined in 62A.10;

(2) employers that are self-insurers as defined in section 62E.02; and

(3) employers with fewer than 11 current employees, except that employers under this clause may voluntarily offer a Section 125 Plan.

(b) Employers that offer a Section 125 Plan may enter into an agreement with the exchange to administer the employer's Section 125 Plan.

Subd. 3. **Tracking compliance.** By July 1, 2008, the exchange, in consultation with the commissioners of commerce, health, employment and economic development, and revenue shall establish a method for tracking employer compliance with the Section 125 Plan requirement.

Subd. 4. **Employer requirements.** Employers that are required to offer or choose to offer a Section 125 Plan shall:

(1) allow employees to purchase an individual market health plan for themselves and their dependents through the exchange;

(2) upon an employee's request, deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages, and remit these employee payments to the exchange; and

(3) provide notice to employees that individual market health plans purchased through the exchange are not employer-sponsored.

Subd. 5. **Section 125 eligible health plans.** Individuals who are eligible to use an employer Section 125 Plan to pay for health insurance coverage purchased through the exchange may enroll in any health plan offered through the exchange for which the individual is eligible including individual market health plans, MinnesotaCare and MinnesotaCare II, and the Minnesota Comprehensive Health Association.

Sec. 4. Minnesota Statutes 2006, section 62E.141, is amended to read:

62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.

No employee of an employer that offers a group health plan, under which the employee is eligible for coverage, is eligible to enroll, or continue to be enrolled, in the comprehensive health association, except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under the employer's health plan. This section does not apply to persons enrolled in the Comprehensive Health Association as of June 30, 1993. With respect to persons eligible to enroll in the health

10.1 plan of an employer that has more than 29 current employees, as defined in section
10.2 62L.02, this section does not apply to persons enrolled in the Comprehensive Health
10.3 Association as of December 31, 1994.

10.4 Sec. 5. Minnesota Statutes 2006, section 62L.12, subdivision 2, is amended to read:

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

10.8 (b) A health carrier may sell, issue, or renew individual conversion policies to
10.9 eligible employees otherwise eligible for conversion coverage as a result of the expiration
10.10 of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21,
10.11 62C.142, 62D.101, and 62D.105.

10.12 (c) A health carrier may sell, issue, or renew conversion policies under section
10.13 62E.16 to eligible employees.

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

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

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

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

10.26 (h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage
10.27 issued as a supplement to Medicare under sections 62A.3099 to 62A.44, or policies or
10.28 contracts that supplement Medicare issued by health maintenance organizations, or those
10.29 contracts governed by sections 1833, 1851 to 1859, 1860D, or 1876 of the federal Social
10.30 Security Act, United States Code, title 42, section 1395 et seq., as amended.

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

10.33 (j) A health carrier may offer, issue, sell, or renew an individual health plan to
10.34 persons eligible for an employer group health plan, if the individual health plan is a high
10.35 deductible health plan for use in connection with an existing health savings account, in

compliance with the Internal Revenue Code, section 223. In that situation, the same or a different health carrier may offer, issue, sell, or renew a group health plan to cover the other eligible employees in the group.

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

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

(l) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans through the Minnesota Health Insurance Exchange under section 62A.67 or 62A.68.

ARTICLE 2

INTERPRETER SERVICE

Section 1. [62Q.40] LANGUAGE INTERPRETER SERVICES.

A health plan must cover sign language interpreter services provided to deaf and hard-of-hearing enrollees and language interpreter services provided to enrollees with limited English proficiency in order to facilitate the provision of health care services

12.1 by a provider or health care facility. For purposes of this section, "provider" has the
12.2 meaning given in section 62J.03, subdivision 8; and "health plan" includes coverage
12.3 excluded under section 62A.011, subdivision 3, clauses (6), (7), (9), and (10). Interpreter
12.4 services may be provided in person, by telephone, or by video conference. The health
12.5 plan shall reimburse either the party providing interpreter services directly for the costs of
12.6 language interpreter services provided to the enrollee or the provider or health care facility
12.7 arranging for the provision of interpreter services. Providers and health care facilities
12.8 that employ or contract with interpreters may bill and shall be reimbursed directly by
12.9 health plan companies for such services. Except where health plan companies are already
12.10 reimbursing a party providing or a provider or health care facility arranging for interpreter
12.11 services, required reimbursement by health plan companies for interpreter services shall
12.12 be phased in over a three-year period beginning July 1, 2008, with one-third of the cost
12.13 reimbursed the first year, two-thirds of the cost reimbursed the second year, and full
12.14 reimbursement the third year. A health plan company shall provide to enrollees, upon
12.15 request, the policies and procedures for addressing the needs of deaf and hard-of-hearing
12.16 enrollees and enrollees with limited English proficiency. All entities providing interpreter
12.17 services must disclose their methods for ensuring competency upon request of any health
12.18 plan company, provider, or consumer.

12.19 Sec. 2. **INTERPRETER SERVICES WORK GROUP.**

12.20 (a) The commissioner of health shall, in consultation with the commissioners of
12.21 commerce, human services, and employee relations, convene a work group to study the
12.22 provision of interpreter services to patients in medical and dental care settings. The work
12.23 group shall include one representative from each of the following groups:

- 12.24 (1) consumers;
12.25 (2) interpreters;
12.26 (3) interpreter service providers or agencies;
12.27 (4) health plan companies;
12.28 (5) self-insured purchasers;
12.29 (6) hospitals;
12.30 (7) health care providers;
12.31 (8) dental providers;
12.32 (9) clinic administrators;
12.33 (10) state agency staff from the Departments of Health, Human Services, and
12.34 Employee Relations;
12.35 (11) local county social services agencies;

- 13.1 (12) local public health agencies; and
13.2 (13) the interpreting stakeholders group.
13.3 (b) The work group shall develop findings and recommendations on the following:
13.4 (1) assuring access to interpreter services;
13.5 (2) compliance with requirements of federal law and guidance;
13.6 (3) developing a quality assurance program to ensure the quality of health care
13.7 interpreting services, including requirements for training and establishing a certification
13.8 process; and
13.9 (4) identifying broad-based funding mechanisms for interpreter services.
13.10 (c) Based on the discussions of the work group, the commissioner shall submit
13.11 the findings and the recommendations to the chairs of the health policy and finance
13.12 committees in the house and senate by January 15, 2008.

13.13 Sec. 3. **EFFECTIVE DATE.**

- 13.14 Section 1 is effective July 1, 2008, and applies to plans issued or renewed to
13.15 provide coverage to Minnesota residents on or after that date unless the legislature enacts
13.16 alternative funding sources based on the recommendations of the commissioner. Section 2
13.17 is effective the day following final enactment.