Sec. 6. **EFFECTIVE DATE; LOCAL APPROVAL.**

Section 5 is effective as to the city of Alexandria the day after the city of Alexandria's governing body and its chief clerical officer timely completes their compliance with Minnesota Statutes, section 645.021, subdivisions 2 and 3.

Presented to the governor April 4, 2002

Signed by the governor April 8, 2002, 2:33 p.m.

CHAPTER 330—H.F.No. 2988

An act relating to insurance; regulating certain licenses, fees, rates, practices, and coverages; providing for health care administrative simplification; making certain technical changes; amending Minnesota Statutes 2000, sections 60A.351; 60D.20, subdivision 2; 61A.092, subdivision 6; 62A.02, subdivision 2; 62A.021, subdivision 1; 62A.25, subdivision 2; 62A.31, subdivision 1h; 62A.65, subdivision 5; 62E.11, subdivision 6; 62E.14, subdivisions 4, 5, 6; 62H.01; 62H.04; 62J.51, subdivision 19; 62J.535, subdivision 2; by adding subdivisions; 62J.581; 62L.03, subdivisions 1, 5; 62L.08, by adding a subdivision; 62Q.68, subdivision 1; 72A.08, subdivision 1; 79A.04, subdivision 9; Minnesota Statutes 2001 Supplement, sections 60A.14, subdivision 1; 60K.56, subdivisions 6, 8, 9; 62M.03, subdivision 2; Laws 2001, chapter 117, article 1, section 29; proposing coding for new law in Minnesota Statutes, chapter 62Q; repealing Minnesota Statutes 2000, section 62J.535, subdivision 1.

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

Section 1. Minnesota Statutes 2001 Supplement, section 60A.14, subdivision 1, is amended to read:

Subdivision 1. **FEES OTHER THAN EXAMINATION FEES.** In addition to the fees and charges provided for examinations, the following fees must be paid to the commissioner for deposit in the general fund:

(a) by township mutual fire insurance companies:

(1) for filing certificate of incorporation $25 and amendments thereto, $10;

(2) for filing annual statements, $15;

(3) for each annual certificate of authority, $15;

(4) for filing bylaws $25 and amendments thereto, $10.

(b) by other domestic and foreign companies including fraternals and reciprocal exchanges:

(1) for filing certified copy of certificate of articles of incorporation, $100;

(2) for filing annual statement, $225;

(3) for filing certified copy of amendment to certificate or articles of incorporation, $100;

(4) for filing bylaws, $75 or amendments thereto, $75;

(5) for each company's certificate of authority, $575, annually.

(c) the following general fees apply:

(1) for each certificate, including certified copy of certificate of authority, renewal, valuation of life policies, corporate condition or qualification, $25;

(2) for each copy of paper on file in the commissioner's office 50 cents per page, and $2.50 for certifying the same;

(3) for license to procure insurance in unadmitted foreign companies, $575;

(4) for valuing the policies of life insurance companies, one cent per $1,000 of insurance so valued, provided that the fee shall not exceed $13,000 per year for any company. The commissioner may, in lieu of a valuation of the policies of any foreign life insurance company admitted, or applying for admission, to do business in this state, accept a certificate of valuation from the company's own actuary or from the commissioner of insurance of the state or territory in which the company is domiciled;

(5) for receiving and filing certificates of policies by the company's actuary, or by the commissioner of insurance of any other state or territory, $50;

(6) for each appointment of an agent filed with the commissioner, $10;

(7) for filing forms and rates, $75 per filing, ~~to~~ which may be paid on a quarterly basis in response to an invoice. Billing and payment may be made electronically;

(8) for annual renewal of surplus lines insurer license, $300.

The commissioner shall adopt rules to define filings that are subject to a fee.

Sec. 2. Minnesota Statutes 2000, section 60A.351, is amended to read:

60A.351 **RENEWAL OF INSURANCE POLICY WITH ALTERED RATES.**

If an insurance company licensed to do business in this state offers or purports to offer to renew any commercial liability and/or property insurance policy at less favorable terms as to the dollar amount of coverage or deductibles, higher rates, and/or higher rating plan, the new terms, the new rates and/or rating plan may take effect on the renewal date of the policy if the insurer has sent to the policyholder notice of the new terms, new rates and/or rating plan at least 60 days prior to the expiration date. If the insurer has not so notified the policyholder, the policyholder may elect to cancel the renewal policy within the 60-day period after receipt of the notice. Earned premium for the period of coverage, if any, shall be calculated pro rata upon the prior rate. This subdivision does not apply to ocean marine insurance, accident and health insurance, and reinsurance.

This section does not apply if the change relates to guide "a" rates or excess rates also known as "consent to rates" or if there has been any change in the risk insured.

Sec. 3. Minnesota Statutes 2000, section 60D.20, subdivision 2, is amended to read:

Subd. 2. **DIVIDENDS AND OTHER DISTRIBUTIONS.** (a) Subject to the limitations and requirements of this subdivision, the board of directors of any domestic insurer within an insurance holding company system may authorize and cause the insurer to declare and pay any dividend or distribution to its shareholders as the directors deem prudent from the earned surplus of the insurer. An insurer's earned surplus, also known as unassigned funds, shall be determined in accordance with the accounting procedures and practices governing preparation of its annual statement. Dividends which are paid from sources other than an insurer's earned surplus as of the end of the immediately preceding quarter for which the insurer has filed a quarterly or annual statement as appropriate, or are extraordinary dividends or distributions may be paid only as provided in paragraphs (d), (e), and (f).

(b) The insurer shall notify the commissioner within five business days following declaration of a dividend declared pursuant to paragraph (a) and at least ten days prior to its payment. The commissioner shall promptly consider the notification filed pursuant to this paragraph, taking into consideration the factors described in subdivision 4.

(c) The commissioner shall review at least annually the dividends paid by an insurer pursuant to paragraph (a) for the purpose of determining if the dividends are reasonable based upon (1) the adequacy of the level of surplus as regards policyholders remaining after the dividend payments, and (2) the quality of the insurer's earnings and extent to which the reported earnings include extraordinary items, such as surplus relief reinsurance transactions and reserve destrengthening.

(d) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until: (1) 30 days after the commissioner has received notice of the declaration of it and has not within the period disapproved the payment; or (2) the commissioner has approved the payment within the 30-day period.

(e) For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds the greater of (1) ten percent of the insurer's surplus as regards policyholders on December 31 of the preceding year; or (2) the net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the 12-month period ending on December 31 of the preceding year, but does not include pro rata distributions of any class of the insurer's own securities.

(f) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditional upon the commissioner's approval, and the declaration shall confer no rights upon shareholders until: (1) the commissioner has approved the payment of such a dividend or distribution; or (2) the commissioner has not disapproved the payment within the 30-day period referred to above.

(g) For purposes of state law, dividends paid to an insurer's parent company from an insurer, which is a member of an insurance holding company system, are not considered income to the parent company.

Sec. 4. Minnesota Statutes 2001 Supplement, section 60K.56, subdivision 6, is amended to read:

Subd. 6. **MINIMUM EDUCATION REQUIREMENT.** Each person subject to this section shall complete a minimum of 30 credit hours of courses accredited by the commissioner during each 24-month licensing period. Any person whose initial licensing period extends more than six months shall complete 15 hours of courses accredited by the commissioner during the initial license period. Any person teaching or lecturing at an accredited course qualifies for ~~1-1/2~~ three times the number of credit hours that would be granted to a person completing the accredited course. No more than ~~15~~ one-half of the credit hours per licensing period required under this section may be credited to a person for ~~courses~~ attending any combination of courses either sponsored by, offered by, or affiliated with an insurance company or its agents; or offered using new delivery technology, including computer, interactive technology, and the Internet. Courses sponsored by, offered by, or affiliated with an insurance company or agent may restrict its students to agents of the company or agency.

Sec. 5. Minnesota Statutes 2001 Supplement, section 60K.56, subdivision 8, is amended to read:

Subd. 8. **REPORTING.** (a) After completing the minimum education requirement, each person subject to this section shall file or cause to be filed a compliance report in accordance with the procedures adopted by the commissioner. ~~The compliance report~~ A producer must not claim credit for continuing education not actually completed at the date of filing the report.

(b) An institution offering an accredited course shall comply with the procedure for reporting compliance adopted by the commissioner.

(c) If a person subject to this section completes a nonaccredited course, that person may submit a ~~written report to the advisory committee~~ an application of the commissioner for approval of the course accompanied by a fee of not more than $10 payable to the state of Minnesota for deposit in the general fund. ~~This report must be accompanied by proof satisfactory to the commissioner that the person has completed the minimum education requirement for the annual period during which the nonaccredited course was completed.~~ Upon ~~the recommendation of the advisory committee~~ a determination that the course satisfies the criteria for course accreditation, the commissioner may approve the nonaccredited course and shall so inform the person. ~~If the nonaccredited course is approved by the commissioner, it may be used to satisfy the minimum education requirement for the person's next annual compliance period.~~

Sec. 6. Minnesota Statutes 2001 Supplement, section 60K.56, subdivision 9, is amended to read:

Subd. 9. **ENFORCEMENT.** If a person subject to this section fails to complete the minimum education or reporting requirement or to pay the prescribed fees for any

licensing period, no license may be renewed or continued in force for that person for any class of insurance beginning ~~June~~ November 1 of the year due and that person may not act as an insurance producer until the person has demonstrated to the satisfaction of the commissioner that all requirements of this section have been complied with or that a waiver or extension has been obtained.

Sec. 7. Minnesota Statutes 2000, section 61A.092, subdivision 6, is amended to read:

Subd. 6. **APPLICATION.** This section applies to a policy, certificate of insurance, or similar evidence of coverage issued to a Minnesota resident or issued to provide coverage to a Minnesota resident. This section does not apply to: (1) a certificate of insurance or similar evidence of coverage that meets the conditions of section 61A.093, subdivision 2; or (2) a group life insurance policy that contains a provision permitting the certificate holder, upon termination or layoff from employment, to retain the coverage provided under the group policy by paying premiums directly to the insurer, provided that the employer shall give the employee notice of the employee's and each related certificate holder's right to continue the insurance by paying premiums directly to the insurer. The insurer may reserve the right to increase premium rates after the first 18 months of continued coverage provided for under clause (2). A related certificate holder is an insured spouse or dependent child of the employee. Upon termination of this group policy or at the option of the insured who has continued coverage under clause (2), each covered employee, spouse, and dependent child is entitled to have issued to them a life conversion policy as prescribed in section 61A.09, subdivision 1, paragraph (h).

Sec. 8. Minnesota Statutes 2000, section 62A.02, subdivision 2, is amended to read:

Subd. 2. **APPROVAL.** (a) The health plan form shall not be issued, nor shall any application, rider, endorsement, or rate be used in connection with it, until the expiration of 60 days after it has been filed unless the commissioner approves it before that time.

(b) Notwithstanding paragraph (a), a rate filed with respect to a policy of accident and sickness insurance as defined in section 62A.01 by an insurer licensed under chapter 60A, may be used on or after the date of filing with the commissioner. Rates that are not approved or disapproved within the 60-day time period are deemed approved.

Sec. 9. Minnesota Statutes 2000, section 62A.021, subdivision 1, is amended to read:

Subdivision 1. **LOSS RATIO STANDARDS.** (a) Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, health care policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate

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

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

(c) A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner shall order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an

amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

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

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

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

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

(g) Notwithstanding paragraphs (a) and (f), the loss ratio shall be 60 percent for a policy or certificate of accident and sickness insurance as defined in section 62A.01, offered by an insurance company licensed under chapter 60A that is assessed less than ten percent of the total annual amount assessed by the Minnesota Comprehensive Health Association. For purposes of the percentage calculation of the association's assessments, an insurance company's assessments include those of its affiliates.

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

Sec. 10. Minnesota Statutes 2000, section 62A.25, subdivision 2, is amended to read:

Subd. 2. (a) Every policy, plan, certificate or contract to which this section applies shall provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.

(b) The coverage limitations on reconstructive surgery in paragraph (a) do not apply to reconstructive breast surgery following mastectomies. In these cases, coverage for reconstructive surgery must be provided if the mastectomy is medically necessary as determined by the attending physician.

(c) Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient. Coverage may be subject to annual deductible, copayment, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Coverage may not:

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

Written notice of the availability of the coverage must be delivered to the participant upon enrollment and annually thereafter.

Sec. 11. Minnesota Statutes 2000, section 62A.31, subdivision 1h, is amended to read:

Subd. 1h. **LIMITATIONS ON DENIALS, CONDITIONS, AND PRICING OF COVERAGE.** No 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 such coverage available for sale in this state, nor may it discriminate in the pricing of such coverage, because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant where an application for such 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 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 another six-month enrollment period provided under this subdivision

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. If an individual enrolled in Medicare Part B voluntarily disenrolls from Medicare Part B because the individual becomes reemployed and is enrolled under an employee welfare benefit plan, the individual is eligible for another six-month enrollment period, as provided in this subdivision, beginning the first day of the month in which the individual later becomes eligible for and enrolls again in Medicare Part B.

Sec. 12. Minnesota Statutes 2000, section 62A.65, subdivision 5, is amended to read:

Subd. 5. **PORTABILITY AND CONVERSION OF COVERAGE.** (a) No individual health plan may be offered, sold, issued, or with respect to children age 18 or under renewed, to a Minnesota resident that contains a preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, unless the limitation or exclusion is permitted under this subdivision and under chapter 62L, provided that, except for children age 18 or under, underwriting restrictions may be retained on individual contracts that are issued without evidence of insurability as a replacement for prior individual coverage that was sold before May 17, 1993. The individual may be subjected to an 18-month preexisting condition limitation, unless the individual has maintained continuous coverage as defined in section 62L.02. The individual must not be subjected to an exclusionary rider. An individual who has maintained continuous coverage may be subjected to a one-time preexisting condition limitation of up to 12 months, with credit for time covered under qualifying coverage as defined in section 62L.02, at the time that the individual first is covered under an individual health plan by any health carrier. Credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. The individual must not be subjected to an exclusionary rider. Thereafter, the individual must not be subject to any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage as defined in section 62L.02.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in section 62L.02. If the individual has available any continuation coverage provided under sections 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or 62D.105, or continuation coverage provided under federal law, the health carrier need not offer coverage under this paragraph until the individual has exhausted the continuation coverage. The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this

paragraph must be a qualified plan as defined in section 62E.02 and must not contain any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. In no event shall the premium rate exceed ~~90~~ 100 percent of the premium charged for comparable individual coverage by the Minnesota comprehensive health association, and the premium rate must be less than that amount if necessary to otherwise comply with this section. An individual health plan offered under this paragraph to a person satisfies the health carrier's obligation to offer conversion coverage under section 62E.16, with respect to that person. Coverage issued under this paragraph must provide that it cannot be canceled or nonrenewed as a result of the health carrier's subsequent decision to leave the individual, small employer, or other group market. Section 72A.20, subdivision 28, applies to this paragraph.

Sec. 13. Minnesota Statutes 2000, section 62E.11, subdivision 6, is amended to read:

Subd. 6. **MEMBER ASSESSMENTS.** The association shall make an annual determination of each contributing member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the contributing members whose aggregate assessments comprised a minimum of 90 percent of the most recent prior annual assessment, in the event that the association deems that methodology to be the most administratively efficient and cost effective means of assessment, and as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment shall be due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days shall be grounds for termination of the contributing member's membership. A contributing member which ceases to do accident and health insurance business within the state shall remain liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment, as determined herein, would not exceed ten dollars.

Sec. 14. Minnesota Statutes 2000, section 62E.14, subdivision 4, is amended to read:

Subd. 4. **WAIVER OF PREEXISTING CONDITIONS FOR MEDICARE SUPPLEMENT PLAN ENROLLEES.** Notwithstanding the above, any Minnesota resident holder of a policy or certificate of Medicare supplement coverages pursuant to sections 62A.315 and 62A.316, or Medicare supplement plans previously approved by the commissioner, may enroll in the comprehensive health insurance plan as described

in section 62E.07, with a waiver of the preexisting condition as described in subdivision 3, without interruption in coverage, provided, the policy or certificate has been terminated by the insurer for reasons other than nonpayment of premium and, provided further, that the option to enroll in the plan is exercised within ~~30~~ 90 days of termination of the existing contract.

Coverage in the state plan for purposes of this section shall be effective on the date of termination upon completion of the proper application and payment of the required premium. The application must include evidence of termination of the existing policy or certificate.

Sec. 15. Minnesota Statutes 2000, section 62E.14, subdivision 5, is amended to read:

Subd. 5. **TERMINATED EMPLOYEES.** An employee who is voluntarily or involuntarily terminated or laid off from employment and unable to exercise the option to continue coverage under section 62A.17 may enroll, within ~~60~~ 90 days of termination or layoff, with a waiver of the preexisting condition limitation set forth in subdivision 3 and a waiver of the evidence of rejection set forth in subdivision 1, paragraph (c).

Sec. 16. Minnesota Statutes 2000, section 62E.14, subdivision 6, is amended to read:

Subd. 6. **TERMINATION OF INDIVIDUAL POLICY OR CONTRACT.** A Minnesota resident who holds an individual health maintenance contract, individual nonprofit health service corporation contract, or an individual insurance policy previously approved by the commissioners of health or commerce, may enroll in the comprehensive health insurance plan with a waiver of the preexisting condition as described in subdivision 3, without interruption in coverage, provided (1) no replacement coverage that meets the requirements of section 62D.121 was offered by the contributing member, and (2) the policy or contract has been terminated for reasons other than (a) nonpayment of premium; (b) failure to make copayments required by the health care plan; (c) moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership; and, provided further, that the option to enroll in the plan is exercised within ~~30~~ 90 days of termination of the existing policy or contract.

Coverage allowed under this section is effective when the contract or policy is terminated and the enrollee has completed the proper application and paid the required premium or fee.

Expenses incurred from the preexisting conditions of individuals enrolled in the state plan under this subdivision must be paid by the contributing member canceling coverage as set forth in section 62E.11, subdivision 10.

The application must include evidence of termination of the existing policy or certificate as required in subdivision 1.

Sec. 17. Minnesota Statutes 2000, section 62H.01, is amended to read:

62H.01 **AUTHORITY TO JOINTLY SELF-INSURE.**

Any two or more employers, excluding the state and its political subdivisions as described in section 471.617, subdivision 1, who are authorized to transact business in Minnesota may jointly self-insure employee health, dental, short-term disability benefits, or other benefits permitted under the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001 et seq. If an employer chooses to jointly self-insure in accordance with this chapter, the employer must participate in the joint plan for at least three consecutive years. If an employer terminates participation in the joint plan before the conclusion of this three-year period, a financial penalty may be assessed under the joint plan, not to exceed the amount contributed by the employer to the plan's reserves as determined under Minnesota Rules, part 2765.1200. Joint plans must have a minimum of ~~100~~ 1,000 covered employees and meet all conditions and terms of sections 62H.01 to 62H.08. Joint plans covering employers not resident in Minnesota must meet the requirements of sections 62H.01 to 62H.08 as if the portion of the plan covering Minnesota resident employees was treated as a separate plan. A plan may cover employees resident in other states only if the plan complies with the applicable laws of that state.

A multiple employer welfare arrangement as defined in United States Code, title 29, section 1002(40)(a), is subject to this chapter to the extent authorized by the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001 et seq. The commissioner of commerce may, on behalf of the state, enter into an agreement with the United States Secretary of Labor for delegation to the state of some or all of the secretary's enforcement authority with respect to multiple employer welfare arrangements, as described in United States Code, title 29, section 1136(c).

Sec. 18. Minnesota Statutes 2000, section 62H.04, is amended to read:

62H.04 **COMPLIANCE WITH OTHER LAWS.**

(a) A joint self-insurance plan is subject to the requirements of chapters 62A, 62E, ~~and~~ 62L, and 62Q, and sections 72A.17 to 72A.32 unless otherwise specifically exempt. ~~A joint self-insurance plan must not offer less than a number two qualified plan or its actuarial equivalent.~~ A joint self-insurance plan must pay assessments made by the Minnesota Comprehensive Health Association, as required under section 62E.11.

(b) A joint self-insurance plan is exempt from providing the mandated health benefits described in chapters 62A, 62E, 62L, and 62Q if it otherwise provides the benefits required under the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001, et seq., for all employers and not just for the employers with 50 or more employees who are covered by that federal law.

(c) A joint self-insurance plan is exempt from section 62L.03, subdivision 1, if the plan offers an annual open enrollment period of no less than 15 days during which all employers that qualify for membership may enter the plan without preexisting condition limitations or exclusions except those permitted under chapter 62L.

(d) A joint self-insurance plan is exempt from sections 62A.16, 62A.17, 62A.20, and 62A.21 if the joint self-insurance plan complies with the continuation requirements

under the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001, et seq., for all employers and not just for the employers with 20 or more employees who are covered by that federal law.

(e) A joint self-insurance plan must provide to all employers the maternity coverage required by federal law for employers with 15 or more employees.

Sec. 19. Minnesota Statutes 2000, section 62J.51, subdivision 19, is amended to read:

Subd. 19. **UNIFORM DENTAL BILLING FORM.** "Uniform dental billing form" means the ~~1990~~ most current version uniform dental claim form developed by the American Dental Association.

Sec. 20. Minnesota Statutes 2000, section 62J.535, is amended by adding a subdivision to read:

Subd. 1a. **ELECTRONIC CLAIM TRANSACTIONS.** Group purchasers, including government programs, not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, that voluntarily agree with providers to accept electronic claim transactions, must accept them in the ANSI X12N 837 standard electronic format as established by federal law. Nothing in this section requires acceptance of electronic claim transactions by entities not covered under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Sec. 21. Minnesota Statutes 2000, section 62J.535, is amended by adding a subdivision to read:

Subd. 1b. **PAPER CLAIM TRANSACTIONS.** All group purchasers that accept paper claim transactions must accept, and health care providers submitting paper claim transactions must submit, these transactions with use of the applicable medical and nonmedical data code sets specified in the federal electronic claim transaction standards adopted under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. The paper claim transaction must also be conducted using the uniform billing forms as specified in section 62J.52 and the identifiers specified in section 62J.54, on and after the compliance date required by law. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Sec. 22. Minnesota Statutes 2000, section 62J.535, subdivision 2, is amended to read:

Subd. 2. **COMPLIANCE.** ~~(a)~~ Subdivision 1a is effective concurrent with the date of required compliance for covered entities established under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time~~, for uniform electronic billing standards, all health care providers must conform to the uniform billing standards developed under subdivision 1~~.

~~(b) Notwithstanding paragraph (a), the requirements for the uniform remittance advice report shall be effective 12 months after the date of the required compliance of the standards for the electronic remittance advice transaction are effective under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time.~~

Sec. 23. Minnesota Statutes 2000, section 62J.581, is amended to read:

62J.581 **STANDARDS FOR MINNESOTA UNIFORM HEALTH CARE REIMBURSEMENT DOCUMENTS.**

Subdivision 1. **MINNESOTA UNIFORM REMITTANCE ADVICE REPORT.** (a) All group purchasers ~~and payers~~ shall provide a uniform remittance advice report to health care providers when a claim is adjudicated. The uniform remittance advice report shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 2. **MINNESOTA UNIFORM EXPLANATION OF BENEFITS DOCUMENT.** (a) All group purchasers ~~and payers~~ shall provide a uniform explanation of benefits document to health care patients when a ~~claim is adjudicated~~ an explanation of benefits document is provided as otherwise required or permitted by law. The uniform explanation of benefits document shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 3. **SCOPE.** For purposes of sections 62J.50 to 62J.61, the uniform remittance advice report and the uniform explanation of benefits document format specified in subdivision 4 shall apply to all health care services delivered by a health care provider or health care provider organization in Minnesota, regardless of the location of the payer. Health care services not paid on an individual claims basis, such as capitated payments, are not included in this section. A health plan company is excluded from the requirements in subdivisions 1 and 2 if they comply with section 62A.01, subdivisions 2 and 3.

Subd. 4. **SPECIFICATIONS.** The uniform remittance advice report and the uniform explanation of benefits document shall be provided by use of a paper document conforming to the specifications in this section or by use of the ANSI X12N 835 standard electronic format as established under United States Code, title 42, sections 1320d to 1320d-8, and as amended from time to time for the remittance advice. The commissioner, after consulting with the administrative uniformity committee, shall specify the data elements and definitions for the uniform remittance advice report and the uniform explanation of benefits document. The commissioner and the administrative uniformity committee must consult with the Minnesota Dental Association and Delta Dental Plan of Minnesota before requiring under this section the use of a paper document for the uniform explanation of benefits document or the uniform remittance advice report for dental care services.

Subd. 5. **EFFECTIVE DATE.** The requirements in subdivisions 1 and 2 are effective ~~12 months after the date of required compliance with the standards for the electronic remittance advice transaction under United States Code, title 42, sections 1320d to 1320d-8, and as amended from time to time~~ October 16, 2004. The requirements in subdivisions 1 and 2 apply regardless of when the health care service was provided to the patient.

Sec. 24. Minnesota Statutes 2000, section 62L.03, subdivision 1, is amended to read:

Subdivision 1. **GUARANTEED ISSUE AND REISSUE.** (a) Every health carrier shall, as a condition of authority to transact business in this state in the small employer market, affirmatively market, offer, sell, issue, and renew any of its health benefit plans, on a guaranteed issue basis, to any small employer, including a small employer covered by paragraph (b), that meets the participation and contribution requirements of subdivision 3, as provided in this chapter.

(b) A small employer that has its workforce reduced to one employee may continue coverage as a small employer for 12 months from the date the group is reduced to one employee.

(c) Notwithstanding paragraph (a), a health carrier may, at the time of coverage renewal, modify the health coverage for a product offered in the small employer market if the modification is consistent with state law, approved by the commissioner, and effective on a uniform basis for all small employers purchasing that product other than through a qualified association in compliance with section 62L.045, subdivision 2.

Paragraph (a) does not apply to a health benefit plan designed for a small employer to comply with a collective bargaining agreement, provided that the health benefit plan otherwise complies with this chapter and is not offered to other small employers, except for other small employers that need it for the same reason. This paragraph applies only with respect to collective bargaining agreements entered into prior to August 21, 1996, and only with respect to plan years beginning before the later of July 1, 1997, or the date upon which the last of the collective bargaining agreements relating to the plan terminates determined without regard to any extension agreed to after August 21, 1996.

~~(c)~~ (d) Every health carrier participating in the small employer market shall make available both of the plans described in section 62L.05 to small employers and shall fully comply with the underwriting and the rate restrictions specified in this chapter for all health benefit plans issued to small employers.

~~(d)~~ (e) A health carrier may cease to transact business in the small employer market as provided under section 62L.09.

Sec. 25. Minnesota Statutes 2000, section 62L.03, subdivision 5, is amended to read:

Subd. 5. **CANCELLATIONS AND FAILURES TO RENEW.** (a) No health carrier shall cancel, decline to issue, or fail to renew a health benefit plan as a result of the claim experience or health status of the persons covered or to be covered by the health benefit plan. For purposes of this subdivision, a failure to renew does not include a uniform modification of coverage at time of renewal, as described in subdivision 1.

(b) A health carrier may cancel or fail to renew a health benefit plan:

(1) for nonpayment of the required premium;

(2) for fraud or misrepresentation by the small employer with respect to eligibility for coverage or any other material fact;

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

(4) for any other reasons or grounds expressly permitted by the respective licensing laws and regulations governing a health carrier, including, but not limited to, service area restrictions imposed on health maintenance organizations under section 62D.03, subdivision 4, paragraph (m), to the extent that these grounds are not expressly inconsistent with this chapter.

(c) A health carrier may fail to renew a health benefit plan:

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

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

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

(d) A health carrier need not renew a health benefit plan, and shall not renew a small employer plan, if an employer ceases to qualify as a small employer as defined in section 62L.02, except as provided in subdivision 1, paragraph (b). If a health benefit plan, other than a small employer plan, provides terms of renewal that do not exclude an employer that is no longer a small employer, the health benefit plan may be renewed

according to its own terms. If a health carrier issues or renews a health plan to an employer that is no longer a small employer, without interruption of coverage, the health plan is subject to section 60A.082.

(e) A health carrier may cancel or fail to renew the coverage of an individual employee or dependent under a health benefit plan for fraud or misrepresentation by the eligible employee or dependent with respect to eligibility for coverage or any other material fact.

Sec. 26. Minnesota Statutes 2000, section 62L.08, is amended by adding a subdivision to read:

Subd. 2a. **RENEWAL PREMIUM INCREASES LIMITED.** (a) Beginning January 1, 2003, the percentage increase in the premium rate charged to a small employer for a new rating period must not exceed the sum of the following:

(1) the percentage change in the index rate measured from the first day of the prior rating period to the first day of the new rating period;

(2) an adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than one year, due to the claims experience, health status, or duration of coverage of the employees or dependents of the employer; and

(3) any adjustment due to change in coverage or in the case characteristics of the employer.

(b) This subdivision does not apply if the employer, employee, or any applicant provides the health carrier with false, incomplete, or misleading information.

Sec. 27. Minnesota Statutes 2001 Supplement, section 62M.03, subdivision 2, is amended to read:

Subd. 2. **NONLICENSED UTILIZATION REVIEW ORGANIZATION.** An organization that meets the definition of a utilization review organization under section 62M.02, subdivision 21, that is not licensed in this state that performs utilization review services for Minnesota residents must register with the commissioner of commerce and must certify compliance with sections 62M.01 to 62M.16.

Initial registration must occur no later than January 1, 1993. The registration is effective for two years and may be renewed ~~for another two years by written request~~. Applications for initial and renewal registrations must be made on forms prescribed by the commissioner. Each utilization review organization registered under this chapter shall notify the commissioner of commerce within 30 days of any change in the name, address, or ownership of the organization. The organization shall pay to the commissioner of commerce a fee of $1,000 for the initial registration application and $1,000 for each two-year renewal.

Sec. 28. Minnesota Statutes 2000, section 62Q.68, subdivision 1, is amended to read:

Subdivision 1. **APPLICATION.** For purposes of sections 62Q.68 to 62Q.72, the terms defined in this section have the meanings given them. For purposes of sections

62Q.69 and 62Q.70, the term "health plan company" does not include an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01 or a nonprofit health service plan corporation regulated under chapter 62C that only provides dental coverage or vision coverage. For purposes of sections 62Q.69 through 62Q.73, the term "health plan company" does not include the comprehensive health association created under chapter 62E.

Sec. 29. **[62Q.731] EXTERNAL REVIEW OF ADVERSE DETERMINATION FROM COMPREHENSIVE HEALTH ASSOCIATION.**

Subdivision 1. **DEFINITIONS.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Enrollee" means an eligible person as defined in section 62E.02, subdivision 13, and who meets the eligibility criteria established in section 62E.14.

(c) "Board" means the board of directors of the comprehensive health association, as described in section 62E.10, subdivision 2.

Subd. 2. **APPEAL TO EXTERNAL REVIEW ENTITY.** If an enrollee receives an adverse determination as a result of the comprehensive health association's internal appeal process, by which an established enrollee appeal committee renders an adverse determination, the enrollee then has the option of:

(1) appealing the adverse determination to the external review entity under section 62Q.73, which shall constitute a final determination subject to the conditions specified in section 62Q.73; or

(2) appealing to the commissioner of commerce from an adverse determination as provided by the operating rules of the comprehensive health association, in which case the commissioner has the option of making a determination regarding the appeal, or submitting the appeal to the external review entity retained under section 62Q.73.

Sec. 30. Minnesota Statutes 2000, section 72A.08, subdivision 1, is amended to read:

Subdivision 1. **REBATE DEFINED AND PROHIBITED.** No insurance company or association, however constituted or entitled, including any affiliate of the insurance company or association, doing business in this state, nor any officer, agent, subagent, solicitor, employee, intermediary, or representative thereof, shall make or permit any advantage or distinction in favor of any insured individual, firm, corporation, or association with respect to the amount of premium named in, or to be paid on, any policy of insurance, or shall offer to pay or allow directly or indirectly or by means of any device or artifice, including by means of participation in any arrangement with an affiliate, as inducements to insurance, any rebate or premium payable on the policy, or any special favor or advantage in the dividends or other profit to accrue thereon, or any valuable consideration or inducement not specified in the policy contract of insurance, including a reduced interest rate, reduced loan-related or financing-related fee, or other consideration or inducement in connection with a loan

or other financing arrangement provided or to be provided by an affiliate, or give, sell, or purchase, offer to give, sell or purchase, as inducement to insure or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, partnership, or individual, or any dividends or profits accrued or to accrue thereon, or anything of value, not specified in the policy. For purposes of this section, "affiliate" has the meaning given in section 60D.15, subdivision 2. No person or entity may offer, sell, issue, or renew insurance if the person or entity knows that an affiliate of the person or entity is violating this subdivision in connection with the offer, sale, issuance, or renewal of the insurance.

Sec. 31. Minnesota Statutes 2000, section 79A.04, subdivision 9, is amended to read:

Subd. 9. **INSOLVENCY, BANKRUPTCY, OR DEFAULT; UTILIZATION OF SECURITY DEPOSIT.** The commissioner of labor and industry shall notify the commissioner and the security fund if the commissioner of labor and industry has knowledge that any private self-insurer has failed to pay workers' compensation benefits as required by chapter 176. ~~If the commissioner determines that a private self-insurer is the subject of a voluntary or involuntary petition under the United States Bankruptcy Code, title 11, or the commissioner determines that a court of competent jurisdiction has declared the private self-insurer to be bankrupt or insolvent, and the private self-insurer has failed to pay workers' compensation as required by chapter 176 or, if the commissioner issues a certificate of default against a private self-insurer for failure to pay workers' compensation as required by chapter 176, or failure to pay an assessment to the self-insurers' security fund when due, then the security deposit shall be utilized to administer and pay the private self-insurers' workers' compensation or assessment obligations or any other current or future obligations of the self-insurers' security fund.~~ The security deposit shall be used to administer and pay the private self-insurers' workers' compensation or assessment obligations or any other current or future obligations of the self-insurers' security fund if any of the following occurs:

(1) the private self-insurer has failed to pay workers' compensation as required by chapter 176 and either:

(a) the commissioner determines that a private self-insurer is the subject of a voluntary or involuntary petition under the United States Bankruptcy Code, title 11; or

(b) the commissioner determines that a court of competent jurisdiction has declared the private self-insurer to be bankrupt or insolvent; or

(2) the commissioner issues a certificate of default against a private self-insurer for failure to pay workers' compensation as required by chapter 176; or

(3) the commissioner issues a certificate of default against a private self-insurer for failure to pay an assessment to the self-insurer's security fund when due.

Sec. 32. Laws 2001, chapter 117, article 1, section 29, is amended to read:

Sec. 29. **EFFECTIVE DATE; APPLICATION.**

Sections 1 to 28 are effective July 1, 2002, and apply to persons who sell, solicit, or negotiate insurance in this state for any class or classes of insurance on or after that date. However, a person required to be licensed under Minnesota Statutes, chapter 60K, who holds a valid license under Minnesota Statutes 2000, sections 60K.01 to 60K.20, on July 1, 2002, may continue to sell, solicit, or negotiate insurance in this state under the authority of that license. Upon the expiration of that license, the person shall not sell, solicit, or negotiate insurance in this state for any class or classes of insurance unless the person is licensed in that line of authority under Minnesota Statutes, chapter 60K.

Sec. 33. **REVISOR INSTRUCTION.**

The revisor of statutes is instructed to amend the headnote of Minnesota Statutes, section 62J.535, to read "Uniform Billing Requirements for Claim Transactions."

Sec. 34. **EXPIRATION.**

Section 30 expires June 1, 2003.

Sec. 35. **REPEALER.**

Minnesota Statutes 2000, section 62J.535, subdivision 1, is repealed.

Sec. 36. **EFFECTIVE DATE.**

Sections 7 and 30 are effective the day following final enactment. Section 3 is effective for dividends paid after December 31, 2000.

Presented to the governor April 4, 2002

Signed by the governor April 8, 2002, 4:20 p.m.

CHAPTER 331—S.F.No. 3015

An act relating to commerce; establishing a division of insurance fraud prevention within the department of commerce to investigate and prosecute insurance fraud; appropriating money; prescribing criminal penalties; amending Minnesota Statutes 2000, sections 60A.951, subdivisions 1, 2, by adding subdivisions; 60A.952, subdivisions 1, 2, by adding subdivisions; 60A.953; proposing coding for new law in Minnesota Statutes, chapters 45; 60A; 609; repealing Minnesota Statutes 2000, section 175.16, subdivision 2; 2002 H.F. No. 2988, sections 30, if enacted, 34, if enacted.

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

Section 1. **[45.0135] DIVISION OF INSURANCE FRAUD PREVENTION.**

Subdivision 1. **CREATION.** The division of insurance fraud prevention is established in the department of commerce. The division of insurance fraud prevention shall: