

CHAPTER 285—H.F.No. 2258

An act relating to commerce; establishing risk-based capital requirements for health organizations; establishing the minimum standard of valuation for health insurance; enacting model regulations of the National Association of Insurance Commissioners; regulating loss revenue certifications; regulating disclosure of information to certain investigatory entities; amending Minnesota Statutes 2002, sections 45.027, subdivision 7a; 60A.03, subdivision 9; 60A.031, subdivision 4; 60A.129, subdivision 2; 62C.09, by adding a subdivision; 62D.04, subdivision 1; 62D.041, subdivision 2; 62D.042, subdivisions 1, 2; 62N.25, subdivision 6; 62N.27, subdivision 1; 62N.29; proposing coding for new law in Minnesota Statutes, chapter 60A; repealing Minnesota Statutes 2002, sections 62C.09, subdivisions 3, 4; 62D.042, subdivisions 5, 6, 7; 62D.043; Minnesota Rules, part 4685.0600.

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

ARTICLE 1

RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS

Section 1. **[60A.50] DEFINITIONS.**

Subdivision 1. SCOPE. For purposes of sections 60A.50 to 60A.592 the terms in subdivisions 2 to 13 have the meanings given them.

Subd. 2. ADJUSTED RBC REPORT. "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with section 60A.51, subdivision 3.

Subd. 3. COMMISSIONER. "Commissioner" means the commissioner of commerce or the commissioner of health, whichever commissioner otherwise regulates the health organization.

Subd. 4. CORRECTIVE ORDER. "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required.

Subd. 5. DOMESTIC HEALTH ORGANIZATION. "Domestic health organization" means a health organization domiciled in this state.

Subd. 6. FOREIGN HEALTH ORGANIZATION. "Foreign health organization" means a health organization that is licensed to do business in this state but is not domiciled in this state.

Subd. 7. NAIC. "NAIC" means the National Association of Insurance Commissioners.

Subd. 8. HEALTH ORGANIZATION. "Health organization" means an entity licensed under this chapter or chapter 62C or 62D. This definition does not include an

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organization that is licensed or regulated as either a life and health insurer or a property and casualty insurer that is otherwise subject to either the life or property and casualty risk-based capital requirements.

Subd. 9. RBC INSTRUCTIONS. "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

Subd. 10. RBC LEVEL. "RBC level" means a health organization's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(1) "company action level RBC" means, with respect to any health organization, the product of 2.0 and its authorized control level RBC;

(2) "regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(3) "authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions; and

(4) "mandatory control level RBC" means the product of .70 and the authorized control level RBC.

Subd. 11. RBC PLAN. "RBC plan" means a comprehensive financial plan containing the elements specified in section 60A.52, subdivision 2. If the commissioner rejects the RBC plan, and it is revised by the health organization, with or without the commissioner's recommendation, the plan must be called the "revised RBC plan."

Subd. 12. RBC REPORT. "RBC report" means the report required in section 60A.51.

Subd. 13. TOTAL ADJUSTED CAPITAL. "Total adjusted capital" means the sum of:

(1) a health organization's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed; and

(2) such other items, if any, as the RBC instructions may provide.

Sec. 2. [60A.51] RBC REPORTS.

Subdivision 1. SUBMISSIONS. A domestic health organization shall, on or before each April 1, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing the information required by the RBC instructions. In addition, a domestic health organization shall file its RBC report:

(1) with the NAIC in accordance with the RBC instructions; and

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(2) with the insurance commissioner in any state in which the health organization is authorized to do business, if the insurance commissioner has notified the health organization of its request in writing, in which case the health organization shall file its RBC report not later than the later of:

- (1) 15 days from the receipt of notice to file its RBC report with that state; or
- (2) the filing date.

Subd. 2. DETERMINATION. A health organization's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take the following into account, and may adjust for the covariance between, determined in each case by applying the factors in the manner set forth in the RBC instructions:

- (1) asset risk;
- (2) credit risk;
- (3) underwriting risk; and

(4) all other business risks and such other relevant risks as are set forth in the RBC instructions.

Subd. 3. ADJUSTED REPORT. If a domestic health organization files an RBC report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health organization of the adjustment. The notice must contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

Sec. 3. [60A.52] COMPANY ACTION LEVEL EVENT.

Subdivision 1. DEFINITION. "Company action level event" means the following events:

(1) the filing of an RBC report by a health organization that indicates that the health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(2) notification by the commissioner to the health organization of an adjusted RBC report that indicates an event in clause (1), provided the health organization does not challenge the adjusted RBC report under section 60A.56; or

(3) if, pursuant to section 60A.56, a health organization challenges an adjusted RBC report that indicates the event in clause (1), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

Subd. 2. RBC PLAN REQUIRED. In the event of a company action level event, the health organization shall prepare and submit to the commissioner an RBC plan that:

- (1) identifies the conditions that contribute to the company action level event;

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(2) contains proposals of corrective actions that the health organization intends to take and that would be expected to result in the elimination of the company action level event;

(3) provides projections of the health organization's financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) identifies the key assumptions impacting the health organization's projections and the sensitivity of the projections to the assumptions; and

(5) identifies the quality of, and problems associated with, the health organization's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

Subd. 3. RBC PLAN SUBMISSION. The RBC plan must be submitted:

(1) within 45 days of the Company Action Level Event; or

(2) if the health organization challenges an adjusted RBC report pursuant to section 60A.56, within 45 days after notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

Subd. 4. RBC PLAN IMPLEMENTATION. Within 60 days after the submission by a health organization of an RBC plan to the commissioner, the commissioner shall notify the health organization whether the RBC plan must be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the health organization must set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the health organization shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(1) within 45 days after the notification from the commissioner; or

(2) if the health organization challenges the notification from the commissioner under section 60A.56, within 45 days after a notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

Subd. 5. UNSATISFACTORY PLAN. In the event of a notification by the commissioner to a health organization that the health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, at the commissioner's discretion, subject to the health organization's right to a hearing under section 60A.56, specify in the notification that the notification constitutes a regulatory action level event.

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Subd. 6. ADDITIONAL FILING. Every domestic health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the health organization is authorized to do business if:

(1) the state has an RBC provision substantially similar in section 60A.57, subdivision 1; and

(2) the insurance commissioner of that state has notified the health organization of its request for the filing in writing, in which case the health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under subdivisions 3 and 4.

Sec. 4. [60A.53] REGULATORY ACTION LEVEL EVENT.

Subdivision 1. DEFINITION. "Regulatory action level event" means, with respect to a health organization, any of the following events:

(1) the filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(2) notification by the commissioner to a health organization of an adjusted RBC report that indicates the event in clause (1), provided the health organization does not challenge the adjusted RBC report under section 60A.56;

(3) if, pursuant to section 60A.56, the health organization challenges an adjusted RBC report that indicates the event in clause (1), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(4) the failure of the health organization to file an RBC report by the filing date, unless the health organization has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within ten days after the filing date;

(5) the failure of the health organization to submit an RBC plan to the commissioner within the time period set forth in section 60A.52, subdivision 3;

(6) notification by the commissioner to the health organization that:

(i) the RBC plan or revised RBC plan submitted by the health organization is, in the judgment of the commissioner, unsatisfactory; and

(ii) notification constitutes a regulatory action level event with respect to the health organization, provided the health organization has not challenged the determination under section 60A.56;

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(7) if, pursuant to section 60A.56, the health organization challenges a determination by the commissioner under clause (6), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge;

(8) notification by the commissioner to the health organization that the health organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the health organization has not challenged the determination under section 60A.50; or

(9) if, pursuant to section 60A.56, the health organization challenges a determination by the commissioner under clause (8), the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge.

Subd. 2. COMMISSIONER'S DUTIES. In the event of a regulatory action level event the commissioner shall:

(1) require the health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) perform any examination or analysis the commissioner considers necessary of the assets, liabilities, and operations of the health organization, including a review of its RBC plan or revised RBC plan; and

(3) after the examination or analysis, issue a corrective order specifying the corrective actions the commissioner determines are required.

Subd. 3. CORRECTIVE ACTIONS. In determining corrective actions, the commissioner may take into account factors the commissioner considers relevant with respect to the health organization based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the health organization, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan must be submitted:

(1) within 45 days after the occurrence of the regulatory action level event;

(2) if the health organization challenges an adjusted RBC report pursuant to section 60A.56 and the challenge is not frivolous in the judgment of the commissioner within 45 days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge; or

(3) if the health organization challenges a revised RBC plan pursuant to section 60A.56 and the challenge is not frivolous in the judgment of the commissioner, within 45 days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

Subd. 4. CONSULTANTS. The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the

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commissioner to review the health organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities, and operations, including contractual relationships, of the health organization and formulate the corrective order with respect to the health organization. The fees, costs, and expenses relating to consultants must be borne by the affected health organization or such other party as directed by the commissioner.

Sec. 5. [60A.54] AUTHORIZED CONTROL LEVEL EVENT.

Subdivision 1. DEFINITION. "Authorized control level event" means any of the following events:

(1) the filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(2) the notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in clause (1), provided the health organization does not challenge the adjusted RBC report under section 60A.56;

(3) if, pursuant to section 60A.56, the health organization challenges an adjusted RBC report that indicates the event in clause (1), notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(4) the failure of the health organization to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the health organization has not challenged the corrective order under section 60A.56; or

(5) if the health organization has challenged a corrective order under section 60A.56 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

Subd. 2. COMMISSIONER'S DUTIES. In the event of an authorized control level event with respect to a health organization, the commissioner shall:

(1) take such actions as are required under section 60A.53 regarding a health organization with respect to which a regulatory action level event has occurred; or

(2) if the commissioner considers it to be in the best interests of the policyholders and creditors of the health organization and of the public, take such actions as are necessary to cause the health organization to be placed under regulatory control under chapter 60B. In the event the commissioner takes such actions, the authorized control level event is considered sufficient grounds for the commissioner to take action under chapter 60B, and the commissioner shall have the rights, powers, and duties with respect to the health organization as are set forth in chapter 60B. In the event the commissioner takes actions under this clause pursuant to an adjusted RBC report, the health organization is entitled to the protections afforded health organizations under sections 60B.11 and 60B.13 pertaining to summary proceedings.

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Sec. 6. [60A.55] MANDATORY CONTROL LEVEL EVENT.

Subdivision 1. DEFINITION. "Mandatory control level event" means any of the following events:

(1) the filing of an RBC report which indicates that the health organization's total adjusted capital is less than its mandatory control level RBC;

(2) notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in clause (1), provided the health organization does not challenge the adjusted RBC report under section 60A.56; or

(3) if, pursuant to section 60A.56, the health organization challenges an adjusted RBC report that indicates the event in clause (1), notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

Subd. 2. COMMISSIONER'S DUTIES. (a) In the event of a mandatory control level event, the commissioner shall take such actions as are necessary to place the health organization under regulatory control under section 60B.13. In that event, the mandatory control level event is considered sufficient grounds for the commissioner to take action under section 60B.13, and the commissioner shall have the rights, powers, and duties with respect to the health organization as are set forth in section 60B.13. If the commissioner takes actions pursuant to an adjusted RBC report, the health organization is entitled to the protections of sections 60B.11 and 60B.13 pertaining to summary proceedings.

(b) Notwithstanding paragraph (a), the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

Sec. 7. [60A.56] HEARINGS.

Upon the occurrence of any of the following events, the health organization has the right to a confidential departmental hearing, on a record, at which the health organization may challenge any determination or action by the commissioner. The health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under clause (1), (2), (3), or (4). Upon receipt of the health organization's request for a hearing, the commissioner shall set a date for the hearing, which must be no less than ten nor more than 30 days after the date of the health organization's request. The events include:

(1) notification to a health organization by the commissioner of an adjusted RBC report;

(2) notification to a health organization by the commissioner that:

(i) the health organization's RBC plan or revised RBC plan is unsatisfactory; and

(ii) notification constitutes a regulatory action level event with respect to the health organization;

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(3) notification to a health organization by the commissioner that the health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event with respect to the health organization in accordance with its RBC plan or revised RBC plan; or

(4) notification to a health organization by the commissioner of a corrective order with respect to the health organization.

Sec. 8. [60A.57] ACCESS TO AND USE OF RBC INFORMATION.

Subdivision 1. CONFIDENTIALITY; PROHIBITION ON ANNOUNCEMENTS. Section 60A.67, subdivisions 1 and 2, apply to sections 60A.50 to 60A.592.

Subd. 2. PROHIBITION FOR RATE MAKING OR PREMIUM SETTING. The RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of health organizations and the need for possible corrective action with respect to health organizations and shall not be used by the commissioner for rate making nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health organization or any affiliate is authorized to write.

Sec. 9. [60A.58] SUPPLEMENTAL PROVISIONS.

Subdivision 1. EFFECT. Sections 60A.50 to 60A.592 are supplemental to any other provisions of the laws of this state, and must not preclude or limit any other powers or duties of the commissioner under such laws, including, but not limited to, chapter 60B and sections 62D.041, 62D.042, 62D.18, and 62D.181.

Subd. 2. EXEMPTION. The commissioner may exempt from the application of sections 60A.50 to 60A.592 a domestic health organization that:

- (1) writes direct business only in this state;
- (2) assumes no reinsurance in excess of five percent of direct premium written;
and
- (3) writes direct annual premiums for comprehensive medical business of \$2,000,000 or less.

Sec. 10. [60A.59] FOREIGN HEALTH ORGANIZATIONS.

Subdivision 1. RBC REPORT. (a) A foreign health organization shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended the later of:

- (1) the date an RBC report would be required to be filed by a domestic health organization under sections 60A.50 to 60A.592; or
- (2) 15 days after the request is received by the foreign health organization.

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(b) A foreign health organization shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

Subd. 2. RBC PLAN. In the event of a company action level event, regulatory action level event, or authorized control level event with respect to a foreign health organization as determined under the RBC statute applicable in the state of domicile of the health organization or, if no RBC statute is in force in that state, under sections 60A.50 to 60A.592, if the insurance commissioner of the state of domicile of the foreign health organization fails to require the foreign health organization to file an RBC plan in the manner specified under that state's RBC statute or, if no RBC statute is in force in that state, under section 60A.52, the commissioner may require the foreign health organization to file an RBC plan with the commissioner. In such event, the failure of the foreign health organization to file an RBC plan with the commissioner shall be grounds to order the health organization to cease and desist from writing new insurance business in this state. This section does not limit the commissioner's authority to require a foreign insurer to file a copy of the risk-based capital plan submitted to the commissioner in the state of domicile.

Subd. 3. LIQUIDATION OF PROPERTY. In the event of a mandatory control level event with respect to a foreign health organization, if no domiciliary receiver has been appointed with respect to the foreign health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health organization, the commissioner may make application to the district court permitted under chapter 60B with respect to the liquidation of property of foreign health organizations found in this state, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

Sec. 11. [60A.591] IMMUNITY.

There is no liability on the part of, and no cause of action arises against, the commissioner or the department or its employees or agents for any action taken by them in the performance of their powers and duties under sections 60A.50 to 60A.592.

Sec. 12. [60A.592] NOTICES.

All notices by the commissioner to a health organization that may result in regulatory action under sections 60A.50 to 60A.592 are effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission are effective upon the health organization's receipt of notice.

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ARTICLE 2

MINIMUM STANDARD OF VALUATION FOR

HEALTH INSURANCE

Section 1. [60A.76] PURPOSE AND SCOPE.

Sections 60A.76 to 60A.768 apply to all individual and group accident and health insurance coverages as defined in section 60A.06, subdivision 1, paragraph (5)(a), including single premium credit disability insurance. Other credit insurance is not subject to sections 60A.76 to 60A.768.

When an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified in sections 60A.76 to 60A.768, the increased reserves must be held and must be considered the minimum reserves for that insurer.

With respect to any block of contracts, or with respect to an insurer's health business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. The prospective gross premium valuation must take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

The prospective gross premium valuation must be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's health business as a whole. In the event inadequacy is found to exist, immediate loss recognition must be made and the reserves restored to adequacy. Adequate reserves, inclusive of claim, premium, and contract reserves, if any, must be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under sections 60A.76 to 60A.768.

Whenever minimum reserves, as defined in sections 60A.76 to 60A.768, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under sections 60A.76 to 60A.768.

Sec. 2. [60A.761] GLOSSARY OF TECHNICAL TERMS USED.

Subdivision 1. SCOPE. As used in sections 60A.76 to 60A.768, the terms in subdivisions 2 to 21 have the meaning given them.

Subd. 2. ANNUAL CLAIM COST. "Annual claim cost" means the net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a \$100 monthly disability benefit, for a maximum disability benefit period of one

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year, with an elimination period of one week, with respect to a male at age 35, in a certain occupation might be \$12, while the gross premium for this benefit might be \$18. The additional \$6 would cover expenses and profit or contingencies.

Subd. 3. CLAIMS ACCRUED. “Claims accrued” means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or before the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for “accrued” benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

Subd. 4. CLAIMS REPORTED. “Claims reported” means when an insurer has been informed that a claim has been incurred, if the date reported is on or before the valuation date, the claim is considered as a reported claim for annual statement purposes.

Subd. 5. CLAIMS UNACCRUED. “Claims unaccrued” means that portion of claims incurred on or before the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest) must be established.

Subd. 6. CLAIMS UNREPORTED. “Claims unreported” means when an insurer has not been informed, on or before the valuation date, concerning a claim that has been incurred on or prior to the valuation date, the claim is considered as an unreported claim for annual statement purposes.

Subd. 7. DATE OF DISABLEMENT. “Date of disablement” means the earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor’s evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

Subd. 8. ELIMINATION PERIOD. “Elimination period” means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

Subd. 9. GROSS PREMIUM. “Gross premium” means the amount of premium charged by the insurer. It includes the net premium (based on claim-cost) for the risk, together with any loading for expenses, profit, or contingencies.

Subd. 10. GROUP INSURANCE. “Group insurance” means the term group insurance includes blanket insurance and franchise insurance and any other forms of group insurance.

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Subd. 11. LEVEL PREMIUM. “Level premium” means a premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time.

Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case, the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

Subd. 12. LONG-TERM CARE INSURANCE. “Long-term care insurance” means a qualified long-term care insurance policy or rider as defined in section 62S.01, subdivision 18, and a nonqualified long-term insurance policy or rider as defined in section 62A.46, subdivision 2.

Subd. 13. MODAL PREMIUM. “Modal premium” refers to the premium paid on a contract based on a premium term which could be annual, semiannual, quarterly, monthly, or weekly. Thus if the annual premium is \$100 and if, instead, monthly premiums of \$9 are paid then the modal premium is \$9.

Subd. 14. NEGATIVE RESERVE. “Negative reserve” means normally the terminal reserve is a positive value. However, if the values of the benefits are decreasing with advancing age or duration it could be a negative value, called a negative reserve.

Subd. 15. PRELIMINARY TERM RESERVE METHOD. “Preliminary term reserve method” means that under this method of valuation the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

Subd. 16. PRESENT VALUE OF AMOUNTS NOT YET DUE ON CLAIMS. “Present value of amounts not yet due on claims” means the reserve for “claims unaccrued” which may be discounted at interest.

Subd. 17. RATING BLOCK. “Rating block” means a grouping of contracts determined by the valuation actuary based on common characteristics, such as a policy form or forms having similar benefit designs.

Subd. 18. RESERVE. “Reserve” includes all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued.

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An insurer under its contracts promises benefits, which result in:

(a) claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves; or

(b) claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves;

Subd. 19. **TERMINAL RESERVE.** "Terminal reserve" means the reserve at the end of a contract year, and is defined as the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

Subd. 20. **UNEARNED PREMIUM RESERVE.** "Unearned premium reserve" means that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of \$120 was paid on November 1, \$20 would be earned as of December 31 and the remaining \$100 would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

Subd. 21. **VALUATION NET MODAL PREMIUM.** "Valuation net modal premium" means the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

Sec. 3. [60A.762] CATEGORIES OF RESERVES.

The following sections set forth minimum standards for three categories of health insurance reserves:

- (1) section 60A.763, claim reserves;
- (2) section 60A.764, premium reserves; and
- (3) section 60A.765, contract reserves.

Adequacy of an insurer's health insurance reserves is to be determined on the basis of all three categories combined. However, sections 60A.76 to 60A.768 emphasize the importance of determining appropriate reserves for each of the three categories separately.

Sec. 4. [60A.763] CLAIM RESERVES.

Subdivision 1. **GENERALLY.** (a) Claim reserves are required for all incurred but unpaid claims on all health insurance policies.

(b) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims.

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(c) Claim reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

Subd. 2. MINIMUM STANDARDS FOR CLAIM RESERVES FOR DISABILITY INCOME. (a) The maximum interest rate for claim reserves is specified in section 60A.768.

(b) Minimum standards with respect to morbidity are those specified in section 60A.768, except that, at the option of the insurer:

(1) for claims with a duration from date of disablement of less than two years, reserves may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities; and

(2) for group disability income claims with a duration from date of disablement of more than two years but less than five years, reserves may, with the approval of the commissioner, be based on the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for approval of a plan of modification to the reserve basis must include:

(i) an analysis of the credibility of the experience;

(ii) a description of how all of the insurer's experience is proposed to be used in setting reserves;

(iii) a description and quantification of the margins to be included;

(iv) a summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement;

(v) a copy of the approval of the proposed plan of modification by the commissioner of the state of domicile; and

(vi) any other information deemed necessary by the commissioner.

(c) For contracts with an elimination period, the duration of disablement must be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

Subd. 3. MINIMUM STANDARDS FOR CLAIM RESERVES FOR ALL OTHER BENEFITS. (a) The maximum interest rate for claim reserves is specified in section 60A.768.

(b) The reserve must be based on the insurer's experience, if the experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

Subd. 4. CLAIM RESERVE METHODS GENERALLY. A generally accepted actuarial reserving method or other reasonable method if the method is approved by the commissioner before the statement date, or a combination of methods as described in this section, may be used to estimate all claim liabilities. The methods used for

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estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, must be determined in the aggregate.

Sec. 5. [60A.764] PREMIUM RESERVES.

Subdivision 1. **GENERALLY.** (a) Unearned premium reserves are required for all contracts with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(b) If premiums due and unpaid are carried as an asset, the premiums must be treated as premiums in force, subject to unearned premium reserve determination. The value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums must be carried as an offsetting liability.

(c) The gross premiums paid in advance for a period of coverage beginning after the next premium due date which follows the date of valuation may be appropriately discounted to the valuation date and must be held either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

Subd. 2. **MINIMUM STANDARDS FOR UNEARNED PREMIUM RESERVES.** (a) The minimum unearned premium reserve with respect to a contract is the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with the premium determined on the basis of:

(1) the valuation net modal premium on the contract reserve basis applying to the contract; or

(2) the gross modal premium for the contract if no contract reserve applies.

(b) However, in no event may the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. The reserve must never be less than the expected claims for the period beyond the valuation date represented by the unearned premium reserve, to the extent not provided for elsewhere.

Subd. 3. **PREMIUM RESERVE METHODS GENERALLY.** The insurer may employ suitable approximations and estimates, including, but not limited to, groupings, averages, and aggregate estimation, in computing premium reserves. Approximations or estimates should be tested periodically to determine the continuing adequacy and reliability.

Sec. 6. [60A.765] CONTRACT RESERVES REQUIRED.

(a) Contract reserves are required, unless otherwise specified in paragraph (b) for:

(1) all individual and group contracts with which level premiums are used; or

(2) all individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds

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the value of any appropriate future valuation net premiums at that time. This evaluation may be applied on a rating block basis if the total premiums for the block were developed to support the total risk assumed and expected expenses for the block each year, and a qualified actuary certifies the premium development. The actuary must state in the certification that premiums for the rating block were developed such that each year's premium was intended to cover that year's costs without any prefunding. If the premium is also intended to recover costs for any prior years, the actuary must also disclose the reasons for and magnitude of the recovery. The values specified in this clause must be determined on the basis specified in section 60A.766, subdivisions 1 to 4.

(b) Contracts not requiring a contract reserve are:

(1) contracts that cannot be continued after one year from issue; or

(2) contracts already in force on the effective date of sections 60A.76 to 60A.768 for which no contract reserve was required under the immediately preceding standards.

(c) The contract reserve is in addition to claim reserves and premium reserves.

(d) The methods and procedures for contract reserves must be consistent with those for claim reserves for a contract, or else appropriate adjustment must be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral must be the same in both determinations.

Sec. 7. [60A.766] MINIMUM STANDARDS FOR CONTRACT RESERVES.

Subdivision 1. BASIS. (a) Minimum standards with respect to morbidity are those set forth in section 60A.768. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration, and period for which gross premiums have been calculated.

Contracts for which tabular morbidity standards are not specified in section 60A.768 must be valued using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner. The morbidity tables must contain a pattern of incurred claims cost that reflects the underlying morbidity and must not be constructed for the primary purpose of minimizing reserves.

(b) The maximum interest rate is specified in section 60A.768.

(c) Termination rates used in the computation of reserves must be on the basis of a mortality table as specified in section 60A.768 except as noted in clauses (1) to (3):

(1) under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard or for return of premium or other deferred cash benefits, total termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(i) 80 percent of the total termination rate used in the calculation of the gross premiums; or

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(ii) eight percent;

(2) for long-term care individual policies or group certificates issued after January 1, 1997, the contract reserve may be established on a basis of separate:

(i) mortality as specified in section 60A.768; and

(ii) terminations other than mortality, where the terminations are not to exceed:

A. for policy years one through four, the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums and eight percent;

B. for policy years five and later, the lesser of 100 percent of the voluntary lapse rate used in the calculation of gross premiums and four percent;

(3) where a morbidity standard specified in section 60A.768 is on an aggregate basis, the morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments must be appropriate to the underwriting and be acceptable to the commissioner.

Subd. 2. RESERVE METHOD. (a) For insurance, except long-term care and return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(b) For long-term care insurance, the minimum reserve is the reserve calculated as follows:

(1) for individual policies and group certificates issued on or before December 31, 1991, reserves calculated on the two-year full preliminary term methods;

(2) for individual policies and group certificates issued on or after January 1, 1992, reserves calculated on the one-year full preliminary term method.

(c) For return of premium or other deferred cash benefits, the minimum reserve is the reserve calculated as follows:

(1) on the one-year preliminary term method if the benefits are provided at any time before the 20th anniversary;

(2) on the two-year preliminary term method if the benefits are only provided on or after the 20th anniversary.

The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions, for example projected inflation rates, or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

Subd. 3. NEGATIVE RESERVES. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

Subd. 4. NONFORFEITURE BENEFITS FOR LONG-TERM CARE INSURANCE. The contract reserve on a policy basis must not be less than the net single

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premium for the nonforfeiture benefits at the appropriate policy duration, where the net single premium is computed according to the specifications in this section. While the consideration for nonforfeiture benefits in this section is specific to long-term care insurance, similar consideration may be applicable for other lines of business.

Subd. 5. ALTERNATIVE VALUATION METHODS AND ASSUMPTIONS GENERALLY. Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified in this section, an insurer may use any reasonable assumptions as to interest rates, termination and mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated in this section in determining a sound value of its liabilities under such contracts, including, but not limited to, the following: the net level premium method; the one-year full preliminary term method; prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses; the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, and grouping of similar contract forms; the computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and the use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

Subd. 6. TEST FOR ADEQUACY AND REASONABLENESS OF CONTRACT RESERVES. Annually, an appropriate review must be made of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of section 60A.766, subdivisions 1 to 4.

In the event a company has a contract or a group of related similar contracts for which future gross premiums will be restricted by contract, department rule, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the company shall establish contract reserves for such shortfall in the aggregate.

Sec. 8. [60A.767] REINSURANCE.

Increases to or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with sections 60A.76 to 60A.768 and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

Sec. 9. [60A.768] SPECIFIC STANDARDS FOR MORBIDITY, INTEREST, AND MORTALITY.

Subdivision 1. MORBIDITY. A. Minimum morbidity standards for valuation of specified individual contract health insurance benefits are as follows:

- (1) Disability Income Benefits Due to Accident or Sickness.

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(a) Contract Reserves:Contracts issued on or after January 1, 2004:The 1985 Commissioners Individual Disability Tables A (85CIDA); orThe 1985 Commissioners Individual Disability Tables B (85CIDB).

Each insurer shall elect, with respect to all individual contracts issued in any one statement year, whether it will use Tables A or Tables B as the minimum standard. The insurer may, however, elect to use the other tables with respect to any subsequent statement year.

(b) Claim Reserves:(i) For claims incurred on or after January 1, 2004:

The 1985 Commissioners Individual Disability Table A (85CIDA) with claim termination rates multiplied by the following adjustment factors:

	<u>Duration</u>	<u>Adjustment Factor</u>	<u>Adjusted Termination Rates*</u>
<u>Week</u>	<u>1</u>	<u>0.366</u>	<u>0.04831</u>
	<u>2</u>	<u>0.366</u>	<u>0.04172</u>
	<u>3</u>	<u>0.366</u>	<u>0.04063</u>
	<u>4</u>	<u>0.366</u>	<u>0.04355</u>
	<u>5</u>	<u>0.365</u>	<u>0.04088</u>
	<u>6</u>	<u>0.365</u>	<u>0.04271</u>
	<u>7</u>	<u>0.365</u>	<u>0.04380</u>
	<u>8</u>	<u>0.365</u>	<u>0.04344</u>
	<u>9</u>	<u>0.370</u>	<u>0.04292</u>
	<u>10</u>	<u>0.370</u>	<u>0.04107</u>
	<u>11</u>	<u>0.370</u>	<u>0.03848</u>
	<u>12</u>	<u>0.370</u>	<u>0.03478</u>
	<u>13</u>	<u>0.370</u>	<u>0.03034</u>
<u>Month</u>	<u>4</u>	<u>0.391</u>	<u>0.08758</u>
	<u>5</u>	<u>0.371</u>	<u>0.07346</u>
	<u>6</u>	<u>0.435</u>	<u>0.07531</u>
	<u>7</u>	<u>0.500</u>	<u>0.07245</u>
	<u>8</u>	<u>0.564</u>	<u>0.06655</u>
	<u>9</u>	<u>0.613</u>	<u>0.05520</u>
	<u>10</u>	<u>0.663</u>	<u>0.04705</u>
	<u>11</u>	<u>0.712</u>	<u>0.04486</u>
	<u>12</u>	<u>0.756</u>	<u>0.04309</u>
	<u>13</u>	<u>0.800</u>	<u>0.04080</u>
	<u>14</u>	<u>0.844</u>	<u>0.03882</u>
	<u>15</u>	<u>0.888</u>	<u>0.03730</u>
<u>16</u>	<u>0.932</u>	<u>0.03448</u>	

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<u>17</u>		<u>0.976</u>	<u>0.03026</u>
<u>18</u>		<u>1.020</u>	<u>0.02856</u>
<u>19</u>		<u>1.049</u>	<u>0.02518</u>
<u>20</u>		<u>1.078</u>	<u>0.02264</u>
<u>21</u>		<u>1.107</u>	<u>0.02104</u>
<u>22</u>		<u>1.136</u>	<u>0.01932</u>
<u>23</u>		<u>1.165</u>	<u>0.01865</u>
<u>24</u>		<u>1.195</u>	<u>0.01792</u>
<u>Year</u>	<u>3</u>	<u>1.369</u>	<u>0.16839</u>
	<u>4</u>	<u>1.204</u>	<u>0.10114</u>
	<u>5</u>	<u>1.199</u>	<u>0.07434</u>
	<u>6 and later</u>	<u>1.000</u>	<u>**</u>

* The adjusted termination rates derived from the application of the adjustment factors to the DTS Valuation Table termination rates shown in exhibits 3a, 3b, 3c, 4, and 5 (Transactions of the Society of Actuaries (TSA) XXXVII, pages 457-463) is displayed. The adjustment factors for age, elimination period, class, sex, and cause displayed in exhibits 3a, 3b, 3c, and 4 should be applied to the adjusted termination rates shown in this table.

** Applicable DTS Valuation Table duration rate from exhibits 3c and 4 (TSA XXXVII, pages 462-463).

The 85CIDA table so adjusted for the computation of claim reserves shall be known as 85C1DC (The 1985 Commissioners Individual Disability Table C).

(2) Hospital Benefits, Surgical Benefits, and Maternity Benefits (Scheduled benefits or fixed time period benefits only).

(a) Contract Reserves.

Contracts issued on or after January 1, 1982:

The 1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX, page 63. Refer to the paper (in the same volume, page 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

(b) Claim Reserves:

No specific standard. See (6).

(3) Cancer Expense Benefits (Scheduled benefits or fixed time period benefits only).

(a) Contract Reserves:

Contracts issued on or after January 1, 2004:

The 1985 NAIC Cancer Claim Cost Tables.

(b) Claim Reserves:

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No specific standard. See (6).

(4) Accidental Death Benefits.

(a) Contract Reserves:

Contracts issued on or after January 1, 2004:

The 1959 Accidental Death Benefits Table.

(b) Claim Reserves:

Actual amount incurred.

(5) Single Premium Credit Disability.

(a) Contract Reserves:

(i) For contracts issued on or after January 1, 2004:

(I) For plans having less than a 30-day elimination period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence rates increased by 12 percent.

(ii)(II) For plans having a 30-day and greater elimination period, the 85CIDA for a 14-day elimination period with the adjustment in item (I).

(b) Claim Reserves:

Claim reserves are to be determined as provided in section 60A.763.

(6) Other Individual Contract Benefits.

(a) Contract Reserves:

For all other individual contract benefits, morbidity assumptions are to be determined as provided in section 60A.765.

(b) Claim Reserves:

For all benefits other than disability, claim reserves are to be determined as provided in section 60A.763.

B. Minimum morbidity standards for valuation of specified group contract health insurance benefits are as follows:

(1) Disability Income Benefits Due to Accident or Sickness.

(a) Contract Reserves:

Contracts issued on or after January 1, 2004:

The 1987 Commissioners Group Disability Income Table (87CGDT).

(b) Claim Reserves:

For claims incurred on or after January 1, 2004:

The 1987 Commissioners Group Disability Income Table (87CGDT);

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(2) Single Premium Credit Disability

(a) Contract Reserves:

(i) For contracts issued on or after January 1, 2004:

(I) For plans having less than a 30-day elimination period, the 1985 Commissioners Individual Disability Table A (85CIDA) with claim incidence rates increased by 12 percent.

(ii)(II) For plans having a 30-day and greater elimination period, the 85CIDA for a 14-day elimination period with the adjustment in item (I).

(b) Claim Reserves:

Claim reserves are to be determined as provided in section 60A.763.

(3) Other Group Contract Benefits.

(a) Contract Reserves:

For all other group contract benefits, morbidity assumptions are to be determined as provided in section 60A.765.

(b) Claim Reserves:

For all benefits other than disability, claim reserves are to be determined as provided in section 60A.763.

Subd. 2. INTEREST. A. For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract.

B. For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurred date.

C. For claim reserves on policies not requiring contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurred date, reduced by 100 basis points.

Subd. 3. MORTALITY. A. For individual long-term care insurance policies or group long-term care insurance certificates issued on or after January 1, 2004, the mortality basis used must be the 1983 Group Annuity Mortality Table without projection.

B. Other mortality tables adopted by the NAIC and adopted by the commissioner may be used in the calculation of the minimum reserves if appropriate for the type of benefits and if approved by the commissioner. The request for approval must include the proposed mortality table and the reason that the standard specified in subsection A is inappropriate.

C. For single premium credit insurance using the 85CIDA table, no separate mortality must be assumed.

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ARTICLE 3

MISCELLANEOUS

Section 1. Minnesota Statutes 2002, section 60A.129, subdivision 2, is amended to read:

Subd. 2. **LOSS RESERVE CERTIFICATION.** (a) Each domestic company engaged in providing the types of coverage described in section 60A.06, subdivision 1, clause (1), (2), (3), (5)(b), (6), (8), (9), (10), (11), (12), (13), or (14), must have its loss reserves certified by a qualified actuary. The company must file the certification with the commissioner within 30 days of completion of the certification, but not later than June 1. The actuary providing the certification may be an employee of the company but the commissioner may still require an independent actuarial certification as described in subdivision 1. This subdivision does not apply to township mutual companies, or to other domestic insurers having less than \$1,000,000 of premiums written in any year and fewer than 1,000 policyholders. The commissioner may allow an exception to the stand alone certification where it can be demonstrated that a company in a group has a pooling or 100 percent reinsurance agreement used in a group which substantially affects the solvency and integrity of the reserves of the company, or where it is only the parent company of a group which is licensed to do business in Minnesota. If these circumstances exist, the company may file a written request with the commissioner for an exception. Companies writing reinsurance alone are not exempt from this requirement. The certification must contain the following statement: "In my opinion, the reserves described in this certification are consistent with reserves computed in accordance with standards and principles established by the Actuarial Standards Board and are fairly stated."

(b) Each foreign company engaged in providing the types of coverage described in section 60A.06, subdivision 1, clause (1), (2), (3), (5)(b), (6), (8), (9), (10), (11), (12), (13), or (14), required by this section to file an annual audited financial report, whose total net earned premium for Schedule P, Part 1A to Part 1H plus Part 1R, (Schedule P, Part 1A to Part 1H plus Part 1R, Column 4, current year premiums earned, from the company's most currently filed annual statement) is equal to one-third or more of the company's total net earned premium (Underwriting and Investment Exhibit, Part 2, Column 4, total line, of the annual statement) must have a reserve certification by a qualified actuary at least every three years. In the year that the certification is due, the company must file the certification with the commissioner within 30 days of completion of the certification, but not later than June 1. The actuary providing the certification ~~must not~~ may be an employee of the company. Companies writing reinsurance alone are not exempt from this requirement. The certification must contain the following statement: "The loss reserves and loss expense reserves have been examined and found to be calculated in accordance with generally accepted actuarial principles and practices and are fairly stated."

(c) Each company providing life and/or health insurance coverages described in section 60A.06, subdivision 1, clause (4) or (5)(a), required by this section to file an

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audited annual financial report, whose premiums and annuity considerations (net of reinsurance) from accident and health equal one-third or more of the company's total premiums and annuity considerations (net of reinsurance), as reported in the summary of operations, must have its aggregate reserve for accident and health policies and liability for policy and contract claims for accident and health certified by a qualified actuary at least once every three years. The actuary providing the certification must not be an employee of the company. Companies writing reinsurance alone are not exempt from this requirement. The certification must contain the following statement: "The policy and contract claims reserves for accident and health have been examined and found to be calculated in accordance with generally accepted actuarial principles and practices and are fairly stated."

Sec. 2. Minnesota Statutes 2002, section 62C.09, is amended by adding a subdivision to read:

Subd. 5. RISK-BASED CAPITAL REQUIREMENT. A service plan corporation is subject to regulation of its financial solvency under sections 60A.50 to 60A.592.

Sec. 3. Minnesota Statutes 2002, section 62D.04, subdivision 1, is amended to read:

Subdivision 1. **APPLICATION REVIEW.** Upon receipt of an application for a certificate of authority, the commissioner of health shall determine whether the applicant for a certificate of authority has:

(a) demonstrated the willingness and potential ability to assure that health care services will be provided in such a manner as to enhance and assure both the availability and accessibility of adequate personnel and facilities;

(b) arrangements for an ongoing evaluation of the quality of health care;

(c) a procedure to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the quality, availability and accessibility of its services, and such other matters as may be reasonably required by regulation of the commissioner of health;

(d) reasonable provisions for emergency and out of area health care services;

(e) demonstrated that it is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner of health shall require the ~~amounts~~ amount of initial net worth and working capital required in section 62D.042, compliance with the risk-based capital standards under sections 60A.50 to 60A.592, the deposit required in section 62D.041, and in addition shall consider:

(1) the financial soundness of its arrangements for health care services and the proposed schedule of charges used in connection therewith;

(2) arrangements which will guarantee for a reasonable period of time the continued availability or payment of the cost of health care services in the event of discontinuance of the health maintenance organization; and

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(3) agreements with providers for the provision of health care services;

(f) demonstrated that it will assume full financial risk on a prospective basis for the provision of comprehensive health maintenance services, including hospital care; provided, however, that the requirement in this paragraph shall not prohibit the following:

(1) a health maintenance organization from obtaining insurance or making other arrangements (i) for the cost of providing to any enrollee comprehensive health maintenance services, the aggregate value of which exceeds \$5,000 in any year, (ii) for the cost of providing comprehensive health care services to its members on a nonelective emergency basis, or while they are outside the area served by the organization, or (iii) for not more than 95 percent of the amount by which the health maintenance organization's costs for any of its fiscal years exceed 105 percent of its income for such fiscal years; and

(2) a health maintenance organization from having a provision in a group health maintenance contract allowing an adjustment of premiums paid based upon the actual health services utilization of the enrollees covered under the contract, except that at no time during the life of the contract shall the contract holder fully self-insure the financial risk of health care services delivered under the contract. Risk sharing arrangements shall be subject to the requirements of sections 62D.01 to 62D.30;

(g) demonstrated that it has made provisions for and adopted a conflict of interest policy applicable to all members of the board of directors and the principal officers of the health maintenance organization. The conflict of interest policy shall include the procedures described in section 317A.255, subdivisions 1 and 2. However, the commissioner is not precluded from finding that a particular transaction is an unreasonable expense as described in section 62D.19 even if the directors follow the required procedures; and

(h) otherwise met the requirements of sections 62D.01 to 62D.30.

Sec. 4. Minnesota Statutes 2002, section 62D.041, subdivision 2, is amended to read:

Subd. 2. **REQUIRED DEPOSIT.** Each health maintenance organization shall deposit with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, bankable funds in the amount required in this section. The commissioner may allow a health maintenance organization's deposit requirement to be funded by a guaranteeing an organization, as defined in section 62D.043 approved by the commissioner.

Sec. 5. Minnesota Statutes 2002, section 62D.042, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS DEFINITION.** (a) For purposes of this section, "guaranteeing organization" means an organization that has agreed to make necessary contributions or advancements to the health maintenance organization to maintain the health maintenance organization's statutorily required net worth.

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(b) For this section, "working capital" means current assets minus current liabilities.

(c) For purposes of this section, if a health maintenance organization offers supplemental benefits as described in section 62D.05, subdivision 6, "expenses" does not include any expenses attributable to the supplemental benefit.

Sec. 6. Minnesota Statutes 2002, section 62D.042, subdivision 2, is amended to read:

Subd. 2. **INITIAL NET WORTH REQUIREMENTS REQUIREMENT.** (a) Beginning organizations shall maintain net worth of at least 8-1/3 percent of the sum of all expenses expected to be incurred in the 12 months following the date the certificate of authority is granted, or \$1,500,000, whichever is greater.

(b) After the first full calendar year of operation, organizations shall maintain net worth of at least 8-1/3 percent and at most 25 percent of the sum of all expenses incurred during the most recent calendar year; but in no case shall net worth fall below \$1,000,000.

(c) Notwithstanding paragraphs (a) and (b), any health maintenance organization owned by a political subdivision of this state, which has a higher than average percentage of enrollees who are enrolled in medical assistance or general assistance medical care, may exceed the maximum net worth limits provided in paragraphs (a) and (b), with the advance approval of the commissioner.

Sec. 7. Minnesota Statutes 2002, section 62N.25, subdivision 6, is amended to read:

Subd. 6. **SOLVENCY.** A community integrated service network is exempt from the deposit, reserve, and solvency requirements specified in sections 62D.041, 62D.042, ~~62D.043~~, and 62D.044 and shall comply instead with sections 62N.27 to 62N.32. To the extent that there are analogous definitions or procedures in chapter 62D or in rules promulgated thereunder, the commissioner shall follow those existing provisions rather than adopting a contrary approach or interpretation.

Sec. 8. Minnesota Statutes 2002, section 62N.27, subdivision 1, is amended to read:

Subdivision 1. **APPLICABILITY.** For purposes of sections 62N.27 to 62N.32, the terms defined in this section have the meanings given. Other terms used in those sections have the meanings given in sections 62D.041, 62D.042, ~~62D.043~~, and 62D.044.

Sec. 9. Minnesota Statutes 2002, section 62N.29, is amended to read:

62N.29 GUARANTEEING ORGANIZATION.

Subdivision 1. USE OF GUARANTEEING ORGANIZATION. (a) A community network may satisfy its net worth and deposit requirements, in whole or in part, through the use of one or more guaranteeing organizations, with the approval of the commissioner, under the conditions permitted in chapter 62D this section. If the

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guaranteeing organization is used, only to satisfy the deposit requirement, the requirements of this section do not apply to the guaranteeing organization.

(b) For purposes of this section, a "guaranteeing organization" means an organization that has agreed to assume the responsibility for the obligation of the community network's net worth requirement.

(c) Governmental entities, such as counties, may serve as guaranteeing organizations subject to the requirements of chapter 62D this section.

Subd. 2. RESPONSIBILITIES OF GUARANTEEING ORGANIZATION. Upon an order of rehabilitation or liquidation, a guaranteeing organization shall transfer funds to the commissioner in the amount necessary to satisfy the net worth requirement.

Subd. 3. REQUIREMENTS FOR GUARANTEEING ORGANIZATION. (a) A community network's net worth requirement may be guaranteed provided that the guaranteeing organization:

(1) transfers into a restricted asset account cash or securities permitted by section 61A.28, subdivisions 2 and 6, in an amount necessary to satisfy the net worth requirement. Restricted asset accounts shall be considered admitted assets for the purpose of determining whether a guaranteeing organization is maintaining sufficient net worth. Permitted securities shall not be transferred to the restricted asset account in excess of the limits applied to the community network, unless approved by the commissioner in advance;

(2) designates the restricted asset account specifically for the purpose of funding the community network's net worth requirement;

(3) maintains positive working capital subsequent to establishing the restricted asset account, if applicable;

(4) maintains net worth, retained earnings, or surplus in an amount in excess of the amount of the restricted asset account, if applicable, and allows the guaranteeing organization:

(i) to remain a solvent business organization, which shall be evaluated on the basis of the guaranteeing organization's continued ability to meet its maturing obligations without selling substantially all its operating assets and paying debts when due; and

(ii) to be in compliance with any state or federal statutory net worth, surplus, or reserve requirements applicable to that organization or lesser requirements agreed to by the commissioner; and

(5) fulfills requirements of clauses (1) to (4) by April 1 of each year.

(b) The commissioner may require the guaranteeing organization to complete the requirements of paragraph (a) more frequently if the amount necessary to satisfy the net worth requirement increases during the year.

Subd. 4. EXCEPTIONS TO REQUIREMENTS. When a guaranteeing organization is a governmental entity, subdivision 3 is not applicable. The commissioner may

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consider factors which provide evidence that the governmental entity is a financially reliable guaranteeing organization. Similarly, when a guaranteeing organization is a Minnesota-licensed health maintenance organization, health service plan corporation, or insurer, subdivision 3, paragraphs (1) and (2), are not applicable.

Subd. 5. AMOUNTS NEEDED TO MEET NET WORTH REQUIREMENTS. The amount necessary for a guaranteeing organization to satisfy the community network's net worth requirement is the lesser of:

(1) an amount needed to bring the community network's net worth to the amount required by section 62N.28; or

(2) an amount agreed to by the guaranteeing organization.

Subd. 6. CONSOLIDATED CALCULATIONS FOR GUARANTEED COMMUNITY NETWORKS. (a) If a guaranteeing organization guarantees one or more community networks, the guaranteeing organization may calculate the amount necessary to satisfy the community networks' net worth requirements on a consolidated basis.

(b) Liabilities of the community network to the guaranteeing organization must be subordinated in the same manner as preferred ownership claims under section 60B.44, subdivision 10.

Subd. 7. AGREEMENT BETWEEN GUARANTEERING ORGANIZATION AND COMMUNITY NETWORK. A written agreement between the guaranteeing organization and the community network must include the commissioner as a party and include the following provisions:

(1) any or all of the funds needed to satisfy the community network's net worth requirement shall be transferred, unconditionally and upon demand, according to subdivision 2;

(2) the arrangement shall not terminate for any reason without the commissioner being notified of the termination at least nine months in advance. The arrangement may terminate earlier if net worth requirements will be satisfied under other arrangements, as approved by the commissioner;

(3) the guaranteeing organization shall pay or reimburse the commissioner for all costs and expenses, including reasonable attorney fees and costs, incurred by the commissioner in connection with the protection, defense, or enforcement of the guarantee;

(4) the guaranteeing organization shall waive all defenses and claims it may have or the community network may have pertaining to the guarantee including, but not limited to, waiver, release, res judicata, statute of frauds, lack of authority, usury, illegality;

(5) the guaranteeing organization waives present demand for payment, notice of dishonor or nonpayment and protest, and the commissioner shall not be required to first resort for payment to other sources or other means before enforcing the guarantee;

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(6) the guarantee may not be waived, modified, amended, terminated, released, or otherwise changed except as provided by the guarantee agreement, and as provided by applicable statutes;

(7) the guaranteeing organization waives its rights under the Federal Bankruptcy Code, United States Code, title 11, section 303, to initiate involuntary proceedings against the community network and agrees to submit to the jurisdiction of the commissioner and Minnesota state courts in any rehabilitation or liquidation of the community network;

(8) the guarantee shall be governed by and construed and enforced according to the laws of the state of Minnesota; and

(9) the guarantee must be approved by the commissioner.

Subd. 8. SUBMISSION OF GUARANTEEING ORGANIZATION'S FINANCIAL STATEMENTS. The community network shall submit to the commissioner the guaranteeing organization's audited financial statements annually by April 1 or at a different date if agreed to by the commissioner. The community network shall also provide other relevant financial information regarding a guaranteeing organization as may be requested by the commissioner.

Subd. 9. PERFORMANCE AS GUARANTEEING ORGANIZATION VOLUNTARY. No provider may be compelled to serve as a guaranteeing organization.

Subd. 10. GUARANTOR STATUS IN REHABILITATION OR LIQUIDATION. Any or all of the funds in excess of the amounts needed to satisfy the community network's obligations as of the date of an order of liquidation or rehabilitation shall be returned to the guaranteeing organization in the same manner as preferred ownership claims under section 60B.44, subdivision 10.

Sec. 10. REVISOR INSTRUCTION.

The revisor of statutes shall change the heading of Minnesota Statutes, section 62D.042, to read "INITIAL NET WORTH REQUIREMENT."

Sec. 11. REPEALER.

(a) Minnesota Statutes 2002, sections 62C.09, subdivisions 3 and 4; 62D.042, subdivisions 5, 6, and 7; and 62D.043, are repealed.

(b) Minnesota Rules, part 4685.0600, is repealed.

ARTICLE 4

SECURITIES REGULATION TECHNICAL CHANGES

Section 1. Minnesota Statutes 2002, section 45.027, subdivision 7a, is amended to read:

Subd. 7a. AUTHORIZED DISCLOSURES OF INFORMATION AND DATA. (a) The commissioner may release and disclose any active or inactive

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investigative information and data on licensees to any national securities exchange or national securities association registered under the Securities Exchange Act of 1934 when necessary for the requesting agency in initiating, furthering, or completing an investigation.

(b) The commissioner may release any active or inactive investigative data relating to the conduct of the business of insurance to the Office of the Comptroller of the Currency or the Office of Thrift Supervision in order to facilitate the initiation, furtherance, or completion of the investigation.

Sec. 2. Minnesota Statutes 2002, section 60A.03, subdivision 9, is amended to read:

Subd. 9. **CONFIDENTIALITY OF INFORMATION.** The commissioner may not be required to divulge any information obtained in the course of the supervision of insurance companies, or the examination of insurance companies, including examination related correspondence and workpapers, until the examination report is finally accepted and issued by the commissioner, and then only in the form of the final public report of examinations. Nothing contained in this subdivision prevents or shall be construed as prohibiting the commissioner from disclosing the content of this information to the insurance department of another state or, the National Association of Insurance Commissioners, or any national securities association registered under the Securities Exchange Act of 1934, if the recipient of the information agrees in writing to hold it as nonpublic data as defined in section 13.02, in a manner consistent with this subdivision. This subdivision does not apply to the extent the commissioner is required or permitted by law, or ordered by a court of law to testify or produce evidence in a civil or criminal proceeding. For purposes of this subdivision, a subpoena is not an order of a court of law.

Sec. 3. Minnesota Statutes 2002, section 60A.031, subdivision 4, is amended to read:

Subd. 4. **EXAMINATION REPORT; FOREIGN AND DOMESTIC COMPANIES.** (a) The commissioner shall make a full and true report of every examination conducted pursuant to this chapter, which shall include (1) a statement of findings of fact relating to the financial status and other matters ascertained from the books, papers, records, documents, and other evidence obtained by investigation and examination or ascertained from the testimony of officers, agents, or other persons examined under oath concerning the business, affairs, assets, obligations, ability to fulfill obligations, and compliance with all the provisions of the law of the company, applicant, organization, or person subject to this chapter and (2) a summary of important points noted in the report, conclusions, recommendations and suggestions as may reasonably be warranted from the facts so ascertained in the examinations. The report of examination shall be verified by the oath of the examiner in charge thereof, and shall be prima facie evidence in any action or proceedings in the name of the state against the company, applicant, organization, or person upon the facts stated therein.

(b) No later than 60 days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under

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oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice which provides the company examined with a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to matters contained in the examination report.

(c) Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with the written submissions or rebuttals and the relevant portions of the examiner's workpapers and enter an order:

(1) adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, rule, or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure the violation;

(2) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information, and refile the report as required under paragraph (b); or

(3) calling for an investigatory hearing with no less than 20 days' notice to the company for purposes of obtaining additional documentation, data, information, and testimony.

(d)(1) All orders entered under paragraph (c), clause (1), must be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers, and any written submissions or rebuttals. The order is a final administrative decision and may be appealed as provided under chapter 14. The order must be served upon the company by certified mail, together with a copy of the adopted examination report. Within 30 days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(2) A hearing conducted under paragraph (c), clause (3), by the commissioner or authorized representative, must be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant workpapers or by the written submission or rebuttal of the company. Within 20 days of the conclusion of the hearing, the commissioner shall enter an order as required under paragraph (c), clause (1).

(3) The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing must proceed expeditiously. Discovery by the company is limited to the examiner's workpapers which tend to substantiate assertions in a written submission or rebuttal. The commissioner or the commissioner's representative may issue subpoenas for the attendance of witnesses or the production of documents considered relevant to the investigation whether under the control of the department, the company, or other persons. The documents produced must be included

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in the record. Testimony taken by the commissioner or the commissioner's representative must be under oath and preserved for the record.

This section does not require the department to disclose information or records which would indicate or show the existence or content of an investigation or activity of a criminal justice agency.

(4) The hearing must proceed with the commissioner or the commissioner's representative posing questions to the persons subpoenaed. Thereafter, the company and the department may present testimony relevant to the investigation. Cross-examination may be conducted only by the commissioner or the commissioner's representative. The company and the department shall be permitted to make closing statements and may be represented by counsel of their choice.

(e)(1) Upon the adoption of the examination report under paragraph (c), clause (1), the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of 30 days except as otherwise provided in paragraph (b). Thereafter, the commissioner may open the report for public inspection if a court of competent jurisdiction has not stayed its publication.

(2) Nothing contained in this subdivision prevents or shall be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating to the reports, to the Commerce Department or the insurance department of another state or country, or to law enforcement officials of this or another state or agency of the federal government at any time, if the agency or office receiving the report or matters relating to the report agrees in writing to hold it confidential and in a manner consistent with this subdivision.

(3) If the commissioner determines that regulatory action is appropriate as a result of an examination, the commissioner may initiate proceedings or actions as provided by law.

(f) All working papers, recorded information, documents and copies thereof produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination made under this subdivision must be given confidential treatment and are not subject to subpoena and may not be made public by the commissioner or any other person, except to the extent provided in paragraph (e). Access may also be granted to the National Association of Insurance Commissioners and any national securities association registered under the Securities Exchange Act of 1934. The parties must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

Sec. 4. **EFFECTIVE DATE.**

Sections 1 to 3 are effective the day following final enactment.

Presented to the governor May 18, 2004

Signed by the governor May 29, 2004, 1:00 p.m.

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