Sec. 17. **CITY OF EDEN PRAIRIE; ON-SALE LICENSE.**

Notwithstanding any law, local ordinance, or charter provision, the city of Eden Prairie may issue an on-sale intoxicating liquor license to any entity holding an operating food service contract with the city for the operation of the cafeteria, for use by the entity at the premises owned by the city of Eden Prairie, at 8080 Mitchell Road in Eden Prairie. The license authorizes sales on all days of the week to persons attending special events in the cafeteria. The licensee may not dispense intoxicating liquor to any person attending or participating in an amateur athletic event held on the premises unless such dispensing is authorized by resolution of the city council. The license authorized by this subdivision may be issued for space that is not compact and contiguous, provided that all such space is within the City Center building and is included in the description of the licensed premises on the approved license application.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 18. **MANKATO; ON-SALE INTOXICATING LIQUOR LICENSE.**

The city of Mankato may issue an on-sale intoxicating liquor license to the premises known as the Midwest Wireless Civic Center. The license authorizes sales on all days of the week to persons attending events at the center. All provisions of Minnesota Statutes, chapter 340A, not inconsistent with this section, apply to the license authorized under this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 19. **OFF-SALE INTOXICATING LIQUOR LICENSE; MILLE LACS COUNTY.**

Notwithstanding Minnesota Statutes, section 340A.405, subdivision 2, paragraph (e), the Mille Lacs County Board may issue an off-sale intoxicating liquor license to an exclusive liquor store located in Eastside Township. All other provisions of Minnesota Statutes, chapter 340A, not inconsistent with this section, apply to the license authorized under this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Presented to the governor May 31, 2005

Signed by the governor June 2, 2005, 5:20 p.m.

CHAPTER 132—H.F.No. 1809

An act relating to insurance; regulating agency terminations, coverages, fees, forms, disclosures, reports, information security, and premiums; amending Minnesota Statutes 2004, sections 60A.14, subdivision 1; 60A.171, subdivision 11; 60A.23, subdivision 8; 60A.966; 60A.969; 62A.136; 62A.31, subdivision 1h; 62A.315; 62A.316; 62E.12; 62E.13, subdivision 2; 62Q.471; 62Q.65; 65A.29, subdivision 11; 65B.48, subdivision 3; 72A.20, subdivisions 13, 36;

79.211, by adding a subdivision; 79.40; 79.56, subdivisions 1, 3; 79.62, subdivision 3; 79A.03, subdivision 9; 79A.04, subdivisions 2, 10; 79A.06, subdivision 5; 79A.12, subdivision 2; 79A.22, subdivision 11, by adding a subdivision; 176.191, subdivision 3; Laws 1985, chapter 85, section 1; proposing coding for new law in Minnesota Statutes, chapters 60A; 62L; 65A; 65B; repealing Minnesota Statutes 2004, sections 61A.072, subdivision 2; 62E.03.

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

Section 1. Minnesota Statutes 2004, 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~~ $90 per filing, ~~which~~ or $75 per filing when submitted via electronic filing system. Filing fees 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;

~~(9) $250 filing fee for a large risk alternative rating option plan that meets the $250,000 threshold requirement~~.

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

Sec. 2. Minnesota Statutes 2004, section 60A.171, subdivision 11, is amended to read:

Subd. 11. Upon termination of an agency, a company is prohibited from soliciting business in the notice of nonrenewal required by section 60A.37. If termination of an agency contract is the ground for nonrenewal of a policy of homeowner's insurance, as defined in section 65A.27, subdivision 4, the company must provide notice to the policyholder that the policy is not being renewed due to the termination of the company's contract with the agency. If the agency is unable to replace the homeowner's insurance policy with a suitable policy from another insurer, the agent must notify the policyholder of the policyholder's right to renew with the company terminating the agency contract. The company must renew the policy if the insured or the insured's agent makes a written request for the renewal before the renewal date.

Sec. 3. Minnesota Statutes 2004, section 60A.23, subdivision 8, is amended to read:

Subd. 8. **SELF-INSURANCE OR INSURANCE PLAN ADMINISTRATORS WHO ARE VENDORS OF RISK MANAGEMENT SERVICES.** (1) **SCOPE.** This subdivision applies to any vendor of risk management services and to any entity which administers, for compensation, a self-insurance or insurance plan. This subdivision does not apply (a) to an insurance company authorized to transact insurance in this state, as defined by section 60A.06, subdivision 1, clauses (4) and (5); (b) to a service plan corporation, as defined by section 62C.02, subdivision 6; (c) to a health maintenance organization, as defined by section 62D.02, subdivision 4; (d) to an employer directly operating a self-insurance plan for its employees' benefits; (e) to an entity which administers a program of health benefits established pursuant to a collective bargaining agreement between an employer, or group or association of employers, and a union or unions; or (f) to an entity which administers a self-insurance or insurance plan if a licensed Minnesota insurer is providing insurance to the plan and if the licensed insurer has appointed the entity administering the plan as one of its licensed agents within this state.

(2) **DEFINITIONS.** For purposes of this subdivision the following terms have the meanings given them.

(a) "Administering a self-insurance or insurance plan" means (i) processing, reviewing or paying claims, (ii) establishing or operating funds and accounts, or (iii) otherwise providing necessary administrative services in connection with the operation of a self-insurance or insurance plan.

(b) "Employer" means an employer, as defined by section 62E.02, subdivision 2.

(c) "Entity" means any association, corporation, partnership, sole proprietorship, trust, or other business entity engaged in or transacting business in this state.

(d) "Self-insurance or insurance plan" means a plan providing life, medical or hospital care, accident, sickness or disability insurance for the benefit of employees or members of an association, or a plan providing liability coverage for any other risk or hazard, which is or is not directly insured or provided by a licensed insurer, service plan corporation, or health maintenance organization.

(e) "Vendor of risk management services" means an entity providing for compensation actuarial, financial management, accounting, legal or other services for the purpose of designing and establishing a self-insurance or insurance plan for an employer.

(3) **LICENSE.** No vendor of risk management services or entity administering a self-insurance or insurance plan may transact this business in this state unless it is licensed to do so by the commissioner. An applicant for a license shall state in writing the type of activities it seeks authorization to engage in and the type of services it seeks authorization to provide. The license may be granted only when the commissioner is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. The commissioner may issue a license subject to restrictions or limitations upon the authorization, including the type of services which may be supplied or the activities which may be engaged in. The license fee is ~~$1,000~~ $1,500 for the initial application and ~~$1,000~~ $1,500 for each ~~two-year~~ three-year renewal. All licenses are for a period of ~~two~~ three years.

(4) **REGULATORY RESTRICTIONS; POWERS OF THE COMMISSIONER.** To assure that self-insurance or insurance plans are financially solvent, are administered in a fair and equitable fashion, and are processing claims and paying benefits in a prompt, fair, and honest manner, vendors of risk management services and entities administering insurance or self-insurance plans are subject to the supervision and examination by the commissioner. Vendors of risk management services, entities administering insurance or self-insurance plans, and insurance or self-insurance plans established or operated by them are subject to the trade practice requirements of sections 72A.19 to 72A.30. In lieu of an unlimited guarantee from a parent corporation for a vendor of risk management services or an entity administering insurance or self-insurance plans, the commissioner may accept a surety bond in a form satisfactory to the commissioner in an amount equal to 120 percent of the total amount of claims handled by the applicant in the prior year. If at any time the total amount of claims handled during a year exceeds the amount upon which the bond was calculated, the administrator shall immediately notify the commissioner. The commissioner may

require that the bond be increased accordingly.

No contract entered into after July 1, 2001, between a licensed vendor of risk management services and a group authorized to self-insure for workers' compensation liabilities under section 79A.03, subdivision 6, may take effect until it has been filed with the commissioner, and either (1) the commissioner has approved it or (2) 60 days have elapsed and the commissioner has not disapproved it as misleading or violative of public policy.

(5) **RULEMAKING AUTHORITY.** To carry out the purposes of this subdivision, the commissioner may adopt rules pursuant to sections 14.001 to 14.69. These rules may:

(a) establish reporting requirements for administrators of insurance or self-insurance plans;

(b) establish standards and guidelines to assure the adequacy of financing, reinsuring, and administration of insurance or self-insurance plans;

(c) establish bonding requirements or other provisions assuring the financial integrity of entities administering insurance or self-insurance plans; or

(d) establish other reasonable requirements to further the purposes of this subdivision.

Sec. 4. Minnesota Statutes 2004, section 60A.966, is amended to read:

60A.966 **APPROVAL OF VIATICAL SETTLEMENTS CONTRACT FORMS.**

A viatical settlement provider or broker may not use a viatical settlement contract form in this state unless it has been filed with and approved by the commissioner. A viatical settlement contract form filed with the commissioner is considered to have been approved if it has not been disapproved within 60 days of the filing. The commissioner shall disapprove a viatical settlement contract form if, in the commissioner's opinion, the contract or contract provisions are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the policy owner.

Sec. 5. Minnesota Statutes 2004, section 60A.969, is amended to read:

60A.969 **DISCLOSURE.**

A viatical settlement provider or a broker shall disclose the following information to the viator no later than the date ~~the viatical settlement contract is signed by all parties~~ an application is given to the viator:

(1) possible alternatives to viatical settlement contracts for persons with catastrophic or life threatening illnesses, including accelerated benefits offered by the issuer of the life insurance policy;

(2) the fact that some or all of the proceeds of the viatical settlement may be taxable and that assistance should be sought from a personal tax advisor;

(3) the fact that the viatical settlement may be subject to the claims of creditors;

(4) the fact that receipt of a viatical settlement may adversely affect the recipients' eligibility for Medicaid or other government benefits or entitlements and that advice should be obtained from the appropriate agencies;

(5) the policy owner's right to rescind a viatical settlement contract within 30 days of the date it is executed by all parties or 15 days of the receipt of the viatical settlement proceeds by the viator, whichever is less, as provided in section 60A.970, subdivision 3; and

(6) the date by which the funds will be available to the viator and the source of the funds.

Sec. 6. **[60A.98] DEFINITIONS.**

Subdivision 1. **SCOPE.** For purposes of sections 60A.98 and 60A.981, the terms defined in this section have the meanings given them.

Subd. 2. **CUSTOMER.** "Customer" means a consumer who has a continuing relationship with a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family, or household purposes.

Subd. 3. **CUSTOMER INFORMATION.** "Customer information" means nonpublic personal information about a customer, whether in paper, electronic, or other form, that is maintained by or on behalf of the licensee.

Subd. 4. **CUSTOMER INFORMATION SYSTEMS.** "Customer information systems" means the electronic or physical methods used to access, collect, store, use, transmit, protect, or dispose of customer information.

Subd. 5. **LICENSEE.** "Licensee" means all licensed insurers, producers, and other persons licensed or required to be licensed, authorized or required to be authorized, or registered or required to be registered pursuant to the insurance laws of this state, except that "licensee" does not include a purchasing group or an ineligible insurer in regard to the surplus line insurance conducted pursuant to sections 60A.195 to 60A.209. "Licensee" does not include producers until January 1, 2007.

Subd. 6. **NONPUBLIC FINANCIAL INFORMATION.** "Nonpublic financial information" means:

(1) personally identifiable financial information; and

(2) any list, description, or other grouping of consumers, and publicly available information pertaining to them, that is derived using any personally identifiable financial information that is not publicly available.

Subd. 7. **NONPUBLIC PERSONAL HEALTH INFORMATION.** "Nonpublic personal health information" means health information:

(1) that identifies an individual who is the subject of the information; or

(2) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

Subd. 8. **NONPUBLIC PERSONAL INFORMATION.** "Nonpublic personal information" means nonpublic financial information and nonpublic personal health information.

Subd. 9. **PERSONALLY IDENTIFIABLE FINANCIAL INFORMATION.** "Personally identifiable financial information" means any information:

(1) a consumer provides to a licensee to obtain an insurance product or service from the licensee;

(2) about a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

(3) the licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

Subd. 10. **SERVICE PROVIDER.** "Service provider" means a person that maintains, processes, or otherwise is permitted access to customer information through its provision of services directly to the licensee.

Sec. 7. **[60A.981] INFORMATION SECURITY PROGRAM.**

Subdivision 1. **GENERAL REQUIREMENTS.** Each licensee shall implement a comprehensive written information security program that includes administrative, technical, and physical safeguards for the protection of customer information. The administrative, technical, and physical safeguards included in the information security program must be appropriate to the size and complexity of the licensee and the nature and scope of its activities.

Subd. 2. **OBJECTIVES.** A licensee's information security program must be designed to:

(1) ensure the security and confidentiality of customer information;

(2) protect against any anticipated threats or hazards to the security or integrity of the information; and

(3) protect against unauthorized access to or use of the information that could result in substantial harm or inconvenience to any customer.

Subd. 3. **EXAMPLES OF METHODS OF DEVELOPMENT AND IMPLEMENTATION.** The following actions and procedures are examples of methods of implementation of the requirements of subdivisions 1 and 2. These examples are nonexclusive illustrations of actions and procedures that licensees may follow to implement subdivisions 1 and 2:

(1) the licensee:

(i) identifies reasonably foreseeable internal or external threats that could result in unauthorized disclosure, misuse, alteration, or destruction of customer information or customer information systems;

(ii) assesses the likelihood and potential damage of these threats, taking into consideration the sensitivity of customer information; and

(iii) assesses the sufficiency of policies, procedures, customer information systems, and other safeguards in place to control risks;

(2) the licensee:

(i) designs its information security program to control the identified risks, commensurate with the sensitivity of the information, as well as the complexity and scope of the licensee's activities;

(ii) trains staff, as appropriate, to implement the licensee's information security program; and

(iii) regularly tests or otherwise regularly monitors the key controls, systems, and procedures of the information security program. The frequency and nature of these tests or other monitoring practices are determined by the licensee's risk assessment;

(3) the licensee:

(i) exercises appropriate due diligence in selecting its service providers; and

(ii) requires its service providers to implement appropriate measures designed to meet the objectives of this regulation, and, where indicated by the licensee's risk assessment, takes appropriate steps to confirm that its service providers have satisfied these obligations; and

(4) the licensee monitors, evaluates, and adjusts, as appropriate, the information security program in light of any relevant changes in technology, the sensitivity of its customer information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to customer information systems.

Sec. 8. **[60A.982] UNFAIR TRADE PRACTICES.**

A violation of sections 60A.98 and 60A.981 is considered to be a violation of sections 72A.17 to 72A.32.

Sec. 9. Minnesota Statutes 2004, section 62A.136, is amended to read:

62A.136 **DENTAL AND VISION PLAN COVERAGE.**

The following provisions do not apply to health plans as defined in section 62A.011, subdivision 3, clause (6), providing dental or vision coverage only: sections 62A.041; 62A.0411; 62A.047; 62A.149; 62A.151; 62A.152; 62A.154; 62A.155; 62A.17, subdivision 6; 62A.21, subdivision 2b; 62A.26; 62A.28; 62A.285; 62A.30; 62A.304; 62A.3093; and 62E.16.

Sec. 10. Minnesota Statutes 2004, 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. 11. Minnesota Statutes 2004, section 62A.315, is amended to read:

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

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

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

(2) coverage for the daily co-payment amount of Medicare Part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, and the Medicare Part B deductible amount;

(4) 80 percent of the usual and customary hospital and medical expenses and supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation established by the Medicare program or state law, the usual and customary hospital and medical expenses and supplies, described in section 62E.06, subdivision 1, while in a

foreign country, and prescription drug expenses, not covered by Medicare;

(5) coverage for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations;

(6) 100 percent of the cost of immunizations not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer, including mammograms and pap smears;

(7) preventive medical care benefit: coverage for the following preventive health services not covered by Medicare:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) and patient education to address preventive health care measures;

(ii) ~~any one or a combination of the following~~ preventive screening tests or preventive services, the selection and frequency of which is ~~considered~~ determined to be medically appropriate~~:~~ by the attending physician.

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

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

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

~~(D) serum cholesterol screening every five years;~~

~~(E) thyroid function test;~~

~~(F) diabetes screening;~~

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

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

(8) at-home recovery benefit: coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:

(i) for purposes of this benefit, the following definitions shall apply:

(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health

care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "at-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;

(ii) coverage requirements and limitations:

(A) at-home recovery services provided must be primarily services that assist in activities of daily living;

(B) the insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as medically necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $100 per visit;

(III) $4,000 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit;

(iii) coverage is excluded for:

(A) home care visits paid for by Medicare or other government programs; and

(B) care provided by unpaid volunteers or providers who are not care providers.

Sec. 12. Minnesota Statutes 2004, section 62A.316, is amended to read:

62A.316 **BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.**

(a) The basic Medicare supplement plan must have a level of coverage that will provide:

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

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

(3) coverage for the coinsurance amount, or in the case of outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare part B regardless of hospital confinement, subject to the Medicare part B deductible amount;

(4) 80 percent of the hospital and medical expenses and supplies incurred during travel outside the United States as a result of a medical emergency;

(5) coverage for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations;

(6) 100 percent of the cost of immunizations not otherwise covered under part D of the Medicare program and routine screening procedures for cancer screening including mammograms and pap smears; and

(7) 80 percent of coverage for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes not otherwise covered under Part D of the Medicare program. Coverage must include persons with gestational, type I, or type II diabetes.

(b) Only the following optional benefit riders may be added to this plan:

(1) coverage for all of the Medicare part A inpatient hospital deductible amount;

(2) a minimum of 80 percent of eligible medical expenses and supplies not covered by Medicare part B, not to exceed any charge limitation established by the Medicare program or state law;

(3) coverage for all of the Medicare part B annual deductible;

(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses;

(5) ~~coverage for the following~~ preventive ~~health services~~ medical care benefit coverage for the following preventative health services not covered by Medicare:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) and patient education to address preventive health care measures;

(ii) ~~any one or a combination of the following~~ preventive screening tests or preventive services, the selection and frequency of which is ~~considered~~ determined to

be medically appropriate: by the attending physician.

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

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

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

~~(D) serum cholesterol screening every five years;~~

~~(E) thyroid function test;~~

~~(F) diabetes screening;~~

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

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

.(6) coverage for services to provide short-term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery:

(i) For purposes of this benefit, the following definitions apply:

(A) "activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(B) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aid, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;

(D) "at-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;

(ii) Coverage requirements and limitations:

(A) at-home recovery services provided must be primarily services that assist in activities of daily living;

(B) the insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;

(C) coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home care visits under a Medicare-approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit;

(iii) Coverage is excluded for:

(A) home care visits paid for by Medicare or other government programs; and

(B) care provided by family members, unpaid volunteers, or providers who are not care providers;

(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses to a maximum of $1,200 paid by the issuer annually under this benefit. An issuer of Medicare supplement insurance policies that elects to offer this benefit rider shall also make available coverage that contains the rider specified in clause (4).

Sec. 13. Minnesota Statutes 2004, section 62E.12, is amended to read:

62E.12 **MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLAN.**

(a) The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan and a number two qualified plan, except that the maximum lifetime benefit on these plans shall be $2,800,000; and an extended basic Medicare supplement plan and a basic Medicare supplement plan as described in sections 62A.31 to 62A.44. The association may also offer a plan that is identical to a number one and number two qualified plan except that it has a $2,000 annual deductible and a $2,800,000 maximum lifetime benefit. The association, subject to the approval of the commissioner, may also offer plans that are identical to the number one or number two qualified plan, except that they have annual deductibles of $5,000 and $10,000, respectively; have limitations on total annual

out-of-pocket expenses equal to those annual deductibles and therefore cover 100 percent of the allowable cost of covered services in excess of those annual deductibles; and have a $2,800,000 maximum lifetime benefit. The association, subject to approval of the commissioner, may also offer plans that meet all other requirements of state law except those that are inconsistent with high deductible health plans as defined in sections 220 and 223 of the Internal Revenue Code and supporting regulations. As of January 1, 2006, the association shall no longer be required to offer an extended basic Medicare supplement plan.

(b) The requirement that a policy issued by the association must be a qualified plan is satisfied if the association contracts with a preferred provider network and the level of benefits for services provided within the network satisfies the requirements of a qualified plan. If the association uses a preferred provider network, payments to nonparticipating providers must meet the minimum requirements of section 72A.20, subdivision 15.

(c) The association shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

(d) Notwithstanding the provisions of section 62E.06 and unless those charges are billed by a provider that is part of the association's preferred provider network, the state plan shall exclude coverage of services of a private duty nurse other than on an inpatient basis and any charges for treatment in a hospital located outside of the state of Minnesota in which the covered person is receiving treatment for a mental or nervous disorder, unless similar treatment for the mental or nervous disorder is medically necessary, unavailable in Minnesota and provided upon referral by a licensed Minnesota medical practitioner.

Sec. 14. Minnesota Statutes 2004, section 62E.13, subdivision 2, is amended to read:

Subd. 2. **SELECTION OF WRITING CARRIER.** The association may select policies and contracts, or parts thereof, submitted by a member or members of the association, or by the association or others, to develop specifications for bids from any entity which wishes to be selected as a writing carrier to administer the state plan. The selection of the writing carrier shall be based upon criteria established by the board of directors of the association and approved by the commissioner. The criteria shall outline specific qualifications that an entity must satisfy in order to be selected and, at a minimum, shall include the entity's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans and the $2,000, $5,000, and $10,000 deductible plans, the ~~qualified~~ Medicare supplement ~~plan~~ plans, and the health maintenance organization contract.

Sec. 15. **[62L.056] SMALL EMPLOYER FLEXIBLE BENEFITS PLANS.**

(a) Notwithstanding any provision of this chapter, chapter 363A, or any other law to the contrary, a health carrier may offer, sell, issue, and renew a health benefit plan

that is a flexible benefits plan under this section to a small employer if the following requirements are satisfied:

(1) the health benefit plan must be offered in compliance with this chapter, except as otherwise permitted in this section;

(2) the health benefit plan to be offered must be designed to enable employers and covered persons to better manage costs and coverage options through the use of co-pays, deductibles, and other cost-sharing arrangements;

(3) the health benefit plan must be issued and administered in compliance with sections 62E.141; 62L.03, subdivision 6; and 62L.12, subdivisions 3 and 4, relating to prohibitions against enrolling in the Minnesota Comprehensive Health Association persons eligible for employer group coverage;

(4) the health benefit plan may modify or exclude any or all coverages of benefits that would otherwise be required by law, except for maternity benefits and other benefits required under federal law;

(5) each health benefit plan must be approved by the commissioner of commerce, but the commissioner may not disapprove a plan on the grounds of a modification or exclusion permitted under clause (4); and

(6) prior to sale of the health benefit plan, the small employer must be given a written list of the coverages otherwise required by law that are modified or excluded in the health benefit plan. The list must include a description of each coverage in the list and indicate whether the coverage is modified or excluded. If a coverage is modified, the list must describe the modification. The list may, but need not, also list any or all coverages otherwise required by law that are included in the health benefit plan and indicate that they are included. The insurer must require that a copy of this written list be provided, prior to the effective date of the health benefit plan, to each employee who is eligible for health coverage under the employer's plan.

(b) The definitions in section 62L.02 apply to this section as modified by this section.

(c) An employer may provide a health benefit plan permitted under this section to its employees, the employees' dependents, and other persons eligible for coverage under the employer's plan, notwithstanding chapter 363A or any other law to the contrary.

Sec. 16. Minnesota Statutes 2004, section 62Q.471, is amended to read:

62Q.471 **EXCLUSION FOR SUICIDE ATTEMPTS PROHIBITED.**

(a) No health plan may exclude or reduce coverage for health care for an enrollee who is otherwise covered under the health plan on the basis that the need for the health care arose out of a suicide or suicide attempt by the enrollee.

(b) For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, clauses (4), (6), and (7) ~~and~~ through (10).

Sec. 17. Minnesota Statutes 2004, section 62Q.65, is amended to read:

62Q.65 **ACCESS TO PROVIDER DISCOUNTS.**

Subdivision 1. **REQUIREMENT.** A high deductible health plan must, when used in connection with a medical savings account or health savings account, provide the enrollee access to any discounted provider fees for services covered by the high deductible health plan, regardless of whether the enrollee has satisfied the deductible for the high deductible health plan.

Subd. 2. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given:

(1) "high deductible health plan" has the meaning given under the Internal Revenue Code of 1986, section 220(c)(2), with respect to a medical savings account; and the meaning given under Internal Revenue Code of 1986, section 223(c)(2), with respect to a health savings account;

(2) "medical savings account" has the meaning given under the Internal Revenue Code of 1986, section 220(d)(1); ~~and~~

(3) "discounted provider fees" means fees contained in a provider agreement entered into by the issuer of the high deductible health plan, or an affiliate of the issuer, for use in connection with the high deductible health plan; and

(4) "health savings account" has the meaning given under the Internal Revenue Code of 1986, section 223(d).

Sec. 18. Minnesota Statutes 2004, section 65A.29, subdivision 11, is amended to read:

Subd. 11. **NONRENEWAL.** Every insurer shall establish a plan that sets out the minimum number and amount of claims during an experience period that may result in a nonrenewal. For purposes of the plan, the insurer may not consider as a claim the insured's inquiry about a hypothetical claim, or the insured's inquiry to the insured's agent regarding a potential claim.

No homeowner's insurance policy may be nonrenewed based on the insured's loss experience unless the insurer has sent a written notice that any future losses may result in nonrenewal due to loss experience.

Any nonrenewal of a homeowner's insurance policy must, at a minimum, comply with the requirements of subdivision 8 and the rules adopted by the commissioner.

Sec. 19. **[65A.297] ACTIVE DUTY MEMBER OF ARMED SERVICES RESERVE OR NATIONAL GUARD; USE IN UNDERWRITING PROHIBITED.**

No insurer, including the Minnesota FAIR plan, shall refuse to renew, decline to offer or write, reduce the limits of, cancel, or charge differential rates for equivalent coverage for any coverage in a homeowner's policy because the dwelling is vacant or occupied by a caretaker if the insured's absence is caused solely by the insured being called to active duty as a member of the armed services reserve or the National Guard.

Sec. 20. **[65B.286] SNOWMOBILE AUXILIARY LIGHTING SYSTEM DISCOUNT.**

Subdivision 1. **DEFINITION.** For the purposes of this section, the term "auxiliary hazard warning lighting system" means a system installed by the manufacturer of a snowmobile as original equipment or installed in a snowmobile by the manufacturer or an authorized dealer of that manufacturer as an aftermarket system that does the following when activated:

(1) a yellow light emitting diode (L.E.D.) light on the front of the snowmobile that flashes at least once per second and is visible at least one-half mile in front of the snowmobile; and

(2) a red light emitting diode (L.E.D.) light on the rear of the snowmobile that flashes at least once per second and is visible at least one-half mile from behind the snowmobile.

Subd. 2. **REQUIRED REDUCTION.** An insurer must provide an appropriate premium reduction of at least five percent on a policy insuring the snowmobile, or on that portion of a policy insuring a snowmobile that is issued, delivered, or renewed in this state, to the insured whose snowmobile is equipped with an authorized auxiliary hazard warning lighting system. The premium reduction required by this subdivision applies to every snowmobile of the insured that is equipped with an auxiliary hazard warning lighting system.

Sec. 21. Minnesota Statutes 2004, section 65B.48, subdivision 3, is amended to read:

Subd. 3. Self-insurance, subject to approval of the commissioner, is effected by filing with the commissioner in satisfactory form:

(1) a continuing undertaking by the owner or other appropriate person to pay tort liabilities or basic economic loss benefits, or both, and to perform all other obligations imposed by sections 65B.41 to 65B.71;

(2) evidence that appropriate provision exists for prompt administration of all claims, benefits, and obligations provided by sections 65B.41 to 65B.71;

(3) evidence that reliable financial arrangements, deposits, or commitments exist providing assurance, substantially equivalent to that afforded by a policy of insurance complying with sections 65B.41 to 65B.71, for payment of tort liabilities, basic economic loss benefits, and all other obligations imposed by sections 65B.41 to 65B.71; and

(4) a nonrefundable initial application fee of ~~$1,500~~ $2,500 and ~~an annual~~ a renewal fee of ~~$400~~ $1,200 for political subdivisions and ~~$500~~ $1,500 for nonpolitical entities every three years.

Sec. 22. Minnesota Statutes 2004, section 72A.20, subdivision 13, is amended to read:

Subd. 13. **REFUSAL TO RENEW.** Refusing to renew, declining to offer or write, or charging differential rates for an equivalent amount of homeowner's insurance coverage, as defined by section 65A.27, for property located in a town or statutory or home rule charter city, in which the insurer offers to sell or writes homeowner's insurance, solely because:

(a) of the geographic area in which the property is located;

(b) of the age of the primary structure sought to be insured;

(c) the insured or prospective insured was denied coverage of the property by another insurer, whether by cancellation, nonrenewal or declination to offer coverage, for a reason other than those specified in section 65A.01, subdivision 3a, clauses (a) to (e); ~~or~~

(d) the property of the insured or prospective insured has been insured under the Minnesota FAIR Plan Act, shall constitute an unfair method of competition and an unfair and deceptive act or practice; or

(e) the insured has inquired about coverage for a hypothetical claim or has made an inquiry to the insured's agent regarding a potential claim.

This subdivision prohibits an insurer from filing or charging different rates for different zip code areas within the same town or statutory or home rule charter city.

This subdivision shall not prohibit the insurer from applying underwriting or rating standards which the insurer applies generally in all other locations in the state and which are not specifically prohibited by clauses (a) to ~~(d)~~ (e). Such underwriting or rating standards shall specifically include but not be limited to standards based upon the proximity of the insured property to an extraordinary hazard or based upon the quality or availability of fire protection services or based upon the density or concentration of the insurer's risks. Clause (b) shall not prohibit the use of rating standards based upon the age of the insured structure's plumbing, electrical, heating or cooling system or other part of the structure, the age of which affects the risk of loss. Any insurer's failure to comply with section 65A.29, subdivisions 2 to 4, either (1) by failing to give an insured or applicant the required notice or statement or (2) by failing to state specifically a bona fide underwriting or other reason for the refusal to write shall create a presumption that the insurer has violated this subdivision.

Sec. 23. Minnesota Statutes 2004, section 72A.20, subdivision 36, is amended to read:

Subd. 36. **LIMITATIONS ON THE USE OF CREDIT INFORMATION.** (a) No insurer or group of affiliated insurers may reject, cancel, or nonrenew a policy of private passenger motor vehicle insurance as defined under section 65B.01 or a policy of homeowner's insurance as defined under section 65A.27, for any person in whole or in part on the basis of credit information, including a credit reporting product known as a "credit score" or "insurance score," without consideration and inclusion of any other applicable underwriting factor.

(b) If credit information, credit scoring, or insurance scoring is to be used in underwriting, the insurer must disclose to the consumer that credit information will be obtained and used as part of the insurance underwriting process.

(c) Insurance inquiries and non-consumer-initiated inquiries must not be used as part of the credit scoring or insurance scoring process.

(d) If a credit score, insurance score, or other credit information relating to a consumer, with respect to the types of insurance referred to in paragraph (a), is adversely impacted or cannot be generated because of the absence of a credit history, the insurer must exclude the use of credit as a factor in the decision to reject, cancel, or nonrenew.

(e) Insurers must upon the request of a policyholder reevaluate the policyholder's score. Any change in premium resulting from the reevaluation must be effective upon the renewal of the policy. An insurer is not required to reevaluate a policyholder's score pursuant to this paragraph more than twice in any given calendar year.

(f) Insurers must upon request of the applicant or policyholder provide reasonable underwriting exceptions based upon prior credit histories for persons whose credit information is unduly influenced by expenses related to a catastrophic injury or illness, temporary loss of employment, or the death of an immediate family member. The insurer may require reasonable documentation of these events prior to granting an exception.

~~(f)~~ (g) A credit scoring or insurance scoring methodology must not be used by an insurer if the credit scoring or insurance scoring methodology incorporates the gender, race, nationality, or religion of an insured or applicant.

~~(g)~~ (h) Insurers that employ a credit scoring or insurance scoring system in underwriting of coverage described in paragraph (a) must have on file with the commissioner:

(1) the insurer's credit scoring or insurance scoring methodology; and

(2) information that supports the insurer's use of a credit score or insurance score as an underwriting criterion.

~~(h)~~ (i) Insurers described in paragraph (g) shall file the required information with the commissioner within 120 days of August 1, 2002, or prior to implementation of a credit scoring or insurance scoring system by the insurer, if that date is later.

~~(i)~~ (j) Information provided by, or on behalf of, an insurer to the commissioner under this subdivision is trade secret information under section 13.37.

Sec. 24. Minnesota Statutes 2004, section 79.211, is amended by adding a subdivision to read:

Subd. 4. **EXPERIENCE MODIFICATION FACTOR REVISION FOR CERTAIN CLOSED CLAIMS.** An insurer or an employer insured under a workers' compensation policy subject to an experience rating plan may request in writing of the data service organization computing the policy's experience modification factor that

the most recent factor be revised if each of the following criteria is met:

(1) a workers' compensation claim under that policy is closed between the normal valuation date for that claim and the next time that valuation is used in computing the experience modification factor on the policy;

(2) the data service organization receives a revised unit statistical report containing data on the closed claim in a form consistent with its filed unit statistical plan; and

(3) inclusion of the closed claim in the experience modification factor calculation would impact that factor by five percentage points or more.

Sec. 25. Minnesota Statutes 2004, section 79.40, is amended to read:

79.40 **PREMIUM INCLUSION IN RATEMAKING.**

Premiums charged members by the reinsurance association shall be recognized in the ratemaking procedures for insurance rates ~~in the same manner as assessments for the special compensation fund~~.

Sec. 26. Minnesota Statutes 2004, section 79.56, subdivision 1, is amended to read:

Subdivision 1. **PREFILING OF RATES.** (a) Each insurer shall file with the commissioner a complete copy of its rates and rating plan, and all changes and amendments thereto, and such supporting data and information that the commissioner may by rule require, at least 60 days prior to its effective date. The commissioner shall advise an insurer within 30 days of the filing if its submission is not accompanied with such supporting data and information that the commissioner by rule may require. The commissioner may extend the filing review period and effective date for an additional 30 days if an insurer, after having been advised of what supporting data and information is necessary to complete its filing, does not provide such information within 15 days of having been so notified. If any rate or rating plan filing or amendment thereto is not disapproved by the commissioner within the filing review period, the insurer may implement it. For the period August 1, 1995, to December 31, 1995, the filing shall be made at least 90 days prior to the effective date and the department shall advise an insurer within 60 days of such filing if the filing is insufficient under this section.

(b) A rating plan or rates are not subject to the requirements of paragraph (a), where the insurer files a certification verifying that it will use the mutually agreed upon rating plan or rates only to write a specific employer that generates $250,000 in annual written workers' compensation premiums before the application of any large deductible rating plan. The certification must be refiled upon each renewal of the employer's policy. The $250,000 threshold includes premiums generated in any state. The designation and certification must be submitted in substantially the following form:

Name and address of insurer:.....

Name and address of insured employer:.....

Policy period:.....

I certify that the employer named above generates $250,000 or more in annual countrywide written workers' compensation premiums, and that the calculation of this threshold is based on the rates and rating plans that have been approved by the appropriate state regulatory authority. The filing of this certification authorizes the use of this rate or rating plan only for the named employer.

Name of responsible officer:.....

Title:.....

Signature:.....

Sec. 27. Minnesota Statutes 2004, section 79.56, subdivision 3, is amended to read:

Subd. 3. **PENALTIES.** ~~(a)~~ Any insurer using a rate or a rating plan which has not been filed or certified under subdivision 1 shall be subject to a fine of up to $100 for each day the failure to file continues. The commissioner may, after a hearing on the record, find that the failure is willful. A willful failure to meet filing requirements shall be punishable by a fine of up to $500 for each day during which a willful failure continues. These penalties shall be in addition to any other penalties provided by law.

~~(b) Notwithstanding this subdivision, an employer that generates $250,000 in annual written workers' compensation premium under the rates and rating plan of an insurer before the application of any large deductible rating plans, may be written by that insurer using rates or rating plans that are not subject to disapproval but which have been filed. For the purposes of this paragraph, written workers' compensation premiums generated from states other than Minnesota are included in calculating the $250,000 threshold for large risk alternative rating option plans.~~

Sec. 28. Minnesota Statutes 2004, section 79.62, subdivision 3, is amended to read:

Subd. 3. **ISSUANCE.** The commissioner, upon finding that the applicant organization is qualified to provide the services required and proposed, or has contracted with a licensed data service organization to purchase these services which are required by this chapter but are not provided directly by the applicant, and that all requirements of law are met, shall issue a license. Each license is subject to annual renewal effective June 30. Each new or renewal license application must be accompanied by a fee of ~~$50~~ $1,000.

Sec. 29. Minnesota Statutes 2004, section 79A.03, subdivision 9, is amended to read:

Subd. 9. **FILING REPORTS.** (a) Incurred losses, paid and unpaid, specifying indemnity and medical losses by classification, payroll by classification, and current estimated outstanding liability for workers' compensation shall be reported to the commissioner by each self-insurer on a calendar year basis, in a manner and on forms available from the commissioner. Payroll information must be filed by April 1 of the following year.

(b) Each self-insurer shall, under oath, attest to the accuracy of each report submitted pursuant to paragraph (a). Upon sufficient cause, the commissioner shall

require the self-insurer to submit a certified audit of payroll and claim records conducted by an independent auditor approved by the commissioner, based on generally accepted accounting principles and generally accepted auditing standards, and supported by an actuarial review and opinion of the future contingent liabilities. The basis for sufficient cause shall include the following factors: where the losses reported appear significantly different from similar types of businesses; where major changes in the reports exist from year to year, which are not solely attributable to economic factors; or where the commissioner has reason to believe that the losses and payroll in the report do not accurately reflect the losses and payroll of that employer. If any discrepancy is found, the commissioner shall require changes in the self-insurer's or workers' compensation service company record-keeping practices.

(c) An annual status report due August 1 by each self-insurer shall be filed in a manner and on forms prescribed by the commissioner.

(d) Each individual self-insurer shall, within four months after the end of its fiscal year, annually file with the commissioner its latest 10K report required by the Securities and Exchange Commission. If an individual self-insurer does not prepare a 10K report, it shall file an annual certified financial statement, together with such other financial information as the commissioner may require to substantiate data in the financial statement.

(e) Each member of the group shall, within ~~seven~~ six months after the end of each fiscal year for that group, ~~file~~ submit to a certified public accountant designated by the group, the most recent annual financial statement, reviewed by a certified public accountant in accordance with the Statements on Standards for Accounting and Review Services, Volume 2, the American Institute of Certified Public Accountants Professional Standards, or audited in accordance with generally accepted auditing standards, together with such other financial information the commissioner may require. In addition, the group shall file with the commissioner, within seven months after the end of each fiscal year for that group, combining financial statements of the group members, compiled by a certified public accountant in accordance with the Statements on Standards for Accounting and Review Services, Volume 2, the American Institute of Certified Public Accountants Professional Standards. The combining financial statements shall include, but not be limited to, a balance sheet, income statement, statement of changes in net worth, and statement of cash flow. Each combining financial statement shall include a column for each individual group member along with a total column. Each combined statement shall have a statement from the certified public accountant confirming that each member has submitted the required financial statement as defined in this section. The certified public accountant shall notify the commissioner if any statement is qualified or otherwise conditional. The commissioner may require additional financial information from any group member.

Where a group has 50 or more members, the group shall file, in lieu of the combining financial statements, a combined financial statement showing only the total column for the entire group's balance sheet, income statement, statement of changes in net worth, and statement of cash flow. Additionally, the group shall disclose, for each member, the total assets, net worth, revenue, and income for the most recent fiscal year.

The combining and combined financial statements may omit all footnote disclosures.

(f) In addition to the financial statements required by paragraphs (d) and (e), interim financial statements or 10Q reports required by the Securities and Exchange Commission may be required by the commissioner upon an indication that there has been deterioration in the self-insurer's financial condition, including a worsening of current ratio, lessening of net worth, net loss of income, the downgrading of the company's bond rating, or any other significant change that may adversely affect the self-insurer's ability to pay expected losses. Any self-insurer that files an 8K report with the Securities and Exchange Commission shall also file a copy of the report with the commissioner within 30 days of the filing with the Securities and Exchange Commission.

Sec. 30. Minnesota Statutes 2004, section 79A.04, subdivision 2, is amended to read:

Subd. 2. **MINIMUM DEPOSIT.** The minimum deposit is 110 percent of the private self-insurer's estimated future liability. The deposit may be used to secure payment of all administrative and legal costs, and unpaid assessments required by section 79A.12, subdivision 2, relating to or arising from its or other employers' self-insuring. As used in this section, "private self-insurer" includes both current and former members of the self-insurers' security fund; and "private self-insurers' estimated future liability" means the private self-insurers' total of estimated future liability as determined by an Associate or Fellow of the Casualty Actuarial Society every year for group member private self-insurers and, for a nongroup member private self-insurer's authority to self-insure, every year for the first five years. After the first five years, the nongroup member's total shall be as determined by an Associate or Fellow of the Casualty Actuarial Society at least every two years, and each such actuarial study shall include a projection of future losses during the period until the next scheduled actuarial study, less payments anticipated to be made during that time.

All data and information furnished by a private self-insurer to an Associate or Fellow of the Casualty Actuarial Society for purposes of determining private self-insurers' estimated future liability must be certified by an officer of the private self-insurer to be true and correct with respect to payroll and paid losses, and must be certified, upon information and belief, to be true and correct with respect to reserves. The certification must be made by sworn affidavit. In addition to any other remedies provided by law, the certification of false data or information pursuant to this subdivision may result in a fine imposed by the commissioner of commerce on the private self-insurer up to the amount of $5,000, and termination of the private self-insurers' authority to self-insure. The determination of private self-insurers' estimated future liability by an Associate or Fellow of the Casualty Actuarial Society shall be conducted in accordance with standards and principles for establishing loss and loss adjustment expense reserves by the Actuarial Standards Board, an affiliate of the American Academy of Actuaries. The commissioner may reject an actuarial report that does not meet the standards and principles of the Actuarial Standards Board, and may further disqualify the actuary who prepared the report from submitting any future actuarial reports pursuant to this chapter. Within 30 days after the actuary has been

served by the commissioner with a notice of disqualification, an actuary who is aggrieved by the disqualification may request a hearing to be conducted in accordance with chapter 14. Based on a review of the actuarial report, the commissioner of commerce may require an increase in the minimum security deposit in an amount the commissioner considers sufficient.

Estimated future liability is determined by first taking the total amount of the self-insured's future liability of workers' compensation claims and then deducting the total amount which is estimated to be returned to the self-insurer from any specific excess insurance coverage, aggregate excess insurance coverage, and any supplementary benefits or second injury benefits which are estimated to be reimbursed by the special compensation fund. However, in the determination of estimated future liability, the actuary for the self-insurer shall not take a credit for any excess insurance or reinsurance which is provided by a captive insurance company which is wholly owned by the self-insurer. Supplementary benefits or second injury benefits will not be reimbursed by the special compensation fund unless the special compensation fund assessment pursuant to section 176.129 is paid and the reports required thereunder are filed with the special compensation fund. In the case of surety bonds, bonds shall secure administrative and legal costs in addition to the liability for payment of compensation reflected on the face of the bond. In no event shall the security be less than the last retention limit selected by the self-insurer with the Workers' Compensation Reinsurance Association, provided that the commissioner may allow former members to post less than the Workers' Compensation Reinsurance Association retention level if that amount is adequate to secure payment of the self-insurers' estimated future liability, as defined in this subdivision, including payment of claims, administrative and legal costs, and unpaid assessments required by section 79A.12, subdivision 2. The posting or depositing of security pursuant to this section shall release all previously posted or deposited security from any obligations under the posting or depositing and any surety bond so released shall be returned to the surety. Any other security shall be returned to the depositor or the person posting the bond.

As a condition for the granting or renewing of a certificate to self-insure, the commissioner may require a private self-insurer to furnish any additional security the commissioner considers sufficient to insure payment of all claims under chapter 176.

Sec. 31. Minnesota Statutes 2004, section 79A.04, subdivision 10, is amended to read:

Subd. 10. **NOTICE; OBLIGATION OF FUND.** In the event of bankruptcy, insolvency, or certificate of default, the commissioner shall immediately notify by certified mail the commissioner of finance, the surety, the issuer of an irrevocable letter of credit, and any custodian of the security required in this chapter. At the time of notification, the commissioner shall also call the security and transfer and assign it to the self-insurers' security fund. The commissioner shall also immediately notify by certified mail the self-insurers' security fund, and order the security fund to assume the insolvent self-insurers' obligations for which it is liable under chapter 176. The security fund shall commence payment of these obligations within 14 days of receipt of this notification and order. Payments shall be made to claimants whose entitlement to

benefits can be ascertained by the security fund, with or without proceedings before the Department of Labor and Industry, the Office of Administrative Hearings, the Workers' Compensation Court of Appeals, or the Minnesota Supreme Court. Upon the assumption of obligations by the security fund pursuant to the commissioner's notification and order, the security fund has the right to immediate possession of any posted or deposited security and the custodian, surety, or issuer of any irrevocable letter of credit or the commissioner, if in possession of it, shall turn over the security, proceeds of the surety bond, or letter of credit to the security fund together with the interest that has accrued since the date of the self-insured employer's insolvency. The security fund has the right to the immediate possession of all relevant workers' compensation claim files and data of the self-insurer, and the possessor of the files and data must turn the files and data, or complete copies of them, over to the security fund within five days of the notification provided under this subdivision. If the possessor of the files and data fails to timely turn over the files and data to the security fund, it is liable to the security fund for a penalty of $500 per day for each day after the five-day period has expired. The security fund is entitled to recover its reasonable attorney fees and costs in any action brought to obtain possession of the workers' compensation claim files and data of the self-insurer, and for any action to recover the penalties provided by this subdivision. The self-insurers' security fund may administer payment of benefits or it may retain a third-party administrator to do so.

Sec. 32. Minnesota Statutes 2004, section 79A.06, subdivision 5, is amended to read:

Subd. 5. **PRIVATE EMPLOYERS WHO HAVE CEASED TO BE SELF-INSURED.** (a) Private employers who have ceased to be private self-insurers shall discharge their continuing obligations to secure the payment of compensation which is accrued during the period of self-insurance, for purposes of Laws 1988, chapter 674, sections 1 to 21, by compliance with all of the following obligations of current certificate holders:

(1) Filing reports with the commissioner to carry out the requirements of this chapter;

(2) Depositing and maintaining a security deposit for accrued liability for the payment of any compensation which may become due, pursuant to chapter 176. However, if a private employer who has ceased to be a private self-insurer purchases an insurance policy from an insurer authorized to transact workers' compensation insurance in this state which provides coverage of all claims for compensation arising out of injuries occurring during the entire period the employer was self-insured, whether or not reported during that period, the policy will:

(i) discharge the obligation of the employer to maintain a security deposit for the payment of the claims covered under the policy;

(ii) discharge any obligation which the self-insurers' security fund has or may have for payment of all claims for compensation arising out of injuries occurring during the period the employer was self-insured, whether or not reported during that period; and

(iii) discharge the obligations of the employer to pay any future assessments to the self-insurers' security fund.

A private employer who has ceased to be a private self-insurer may instead buy an insurance policy described above, except that it covers only a portion of the period of time during which the private employer was self-insured; purchase of such a policy discharges any obligation that the self-insurers' security fund has or may have for payment of all claims for compensation arising out of injuries occurring during the period for which the policy provides coverage, whether or not reported during that period.

A policy described in this clause may not be issued by an insurer unless it has previously been approved as to form and substance by the commissioner; and

(3) Paying within 30 days all assessments of which notice is sent by the security fund, for a period of seven years from the last day its certificate of self-insurance was in effect. Thereafter, the private employer who has ceased to be a private self-insurer may either: (i) continue to pay within 30 days all assessments of which notice is sent by the security fund until it has no incurred liabilities for the payment of compensation arising out of injuries during the period of self-insurance; or (ii) pay the security fund a cash payment equal to four percent of the net present value of all remaining incurred liabilities for the payment of compensation under sections 176.101 and 176.111 as certified by a member of the casualty actuarial society. Assessments shall be based on the benefits paid by the employer during the calendar year immediately preceding the calendar year in which the employer's right to self-insure is terminated or withdrawn.

(b) With respect to a self-insurer who terminates its self-insurance authority after April 1, 1998, that member shall obtain and file with the commissioner an actuarial opinion of its outstanding liabilities as determined by an associate or fellow of the Casualty Actuarial Society within 120 days of the date of its termination. If the actuarial opinion is not timely filed, the self-insurers' security fund may, at its discretion, engage the services of an actuary for this purpose. The expense of this actuarial opinion must be assessed against and be the obligation of the self-insurer. The commissioner may issue a certificate of default against the self-insurer for failure to pay this assessment to the self-insurers' security fund as provided by section 79A.04, subdivision 9. The opinion must separate liability for indemnity benefits from liability from medical benefits, and must discount each up to four percent per annum to net present value. Within 30 days after notification of approval of the actuarial opinion by the commissioner, the member shall pay to the security fund an amount equal to 120 percent of that discounted outstanding indemnity liability, multiplied by the greater of the average annualized assessment rate since inception of the security fund or the annual rate at the time of the most recent assessment before termination. If the payment is not made within 30 days of the notification, interest on it at the rate prescribed by section 549.09 must be paid by the former member to the security fund until the principal amount is paid in full.

(c) A former member who terminated its self-insurance authority before April 1, 1998, who has paid assessments to the self-insurers' security fund for seven years, and

whose annualized assessment is $500 or less, may buy out of its outstanding liabilities to the self-insurers' security fund by an amount calculated as follows: 1.35 multiplied by the indemnity case reserves at the time of the calculation, multiplied by the then current self-insurers' security fund annualized assessment rate.

(d) A former member who terminated its self-insurance authority before April 1, 1998, and who is paying assessments within the first seven years after ceasing to be self-insured under paragraph (a), clause (3), may elect to buy out its outstanding liabilities to the self-insurers' security fund by obtaining and filing with the commissioner an actuarial opinion of its outstanding liabilities as determined by an associate or fellow of the Casualty Actuarial Society. The opinion must separate liability for indemnity benefits from liability for medical benefits, and must discount each up to four percent per annum to net present value. Within 30 days after notification of approval of the actuarial opinion by the commissioner, the member shall pay to the security fund an amount equal to 120 percent of that discounted outstanding indemnity liability, multiplied by the greater of the average annualized assessment rate since inception of the security fund or the annual rate at the time of the most recent assessment.

(e) A former member who has paid the security fund according to paragraphs (b) to (d) and subsequently receives authority from the commissioner to again self-insure shall be assessed under section 79A.12, subdivision 2, only on indemnity benefits paid on injuries that occurred after the former member received authority to self-insure again; provided that the member furnishes verified data regarding those benefits to the security fund.

(f) In addition to proceedings to establish liabilities and penalties otherwise provided, a failure to comply may be the subject of a proceeding before the commissioner. An appeal from the commissioner's determination may be taken pursuant to the contested case procedures of chapter 14 within 30 days of the commissioner's written determination.

Any current or past member of the self-insurers' security fund is subject to service of process on any claim arising out of chapter 176 or this chapter in the manner provided by section 5.25, or as otherwise provided by law. The issuance of a certificate to self-insure to the private self-insured employer shall be deemed to be the agreement that any process which is served in accordance with this section shall be of the same legal force and effect as if served personally within this state.

Sec. 33. Minnesota Statutes 2004, section 79A.12, subdivision 2, is amended to read:

Subd. 2. **ASSESSMENT.** The security fund may assess each of its members a pro rata share of the funding necessary to carry out its obligation and the purposes of this chapter. Total annual assessments in any calendar year shall not exceed ten percent of ~~the workers' compensation benefits paid under sections 176.101 and 176.111 during the previous~~ paid indemnity losses, as defined in section 176.129, made by the self-insured employer during the preceding calendar year. The annual assessment calculation shall not include supplementary benefits paid which will be reimbursed by

the special compensation fund. Funds obtained by assessments pursuant to this subdivision may only be used for the purposes of this chapter. The trustees shall certify to the commissioner the collection and receipt of all money from assessments, noting any delinquencies. The trustees shall take any action deemed appropriate to collect any delinquent assessments.

Sec. 34. Minnesota Statutes 2004, section 79A.22, subdivision 11, is amended to read:

Subd. 11. **DISBURSEMENT OF FUND SURPLUS.** (a) ~~One hundred~~ Except as otherwise provided in paragraphs (b) and (c), 100 percent of any surplus money for a fund year in excess of 125 percent of the amount necessary to fulfill all obligations under the Workers' Compensation Act, chapter 176, for that fund year may be declared refundable to a ~~member~~ eligible members at any time. ~~The date shall be no earlier than 18 months following the end of such fund year. The first disbursement of fund surplus may not be made prior to the written approval of the commissioner. There can be no more than one refund made in any 12-month period.~~

(b) Except as otherwise provided in paragraph (c), for groups that have been in existence for five years or more, 100 percent of any surplus money for a fund year in excess of 110 percent of the amount necessary to fulfill all obligations under the Workers' Compensation Act, chapter 176, for that fund year may be declared refundable to eligible members at any time.

(c) Excess surplus distributions under paragraphs (a) and (b) may not be greater than the combined surplus of the group at the time of the distribution.

(d) When all the claims of any one fund year have been fully paid, as certified by an actuary, all surplus money from that fund year may be declared refundable.

~~(b)~~ (e) The commercial self-insurance group shall give ten days' prior notice to the commissioner of any refund. ~~Said~~ The notice ~~shall~~ must be accompanied by a statement from the commercial self-insurer group's certified public accountant certifying that the proposed refund is in compliance with ~~paragraph (a)~~ this subdivision.

Sec. 35. Minnesota Statutes 2004, section 79A.22, is amended by adding a subdivision to read:

Subd. 14. **ALL STATES COVERAGE.** Policies issued by commercial self-insurance groups pursuant to this chapter may also provide workers' compensation coverage required under the laws of states other than Minnesota, commonly known as "all states coverage." The coverage must be provided to members of the group which are temporarily performing work in another state.

Sec. 36. Minnesota Statutes 2004, section 176.191, subdivision 3, is amended to read:

Subd. 3. **INSURER PAYMENT.** If a dispute exists as to whether an employee's injury is compensable under this chapter and the employee is otherwise covered by an insurer or entity pursuant to chapters 62A, 62C ~~and~~, 62D, 62E, 62R, and 62T, that

insurer or entity shall pay any medical costs incurred by the employee for the injury up to the limits of the applicable coverage and shall make any disability payments otherwise payable by that insurer or entity in the absence of or in addition to workers' compensation liability. If the injury is subsequently determined to be compensable pursuant to this chapter, the workers' compensation insurer shall be ordered to reimburse the insurer or entity that made the payments for all payments made under this subdivision by the insurer or entity, including interest at a rate of 12 percent a year. If a payment pursuant to this subdivision exceeds the reasonable value as permitted by sections 176.135 and 176.136, the provider shall reimburse the workers' compensation insurer for all the excess as provided by rules promulgated by the commissioner.

Sec. 37. Laws 1985, chapter 85, section 1, is amended to read:

Section 1. **CERTAIN COUNTIES; JOINT AGREEMENTS FOR INSURANCE COVERAGE.**

(a) The counties of Aitkin, Itasca, Koochiching and St. Louis, and political subdivisions located in those counties, except the city of Duluth, when two or more of them are acting jointly under Minnesota Statutes, section 471.61, subdivision 1, or section 471.59 for purposes of section 471.61, may act jointly for the same purposes with any nonprofit organization organized under the laws of Minnesota and which is exempt from taxation pursuant to section 501(c)(3) of the Internal Revenue Code 1954, as amended through December 31, 1984.

(b) Notwithstanding Minnesota Statutes, sections 62L.03; 62L.04; 62L.045; or any other provision of Minnesota Statutes, chapter 62L, an arrangement described in paragraph (a) may provide the same health coverage under the same plan and premium rates to its member employers that have 50 or fewer employees that the arrangement provides to its member employers that have more than 50 employees. The insurer offering the plan need not offer this same plan to small employers that are not member employers in the arrangement described in paragraph (a).

(c) Paragraph (b) is a pilot project that expires at the end of its third full plan year after its date of enactment. After the second full plan year, the entity operating an arrangement described in paragraph (a) shall provide a written report to the commissioner of commerce summarizing the advantages and disadvantages of the pilot project and recommending whether to make it permanent.

Sec. 38. **REPEALER.**

Minnesota Statutes 2004, sections 61A.072, subdivision 2; and 62E.03 are repealed.

Sec. 39. **EFFECTIVE DATES.**

(a) Sections 9, 13, 14, 15, 18, 22, 23, 25, and 31 to 36 are effective the day following final enactment. Section 19 is effective the day following final enactment and applies to any action taken by an insurer on or after that date. Sections 1, 3, 21, and 26 to 28 are effective July 1, 2005. The remaining sections are effective August 1, 2005.

(b) Pursuant to Minnesota Statutes, section 645.023, subdivision 1, clause (a), local approval of section 37 is not required. Section 37 is effective the day following final enactment.

Presented to the governor May 31, 2005

Signed by the governor June 3, 2005, 8:15 a.m.

CHAPTER 133—S.F.No. 1780

An act relating to employment; permitting employers of professional athletes to request or require random drug testing; amending Minnesota Statutes 2004, section 181.951, subdivision 4.

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

Section 1. Minnesota Statutes 2004, section 181.951, subdivision 4, is amended to read:

Subd. 4. **RANDOM TESTING.** An employer may request or require ~~only~~ employees ~~in safety-sensitive positions~~ to undergo drug and alcohol testing on a random selection basis only if (1) they are employed in safety-sensitive positions, or (2) they are employed as professional athletes if the professional athlete is subject to a collective bargaining agreement permitting random testing but only to the extent consistent with the collective bargaining agreement.

EFFECTIVE DATE. This section is effective the day following final enactment.

Presented to the governor May 31, 2005

Signed by the governor June 1, 2005, 3:15 p.m.

CHAPTER 134—H.F.No. 742

An act relating to employment; providing exemptions from employment agency licensing requirements; prohibiting certain fee payments; extending a pilot project; amending Minnesota Statutes 2004, section 184.22, by adding subdivisions; Laws 2004, chapter 188, section 1.

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

Section 1. Minnesota Statutes 2004, section 184.22, is amended by adding a subdivision to read:

Subd. 6. **EXEMPTIONS.** (a) Except as otherwise provided, sections 184.21 to 184.41 do not apply to any person, firm, corporation, partnership, or association