1 Department of Commerce
2
3 Adopted Rules Governing Employee Health and Disability Joint
4 Self-Insurance
5
6 Rules as Adopted
7 CHAPTER 2765
8 DEPARTMENT OF COMMERCE
9 EMPLOYEE HEALTH AND DISABILITY JOINT SELF-INSURANCE PLANS

10 2765.0100 DEFINITIONS.
11 Subpart 1. **Scope.** For the purposes of parts 2765.0100 to
12 2765.1500, the terms defined in this part have the meanings
13 given them.
14 Subp. 2. **Board.** "Board" means a plan's board of trustees.
15 Subp. 3. **Bylaws.** "Bylaws" means the statements adopted by
16 a plan that prescribe its purpose, government, and
17 administration.
18 Subp. 4. **Commissioner.** "Commissioner" means the
19 commissioner of the Department of Commerce.
20 Subp. 5. **Coverage.** "Coverage" means the right of a
21 covered person to benefits provided directly or indirectly by a
22 plan, by virtue of the coverage document.
23 Subp. 6. **Coverage document.** "Coverage document" means the
24 document specifying the characteristics and duration of coverage
25 provided through a plan.
26 Subp. 7. **Covered employee.** "Covered employee" means a
27 plan member's employee who is covered through the plan, and a
28 plan member's former employee receiving continued coverage under
29 Minnesota Statutes, section 62A.17, subdivisions 1 to 5.
30 "Covered employee" does not include dependents or other persons
31 included under the coverage extended to a plan member's current
32 or former employee.
33 Subp. 8. **Days.** "Days" means calendar days.
34 Subp. 9. **Financial administrator.** "Financial
35 administrator" means an entity employing persons trained and
36 experienced in money management and investments, and possessing

1 no less than five years experience as an organization with
2 demonstrated competence in money management and investments.
3 Subp. 10. **Fund year.** "Fund year" means a plan's fiscal
4 year, and must be the calendar year.
5 Subp. 11. **Incurred basis stop-loss insurance.** "Incurred
6 basis stop-loss insurance" means the aggregate excess stop-loss
7 insurance required by part 2765.1300, if on an incurred basis.
8 The insurance is on an incurred basis if payments are charged
9 against a fund year's deductible according to when liability for
10 the payment was incurred.
11 Subp. 12. **Insurer.** "Insurer" means an insurance company
12 licensed under Minnesota Statutes, section 60A.07, subdivision
13 4, and authorized by Minnesota Statutes, section 60A.06 to write
14 sickness and disability insurance, or a service plan corporation
15 licensed under Minnesota Statutes, section 62C.08.
16 Subp. 13. **Member.** "Member" means an employer that belongs
17 to or participates in a plan. Reference to actions of a member
18 includes actions on behalf of the member's covered employees and
19 other covered persons.
20 Subp. 14. **Paid basis stop-loss insurance.** "Paid basis
21 stop-loss insurance" means the aggregate excess stop-loss
22 insurance required by part 2765.1300, if on a paid basis. The
23 insurance is on a paid basis if payments are charged against a
24 fund year's deductible according to when the payment was made.
25 Subp. 15. **Plan.** "Plan" means a joint self-insurance
26 employee benefit plan approved under parts 2765.0100 to
27 2765.0250. Reference to actions of a plan includes actions by
28 the plan's designated agents.
29 Subp. 16. **Premium.** "Premium" means the amount paid or to
30 be paid for coverage by members. Premium does not include
31 assessments or penalties.
32 Subp. 17. **Runoff plan.** "Runoff plan" means a plan that no
33 longer has authority to self-insure, but that continues to exist
34 for the purpose of paying claims, preparing reports, and
35 administering transactions associated with the period when the
36 plan provided coverage.

1 Subp. 18. **Self-insure.** "Self-insure" means to assume
2 primary liability or responsibility for certain risks or
3 benefits, rather than transferring liability or responsibility
4 to some other entity.
5 Subp. 19. **Separate employer.** "Separate employer," for the
6 purposes of meeting the minimum three-employer requirement,
7 means an employer that is not the parent, subsidiary, or
8 affiliate with a common parent of any other employer in the plan.
9 Subp. 20. **Service company.** "Service company" means an
10 entity licensed under Minnesota Statutes, section 60A.23,
11 subdivision 8 and rules adopted thereunder as a self-insurance
12 plan administrator, or an entity named in Minnesota Statutes,
13 section 60A.23, subdivision 8, paragraph (1), clause (a) or (b).
14 Subp. 21. **Short-term disability benefit.** "Short-term
15 disability benefit" means income replacement payments of not
16 more than one year's duration.

17 2765.0200 PURPOSE.
18 Parts 2765.0100 to 2765.1500 govern the formation,
19 operation, and dissolution of multiple employer plans for joint
20 self-insurance of employee health, dental, or short-term
21 disability benefits. They are intended to ensure that the
22 financial integrity of these plans is maintained, and that they
23 are administered competently and equitably.

24 2765.0300 SCOPE.
25 The following are subject to the requirements of parts
26 2765.0100 to 2765.1500:
27 A. employers authorized to transact business in
28 Minnesota that seek to jointly self-insure employee health,
29 dental, or short-term disability benefits;
30 B. service companies that provide services to a plan;
31 and
32 C. insurance companies licensed under Minnesota
33 Statutes, section 60A.07, subdivision 4, or service plan
34 corporations licensed under Minnesota Statutes, section 62C.08,
35 that provide required stop-loss insurance to a plan.

1 2765.0400 BYLAWS.

2 Subpart 1. Content. Bylaws may contain any provisions
3 that do not conflict with parts 2765.0100 to 2765.1500. Bylaws
4 must, at a minimum, contain the following provisions:
5 A. the plan's name, purpose, and initial date of
6 existence;
7 B. definitions of key terms;
8 C. a statement of the powers, duties, and
9 responsibilities assigned to the board, the service company, and
10 the financial administrator, and reserved to the membership;
11 D. the number, term of office, method of selection,
12 and method of replacement of the members of the board;
13 E. the procedure for calling board meetings;
14 F. the method of periodic selection and review of the
15 service company and financial administrator;
16 G. the procedure for amending the bylaws;
17 H. the procedure for resolving disputes among
18 members, which must not include submitting disputes to the
19 commissioner;
20 I. the criteria for membership in the plan, including
21 standards of financial integrity and loss experience;
22 J. the procedure for admitting new members to the
23 plan;
24 K. the criteria for expelling members from the plan,
25 including nonpayment of premium;
26 L. the procedure for withdrawal and expulsion of
27 members from the plan, including the minimum required period of
28 membership;
29 M. a statement of the coverages the plan intends to
30 provide;
31 N. the procedure for adding and dropping a member's
32 participation in a particular coverage;
33 O. a schedule for premium payments by members and, if
34 applicable, their employees;
35 P. the procedure for changing premium rates;
36 Q. the procedure for levying and collecting an

1 assessment;
2 R. a statement of who may have access to plan funds
3 and for what purposes;
4 S. the procedure for distributing dividends, and the
5 eligibility of past members and past covered employees for
6 dividends; and
7 T. the procedure for distributing assets remaining
8 upon the plan's dissolution.
9 Subp. 2. **Adoption and changes.** The bylaws must be adopted
10 in writing by all initial members. Authority to change the
11 bylaws must reside with the membership or the board, according
12 to the terms of the bylaws. Authority to change the bylaws may
13 not be delegated to a contractor or other outside party. The
14 plan must file bylaw changes with the commissioner not less than
15 30 days after adoption.

16 2765.0500 BOARD.
17 Subpart 1. **Structure.** A plan must have a board of
18 trustees consisting of officials or employees of the members.
19 No member may have more than one representative on the board.
20 No trustee may be an employee, agent, or representative of the
21 plan's service company, financial administrator, insurer, or
22 other person or entity under contract with the plan. Trustees
23 shall be elected by vote of the membership. There shall be an
24 odd number of trustees, with staggered terms to provide
25 continuity. One trustee shall be designated the chairperson.
26 The board shall meet no less than four times annually.
27 Subp. 2. **Duties.** The board is responsible for operation
28 of the plan. The board may delegate some or all of its
29 responsibilities to the chairperson or other trustees between
30 board meetings. All responsibilities of the plan not expressly
31 delegated by the board or parts 2765.0100 to 2765.1500 are the
32 responsibility of the board. The board shall, at a minimum,
33 have the following responsibilities:
34 A. fiduciary responsibility for the plan's operation
35 and financial condition;
36 B. selection, supervision, and evaluation of the

1 service company, financial administrator, accountant, insurer,
2 and any other contractors;
3 C. on the basis of the plan's overall financial
4 condition, authorizing changes in premium, reserve, or
5 investment practices; and declaring assessments or dividends as
6 appropriate;
7 D. approving all reports concerning the plan's
8 operations and status to the commissioner and the members;
9 E. monitoring delinquent premiums, loss experience,
10 and the financial condition of individual members; and
11 authorizing disciplinary action or expulsion as appropriate;
12 F. authorizing acceptance or rejection of
13 applications for membership;
14 G. as permitted by the bylaws, making or recommending
15 changes to the bylaws for the improvement of the plan's
16 operation and financial integrity; and
17 H. monitoring the plan's compliance with all statutes
18 and rules governing its operation.

19 2765.0600 APPLICATION.

20 Subpart 1. **Initial application.** Three or more separate
21 employers may apply to the commissioner for authority to form a
22 joint self-insurance plan, using forms available from the
23 commissioner. Applications must be submitted not later than 60
24 days prior to the requested date for authority to self-insure.
25 All reinsurance contracts must be submitted not later than 30
26 days prior to the requested date. Applications submitted
27 without responses to certain questions, or with responses that
28 are inadequate must be returned to the applicant for
29 resubmission. Applications not returned to the applicant for
30 resubmission within 14 days of receipt must be approved or
31 disapproved within 60 days of receipt.

32 Subp. 2. **Renewal application.** Existing plans may apply
33 for renewal of their self-insurance authority by so indicating
34 on their annual status report preceding expiration of their
35 current authority. Applications must be approved or disapproved
36 within 60 days of receipt of the status report.

1 Subp. 3. **Exemptions.** Joint self-insurance plans that
2 offer a program of coverage qualified under the Employees
3 Retirements Income Security Act (ERISA), United States Code,
4 title 29, sections 1001 et seq., are exempted from parts
5 2765.0100 to 2765.1500 upon filing with the commissioner notice
6 of this qualification from the United States Department of Labor.
7 Subp. 4. **Merger.** Two or more existing plans may apply to
8 merge if the new plan assumes all obligations of the former
9 plans. Merger applications are subject to the same requirements
10 as prospective new plans.
11 Subp. 5. **Approval and disapproval.** Upon approval of an
12 application, the commissioner shall issue an order authorizing
13 the proposed joint self-insurance plan. Initial authorization
14 orders for new plans are effective until the third May 1st after
15 the initial authorization date. Renewal authorization orders
16 are for two-year periods commencing May 1st. Approval of
17 applications for authority to self-insure must be granted if the
18 proposed plan conforms with:
19 A. all requirements of parts 2765.0100 to 2765.1500;
20 B. all applicable requirements of Minnesota Statutes,
21 chapters 62A and 62E, and related rules, as described in part
22 2765.1000, subpart 1;
23 C. Minnesota Statutes, sections 72A.19 to 72A.32; and
24 D. other applicable Minnesota statutes and rules.

25 2765.0700 ENDING SELF-INSURANCE, RUNOFF PERIOD, AND PLAN
26 DISSOLUTION.
27 Subpart 1. **Ending self-insurance authority.** A plan may
28 decide to end its self-insurance authority and cease to provide
29 coverage, effective at the end of a fund year. The plan must
30 notify the commissioner within 14 days of such a decision. A
31 plan may not elect to end its self-insurance authority less than
32 45 days prior to the end of the fund year in question.
33 Voluntary ending of self-insurance authority does not constitute
34 plan dissolution under subpart 4.
35 Subp. 2. **Revocation of self-insurance authority.** The
36 commissioner shall, by order, revoke the authority of a plan to

1 self-insure upon ten-days written notice if any of the following
2 events occur or conditions develop, and if the commissioner
3 judges them to be material:
4 A. failure of the plan to comply with parts 2765.0100
5 to 2765.1500; with all applicable requirements of Minnesota
6 Statutes, chapters 62A, 62D, 62E, and related rules, as
7 described in part 2765.1000, subpart 1; or with other applicable
8 Minnesota statutes or rules;
9 B. failure of the plan to comply with any lawful
10 order of the commissioner;
11 C. commission by the plan of an unfair or deceptive
12 practice as defined in Minnesota Statutes, sections 72A.17 to
13 72A.32, or in related rules; or
14 D. a deterioration of the plan's financial integrity
15 to the extent that its present or future ability to meet
16 obligations promptly and in full is or will be significantly
17 impaired.
18 Subp. 3. **Runoff period.** A plan shall continue to exist as
19 a runoff plan after its authority to self-insure has ended, for
20 the purpose of paying claims, preparing reports, and
21 administering transactions associated with the period when the
22 plan provided coverage. A runoff plan must continue to comply
23 with all appropriate provisions of parts 2765.0100 to 2765.1500,
24 and with all other applicable Minnesota statutes and rules.
25 Authority to exist as a runoff plan is open-ended, and does not
26 require renewal of authority under part 2765.0600, subpart 2.
27 Subp. 4. **Dissolution.** A plan, including a runoff plan,
28 that desires to cease existence shall apply to the commissioner
29 for authorization to dissolve. Applications must be approved or
30 disapproved within 60 days of receipt. Dissolution without
31 authorization is prohibited and void, and does not absolve a
32 plan or runoff plan from fulfilling its continuing obligations,
33 and does not absolve its members from assessment under part
34 2765.1400, subpart 6. The plan's assets at the time of
35 dissolution must be distributed to the members and covered
36 employees as provided in the bylaws. Authorization to dissolve

1 must be granted if either of the following conditions are met:
2 A. the plan demonstrates that it has no outstanding
3 liabilities, including incurred but not reported liabilities; or
4 B. the plan has obtained an irrevocable commitment
5 from a licensed insurer that provides for payment of all
6 outstanding liabilities, and for providing all related services,
7 including payment of claims, preparation of reports, and
8 administration of transactions associated with the period when
9 the plan provided coverage.

10 2765.0800 ADMINISTRATION.

11 Subpart 1. **Service company.** A plan must contract with a
12 service company for services necessary to the plan's day-to-day
13 operations, except services and responsibilities reserved to the
14 members, the board, individual trustees, the financial
15 administrator, or other contractors. The service company must
16 have expertise in and be licensed for administering health
17 benefits. Subject to the oversight of the board, the service
18 company shall, directly or through subcontractors, provide all
19 services directly related to the administration of coverage.
20 These services include but are not limited to:
21 A. accounting and recordkeeping;
22 B. billing and collection of premiums and assessments;
23 C. claims investigation, settlement, and reserving;
24 D. claims payment, including claims wholly or
25 partially subject to stop-loss insurance or member deductibles;
26 E. general administration;
27 F. loss control, safety programs, or both; and
28 G. underwriting.
29 Subp. 2. **Financial administrator.** A plan must contract
30 with a financial administrator for investment of the plan's
31 assets and other financial or accounting services. No staff
32 members of the financial administrator may be an owner, officer,
33 employee, or agent of the service company, or of a subcontractor
34 of the service company.
35 Subp. 3. **Recordkeeping.** A plan must maintain within the
36 state of Minnesota all records necessary to verify the accuracy

1 and completeness of all reports submitted to the commissioner
2 under part 2765.1500. The commissioner may examine the plan's
3 records in order to ascertain the plan's compliance with parts
4 2765.0100 to 2765.1500, and with other applicable statutes and
5 rules. All records concerning claims, reserves, financial
6 transactions, and other matters necessary to the plan's
7 operations are the plan's property.

8 2765.0900 MEMBERSHIP.

9 Subpart 1. **Availability.** Plan membership is available
10 only to employers domiciled and authorized to transact business
11 in Minnesota. A plan may establish other nondiscriminatory
12 criteria for membership. Nothing in these rules requires a plan
13 to offer membership to an employer that does not meet the plan's
14 underwriting standards.

15 Subp. 2. **Joining.** New members must be admitted according
16 to the standards and procedures specified in the bylaws.
17 Membership is not effective before the applicant has signed a
18 membership agreement affirming its commitment to comply with the
19 bylaws and parts 2765.0100 to 2765.1500. The membership
20 agreement must disclose that under the rules governing this
21 plan, the Minnesota commissioner of commerce may order that an
22 assessment be levied against member employers, if necessary to
23 maintain the plan's sound financial condition.

24 Subp. 3. **Leaving.** The membership agreement must state the
25 procedures for leaving the plan. A member must notify the plan
26 of its desire to withdraw not less than 30 days before the date
27 upon which it desires to withdraw. If the board determines that
28 the withdrawal would cause the plan to be in violation of the
29 minimum number of employers and covered employees requirement of
30 Minnesota Statutes, section 62H.01, or any other requirement of
31 parts 2765.0100 to 2765.1500 the plan shall notify the
32 commissioner as required under subpart 5. Withdrawal from a
33 plan is prohibited and void unless:

34 A. the member will have belonged to the plan
35 continuously:

36 (1) until the end of the current fund year; or

1 (2) until the end of the succeeding fund year for
2 new members that join in the last three months of the fund year;
3 or
4 (3) for a longer period if required by the bylaws;
5 and
6 B. all outstanding premiums and assessments owed by
7 the member have been paid.
8 Subp. 4. **Expulsion.** At least annually the plan shall
9 review the status and experience of each member by comparison
10 with the criteria for expulsion in the bylaws. Expulsion is
11 subject to the procedures and requirements for voluntary
12 withdrawal of a member, except that:
13 A. a member may be expelled with outstanding premiums
14 or assessments owing; and
15 B. a member may be expelled notwithstanding that the
16 minimum term of membership has not been satisfied.
17 Subp. 5. **Minimum covered employees and employers.** A plan
18 shall monitor the number of employees it covers. If the number
19 of covered employees is less than 300, the plan shall notify the
20 commissioner at monthly intervals of the number of covered
21 employees, until the number exceeds 300 for two consecutive
22 months. If the number of covered employees becomes less than
23 250, or the number of members becomes less than three, the plan
24 shall notify the commissioner:
25 A. of its intent to end its self-insurance authority;
26 or
27 B. of its proposal for restoring compliance with
28 Minnesota Statutes, section 62H.01.
29 If the proposal is unlikely, in the commissioner's
30 judgment, to restore compliance within 90 days, or if after 90
31 days the plan continues to have less than 250 covered employees
32 or less than three members, the commissioner shall revoke the
33 plan's self-insurance authority.
34 Subp. 6. **Runoff plan membership.** After revocation of a
35 plan's self-insurance authority, or after a plan notifies the
36 commissioner in writing of its intent to end self-insurance

1 authority voluntarily, no member may join, leave, or be expelled
2 from the plan.

3 2765.1000 COVERAGE.

4 Subpart 1. **Coverage administration and related**
5 **requirements.** Plans are subject to the requirements of
6 Minnesota statutes and rules applicable to insurance companies
7 providing insurance in Minnesota similar to the plan's
8 coverage. These include requirements concerning coverage
9 content, coverage administration, rates, underwriting, and
10 related matters, including but not limited to:
11 A. the requirements of Minnesota Statutes, section
12 60A.082, and related rules, as applicable to group medical
13 expense insurance and group disability income insurance;
14 B. the requirements of Minnesota Statutes, chapter
15 62A, and related rules, as applicable to group accident and
16 health insurance as defined in Minnesota Statutes, section
17 62A.10, including but not limited to:
18 (1) filing and requesting approval for coverage
19 documents and rates;
20 (2) coverage document language requirements;
21 (3) mandated benefits;
22 (4) employee notice requirements;
23 (5) requirements to offer continuation of
24 coverage to employees and other covered persons; and
25 (6) requirements to offer conversion coverage
26 through licensed insurers or health maintenance organizations to
27 employees and other covered persons;
28 C. the requirements of Minnesota Statutes, sections
29 62A.23 and 62A.24, and related rules, as applicable to group
30 disability income insurance;
31 D. the requirements of Minnesota Statutes, sections
32 62A.31 to 62A.42, and related rules, as applicable to insurance
33 covering persons covered by medicare; and
34 E. the requirements of Minnesota Statutes, chapter
35 62E, and related rules, as applicable to plans of health
36 coverage as defined in Minnesota Statutes, section 62E.02,

1 subdivision 9.
2 Subp. 2. **Coverage to individuals.** Joint self-insurance
3 plans shall not offer coverage to individuals other than
4 members' employees and their dependents, except as required
5 following termination of employment under Minnesota Statutes,
6 section 62A.17, subdivisions 1 to 5. Plans must comply with the
7 conversion coverage requirements of Minnesota Statutes, sections
8 62A.17, subdivision 6, and 62E.16, by arrangements with licensed
9 insurers or health maintenance organizations.
10 Subp. 3. **Health maintenance organization coverage.** A plan
11 may arrange for covered persons to have an option of health
12 maintenance organization coverage, including employees of
13 employers required to provide such an option by Minnesota
14 Statutes, section 62E.17. Such an arrangement must be through a
15 licensed health maintenance organization.
16 Subp. 4. **Uniform underwriting.** All coverages offered by a
17 plan must be available according to the same underwriting
18 standards to all employees of all members.
19 Subp. 5. **Term of coverage.** A plan shall not commit itself
20 to providing coverage for any period which extends beyond the
21 term of any stop-loss insurance policies required under part
22 2765.1300.
23 Subp. 6. **Continuing responsibility.** Notwithstanding
24 cancellation or termination of coverage to a particular member,
25 ceasing to offer a particular coverage, or ending or revocation
26 of authority to self-insure, a plan retains indefinitely all
27 responsibilities to covered employees and other covered persons
28 associated with the period while coverage was in force. This
29 responsibility ceases only after a plan dissolves under part
30 2765.0700, subpart 4.

31 2765.1100 PREMIUMS AND DIVIDENDS.
32 Subpart 1. **Premium payments.** The fund year must be the
33 basis for calculating members' premiums. A plan may permit
34 installment payments if payment is always due before premium is
35 to be earned. Any delinquencies in payments by employees must
36 be paid on their behalf by the employer, with the employer

1 having the right to seek reimbursement from the employee. A
2 plan shall promptly take appropriate action to collect any
3 members' premiums or assessments that are past due. Collection
4 costs are the obligation of the delinquent member. Payments
5 determined to be uncollectible must be presented to the
6 stop-loss insurer for reimbursement, as required by part
7 2765.1300, subpart 4.
8 Subp. 2. **Dividends.** A plan may declare and pay a dividend
9 or distribution from its surplus only if:
10 A. the dividend would not cause the plan's surplus to
11 be negative;
12 B. the plan does not have a stop-loss aggregate
13 advancement liability; and
14 C. the dividend is apportioned on the basis of the
15 relative amounts of premium paid by members and covered
16 employees, and provides for proportional payments to members and
17 covered employees.

18 2765.1200 RESERVES.
19 Subpart 1. **Loss and premium reserves.** A plan must
20 establish reserves for all incurred losses, both reported and
21 unreported, and for unearned premiums. To the extent that the
22 amount of a loss is uncertain, reserves must be set
23 conservatively. As the degree of uncertainty concerning a loss
24 is changed by new events or information, the amount of the
25 reserve must be changed appropriately. Accounting for reserves
26 must be as required by the financial statement forms and
27 instructions, under part 2765.1500, subpart 1.
28 Subp. 2. **Full funding reserves.** To comply with the full
29 funding requirement of Minnesota Statutes, section 62H.02, a
30 plan must establish full funding reserves corresponding to its
31 aggregate excess stop-loss insurance for each fund year.
32 A. The amount of the reserves must be calculated as
33 required by the financial statement forms and instructions,
34 under part 2765.1500, subpart 1. The forms and instructions
35 must provide that the base amount of the full funding reserves
36 is equal to the plan's maximum possible liability under the

1 aggregate excess stop-loss insurance, with credits for:
2 (1) individual excess stop-loss insurance
3 reimbursements; and
4 (2) losses paid and reserves expected to be
5 chargeable against the aggregate excess stop-loss insurance
6 deductible.
7 B. Separate full funding reserves must be maintained
8 for each fund year, beginning at the fund year's inception.
9 Plans with paid basis stop-loss insurance must maintain each
10 year's full funding reserve until 90 days after the fund year's
11 end. Plans with incurred basis stop-loss insurance must
12 maintain each year's full funding reserve until one year after
13 the fund year's end.
14 C. Plans with paid basis stop-loss insurance must
15 also maintain a separate runoff full funding reserve. The
16 runoff reserve's purpose is to fully fund the plan's liability
17 in the event of stop-loss insurance non-renewal. The runoff
18 full funding reserve must be maintained until plan dissolution.
19 Subp. 3. **Surplus or aggregate advancement.** A plan must
20 protect itself from cash flow difficulties by either of the
21 following two methods.
22 A. Establishing and maintaining a surplus equal to
23 the greater of:
24 (1) three times the average paid monthly premium
25 during the most recent fund year;
26 (2) three times estimated monthly premium, for
27 plans that do not yet have one fund year's experience; or
28 (3) $100,000.
29 B. Obtaining language in the plan's aggregate excess
30 stop-loss insurance policy requiring the insurer to advance
31 funds to the plan under the conditions prescribed by this item.
32 Any funds so advanced must be included in the fund-year
33 settle-up calculation under the stop-loss insurance terms, if
34 not previously repaid. No limit may be set on the amount of
35 funds that the plan may require to be advanced. The policy
36 language must include these sentences: "If, in good faith, the

1 plan judges that it is suffering, or will soon suffer cash flow
2 difficulties, to the extent that its ability to meet its
3 obligations promptly and in full is or will be significantly
4 impaired, the plan may borrow from the insurer funds sufficient
5 in the plan's good faith judgment to correct the difficulties.
6 Such funds shall be considered an advance against the insurer's
7 potential aggregate excess insurance liability for the current
8 fund year. If, as of the final reporting for that fund year,
9 the insurer's liability is determined to be less than the amount
10 of the aggregate advancement, the difference shall then be
11 considered a debt of the plan to the insurer, and reasonable
12 interest may be charged commencing at that time. Until the
13 final reporting, no interest may be charged. The plan shall, in
14 good faith, repay the advance or debt as rapidly as its
15 financial resources permit, without incurring further cash flow
16 difficulties." The policy must not alter or qualify these terms
17 to harm the plan's rights materially.

18 2765.1300 STOP-LOSS INSURANCE.

19 Subpart 1. **Purchase and alteration.** The plan must inform
20 the commissioner at least 90 days prior to expiration of any
21 required stop-loss insurance policy whether it intends to renew
22 the policy, and whether the insurer is willing to renew the
23 policy. Alteration of a required stop-loss insurance policy
24 mid-term with the effect of reducing coverage, and cancellation
25 by the plan mid-term, are prohibited. Required stop-loss
26 insurance policies must be noncancellable for a minimum of two
27 years, for any cause including nonpayment of premium. If more
28 than one stop-loss insurance policy is obtained in fulfillment
29 of this part's requirements, their expiration dates must be the
30 same.

31 Subp. 2. **Individual excess.** A plan must have and maintain
32 individual excess stop-loss insurance, that provides for the
33 insurer to assume all liability in excess of $25,000 per person
34 per year under all coverages the plan offers. The reporting
35 period under this coverage must be no less than one year after
36 the fund year's conclusion. A plan may apply to the

1 commissioner for increasing the individual excess stop-loss
2 insurance limit, up to $50,000. The commissioner must approve
3 this application if the increased limit would not be detrimental
4 to the solvency and stability of the plan, considering the
5 plan's experience, size, surplus, and other factors affecting
6 financial integrity.

7 Subp. 3. **Aggregate excess.** A plan must have and maintain
8 aggregate excess stop-loss insurance that provides for the
9 insurer to assume all liability in excess of a specified amount
10 of losses for each fund year. The aggregate excess coverage may
11 be in the form of incurred basis stop-loss insurance or paid
12 basis stop-loss insurance. Plans using paid basis stop-loss
13 insurance must have and maintain extended or runoff aggregate
14 excess stop-loss insurance on an incurred basis. The extended
15 or runoff coverage must provide for the insurer to assume all
16 liability in excess of a specified amount of losses incurred
17 while the paid basis stop-loss insurance was in force, but paid
18 after its termination or nonrenewal. The reporting period under
19 paid basis insurance must be no less than three months after the
20 fund year's conclusion. The reporting period under incurred
21 basis insurance, including extended or runoff insurance, must be
22 no less than one year after the fund year's conclusion.

23 Subp. 4. **Delinquencies and insolvencies.** A plan must have
24 and maintain the following language in its required aggregate
25 excess stop-loss insurance policy: "The insurer shall, at the
26 plan's or the commissioner's request, pay premium to the plan on
27 behalf of a member that fails to pay due to insolvency,
28 unauthorized withdrawal from the plan, or any other reason. The
29 insurer may attempt to collect reimbursement from the member on
30 whose behalf the insurer is called upon to pay premium." The
31 policy must not alter or qualify these terms to harm the plan's
32 rights materially.

33 Subp. 5. **Surety coverage.** A plan must have and maintain
34 the following language in its required aggregate excess
35 stop-loss insurance policy: "The insurer shall, at the
36 commissioner's request, assume direct responsibility for the

1 plan's coverage and all other responsibilities under parts
2 2765.0100 to 2765.1500 and related statutes, if the plan becomes
3 insolvent, ceases operations without authorization, or otherwise
4 fails to fulfill its responsibilities under parts 2765.0100 to
5 2765.1500 and related statutes. The insurer may attempt to
6 collect reimbursement from the plan or a member on whose behalf
7 the insurer is called upon to pay premium, pay claims, or incur
8 other extraordinary expenses. However, the insurer must fulfill
9 its responsibilities under this section while any collection
10 attempts are pending. The insurer's responsibilities extend to
11 all matters arising during or attributable to the policy period,
12 and do not terminate with the end of the policy period." The
13 policy must not alter or qualify these terms to harm the plan's
14 rights materially.

15 Subp. 6. **Return of liability.** No liability or other
16 responsibilities transferred to an insurer under this part may,
17 directly or indirectly, be returned to a plan, a member, or a
18 member's parent, subsidiary, or affiliate. This does not
19 prohibit the insurer from seeking reimbursement from the plan or
20 a member, as permitted under subparts 4 and 5.

21 2765.1400 FINANCIAL INTEGRITY.

22 Subpart 1. **Fidelity bond.** All contractors and individuals
23 who handle plan funds or who will have authority to gain access
24 to plan funds, including trustees, must be covered by a fidelity
25 bond. The bond must cover losses from dishonesty, robbery,
26 forgery or alteration, misplacement, and mysterious and
27 unexplainable disappearance. The amount of coverage for each
28 occurrence must be $300,000 or more. The plan must purchase a
29 fidelity bond covering the required contractors and individuals,
30 or submit separate proof of coverage for all required
31 contractors and individuals not covered under the plan's bond.

32 Subp. 2. **Integrity of assets.** A plan's assets:

33 A. must not be commingled with the assets of any
34 member;

35 B. must not be loaned to anyone for any purpose, or
36 used as security for a loan, except as permitted under subpart 5

1 for investments;
2 C. must be employed solely for the purposes stated in
3 the bylaws, and in compliance with parts 2765.0100 to 2765.1500
4 and related statutes; and
5 D. must not be considered the property or right of
6 any member, covered employee, or other covered person, except:
7 (1) for benefits under the coverage documents;
8 (2) for dividends declared in accordance with
9 part 2765.1100, subpart 2; and
10 (3) for a portion of the assets remaining after
11 the plan's dissolution, in accordance with part 2765.0700,
12 subpart 4.
13 Subp. 3. **Sources and uses of funds.** A plan may expend
14 funds for payment of losses and expenses, and for other costs
15 customarily borne by insurers under conventional insurance
16 policies in Minnesota. Except as provided in part 2765.1200,
17 subpart 3, item B, a plan must not borrow money or issue debt
18 instruments. A plan may bring legal suits to collect delinquent
19 debts. A plan must not obtain funds through subrogation of the
20 rights of covered employees or other covered persons. A plan
21 may receive funds only from:
22 A. its members as premiums, assessments, or penalties;
23 B. its insurers or indemnitors pursuant to insurance
24 or indemnification agreements;
25 C. dividends, interest, or the proceeds of sale of
26 investments;
27 D. refunds of excess payments;
28 E. coordination of benefits with automobile coverage,
29 workers' compensation coverage, and other employee health
30 benefit coverage; or
31 F. collection of money owed to the plan.
32 Subp. 4. **Separate accounts.** A plan may establish separate
33 accounts for the payment of claims or certain types of
34 expenses. These accounts must be used only by the service
35 company, its authorized subcontractors, or the financial
36 administrator, as appropriate to the account's purpose. The

1 amount in these special accounts must not exceed an amount
2 reasonably sufficient to pay the claims or expenses for which it
3 is established. All monetary and investment assets not in these
4 accounts must be under the control of the financial
5 administrator.

6 Subp. 5. **Investments.** A plan's investments are subject to
7 the requirements of Minnesota Statutes, section 475.66, as
8 regards both permitted types of investments, maturities, and
9 depositories. In addition, a plan must not invest in securities
10 or debt of a member, or a member's parent, subsidiary, or
11 affiliate; or any person or entity under contract with the plan.

12 Subp. 6. **Monitoring financial condition.** The board must
13 regularly monitor the plan's revenues, expenses, and loss
14 development, and evaluate its current and expected financial
15 condition. The board must attempt in good faith to maintain or
16 restore the plan's sound financial condition, using any means at
17 its disposal. These means include but are not limited to
18 adjusting premium rates, underwriting standards, dividend rates,
19 expulsion standards, and other powers granted in parts 2765.0100
20 to 2765.1500 and the bylaws. If the commissioner judges that
21 the board's actions are inadequate to maintain or restore the
22 plan's sound financial condition, the commissioner shall, as
23 appropriate: order an increase in the premium rates; revoke the
24 plan's self-insurance authority; or order that an assessment be
25 levied against the members.

26 Members must not require covered employees to pay a portion
27 of an assessment, nor must covered employees be required to pay
28 any amount for premium increases on coverage in force. The
29 amount of assessments must not be more than the amount of
30 members' most recent annual premium, including the portion paid
31 by covered employees.

32 2765.1500 REPORTING.

33 Subpart 1. **Financial statements.** A plan must prepare
34 annual financial statements containing a balance sheet; a full
35 funding reserves calculation worksheet; a statement of revenues,
36 expenses, and surplus; a statement of changes in financial

1 position; and a schedule of investments. The statements must be
2 prepared on forms and according to instructions prescribed by
3 the commissioner. The financial statements must be filed with
4 the commissioner no later than 30 days after the fund year's
5 conclusion. The financial statements must be audited by an
6 independent certified public accountant, and an audit report
7 must be filed with the commissioner no later than 180 days after
8 the fund year's conclusion. A plan's first annual financial
9 statement, and every second annual financial statement
10 thereafter must be accompanied by a statement from a qualified
11 actuary concerning the balance sheet items that are based on
12 actuarial assumptions and methods. The form of the actuary's
13 statement and the scope of the actuarial review must be
14 according to instructions prescribed by the commissioner.
15 Subp. 2. **Quarterly reports.** A plan must file quarterly
16 reports with the commissioner no later than 30 days after the
17 end of the first, second, and third quarters of each fund year.
18 Quarterly reports must contain statements of the plan's:
19 A. current total cash on hand and on deposit, and
20 total investments;
21 B. current total reserve for unearned and advance
22 premiums, total reserve for outstanding losses reported and
23 unreported, total operating full funding reserve, and total
24 runoff full funding reserve;
25 C. dividends declared during the quarter;
26 D. gross premiums written during the quarter;
27 E. losses paid during the quarter;
28 F. proximity to the aggregate excess stop-loss
29 insurance attachment point for the current fund year and, if
30 applicable, the past fund year;
31 G. current total members and covered employees; and
32 H. any other matters the commissioner requests that
33 the board address.
34 Subp. 3. **Extraordinary audits.** Upon sufficient cause, the
35 commissioner shall require a plan to investigate the accuracy of
36 one or more entries on its financial statements or quarterly

1 reports, and to report its findings. If necessary for the
2 investigation's purposes, the commissioner shall require a plan
3 to contract with a qualified actuary, claims specialist,
4 auditor, or other specialists as appropriate to the type of
5 entry being investigated. If warranted by investigation's
6 findings, the commissioner shall require changes in the plan's
7 reserving, accounting, or recordkeeping practices. These
8 extraordinary audits are in addition to the commissioner's
9 rights to examine self-insurance plans under Minnesota Statutes,
10 section 60A.03, subdivisions 3, 5, and 6, and section 60A.031.
11 Sufficient cause includes:
12 A. losses that appear significantly different than
13 losses experienced by other self-insurance plans or insurance
14 companies for similar coverage;
15 B. unusual changes in the amount of entries from
16 period to period that are not sufficiently explained by the
17 financial statements, quarterly reports, or footnotes; or
18 C. other indications that a plan's financial
19 statements or quarterly reports may not accurately reflect the
20 plan's status and transactions.
21 Subp. 4. **Annual status report.** No later than 30 days
22 after the fund year's conclusion, a plan must file with the
23 commissioner a statement describing any changes that have
24 occurred in the information filed with its initial application
25 for authority to self-insure, or with the plan's most recent
26 status report. The status report must be filed in a form and
27 according to instructions prescribed by the commissioner.
28 Subp. 5. **Penalty.** The financial statements and status
29 report required under subparts 1 and 4 are considered together
30 to be a plan's annual statement. This filing and other filings
31 required by parts 2765.0100 to 2765.1500 and related statutes
32 are subject to Minnesota Statutes, section 72A.061, as
33 applicable to licensed insurance companies for comparable
34 filings.
35 Subp. 6. **Revenue fee.** No later than 60 days after each
36 fund year's conclusion, a plan must file a report with the

1 commissioner of revenue disclosing the total amount of claims
2 paid during the fund year, with no deduction for claims wholly
3 or partially reimbursed through stop-loss insurance. The report
4 must be filed on a form available from the commissioner of
5 revenue. At the time of filing the report, the plan shall pay
6 the fee required by Minnesota Statutes, section 62H.07, to the
7 commissioner of revenue in the amount of two percent of the
8 total amount of claims paid during the fund year, with no
9 deduction for claims wholly or partially reimbursed through
10 stop-loss insurance.