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State Register

STATE OF MINNESOTA

HIGHLIGHTS

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VOLUME 2, NUMBER 36

MARCH 13, 1978

State Register

Notice of *State Register* Format Changes

Beginning with *State Register* Vol. 2, issue No. 26, dated January 2, 1978, the Office of the State Register will be making the following enhancements in the *State Register* format:

- Highlights on the front cover will be arranged under section headings, as they appear within the *State Register*, and will include page numbers. The Highlights section will also include a notation directing readers to a more complete table of contents within the issue.
- An introductory statement will be included for each section of the *State Register*. These statements will give a brief explanation of the kinds of material contained in the section; effective lead times for notices of hearing, rules, or executive orders; and cites to applicable statutes.
- A new key using ~~strike outs~~ to indicate deleted language and underlining to indicate new language. Strike outs and underlining in proposed rules will indicate changes from original language to proposed new language. Strike outs and underlining in adopted rules will indicate changes from proposed to adopted language.
- Guide rule-numbers will be printed, when applicable, at the outside top of each page to indicate the beginning rule number on the left hand pages and the ending rule number on the right hand pages.
- Chapter and rule numbers that begin the text of an adopted or proposed rule will be printed in bold face.

The *State Register* is the official publication of the State of Minnesota. It contains all executive orders, rules and notices filed with the Office of the State Register as of noon of the second Wednesday preceding the Monday of publication. The text of documents published in the *State Register* is to be accorded the following presumptions:

(1) The rule or order was duly adopted, issued or promulgated;

(2) The rule or order was duly filed with the Secretary of State and available for public inspection; and

(3) The copy of the rule or order published in the *State Register* is a true copy of the original.

Judicial notice shall be taken of material published in the *State Register*.

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MCAR AMENDMENTS AND ADDITIONS

EXECUTIVE ORDERS

Executive Order No. 168

Providing for the Reaffirmation of the Establishment of an Affirmative Action Program and Repealing Executive Order Nos. 76 and 76A

I, Rudy Perpich, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

WHEREAS, the State of Minnesota is committed by the Minnesota Human Rights Act to actively promote Equal Employment Opportunity throughout State government; and

WHEREAS, the State of Minnesota is committed by Federal laws to formulate an Affirmative Action Program to provide Equal Employment Opportunity in all positions in State government employment; and

WHEREAS, the State of Minnesota has a responsibility to insure the optimum use of the State's human resources and the career development of State employees;

NOW THEREFORE, I order that the State of Minnesota shall take immediate affirmative action to insure equal employment opportunity for all its employees and for all applicants seeking employment in State government. A Statewide Affirmative Action Program shall be established and maintained and shall include, but not be limited to, the following personnel functions: hiring, recruitment, selection, benefits, promotion, transfer, layoff, return from layoff, compensation, equality of wages, and employee development programs such as apprenticeship and training.

1. The Commissioner of Personnel shall be responsible for the overall administration of the State's affirmative action program. The Commissioner shall establish within the Department of Personnel a Division of Equal Opportunity to be managed by a State Director of Equal Opportunity.

2. The State Director of Equal Opportunity, appointed by and directly accountable to the Commissioner, shall have the authority and responsibility for development, implementation, and administration of the Statewide Affirmative Action Program. The State Director shall be indirectly accountable to the Governor for the success of the program.

3. The State Director of Equal Opportunity shall issue such policies and procedures as are appropriate and in accordance with State and Federal laws and with this order.

4. The State Director shall be responsible for coordinating the State's compliance with all Federal laws, orders, and regulations relating to affirmative action and equal employment opportunity. The State Director is hereby designated as the liaison between the State and Federal governments for all such matters.

5. Each Commissioner or Department Head shall be held accountable directly to the Governor and indirectly to the State Director of Equal Opportunity for his or her department's compliance with this order, with the Statewide Affirmative Action Plan, and with State and Federal laws, regulations, and orders relating to equal employment opportunity. As such, each Commissioner or Department Head will:

a. Develop, implement, and maintain in his or her department an affirmative action plan consistent with the Statewide Affirmative Action Plan.

b. Include in his or her Position Description, Performance Evaluation and Activity Report, and Individual Development Plan specific objectives and plans designed to facilitate affirmative action and equal employment opportunity. Performance will be judged, in part, on the basis of accomplishment in this area.

c. Require all managers and supervisors to include such objectives and plans in their Position Descriptions, Performance Evaluation and Activity Reports, and Individual Development Plans and will notify them that merit increases will be awarded, in part, on the basis of their accomplishments in affirmative action.

d. Require the appropriate employees to take such affirmative action-related training courses as may be made available by the Department of Personnel or the departmental Training Coordinators/ Affirmative Action Officers.

6. The State Director of Equal Opportunity shall determine the compliance status of each department and shall report same to the Governor quarterly. The Governor will take any appropriate action to ensure a department's compliance with the Statewide Affirmative Action Plan.

7. This Order supersedes Executive Order No. 76, issued March 1, 1974, and Executive Order No. 76A, issued December 31, 1975. This Order shall be effective fifteen days after publication in the *State Register*.

IN TESTIMONY WHEREOF, I hereunto set my hand on this 28th day of February, 1978.

Pursuant to the provisions of Minn. Stat. § 15.0411 to § 15.052, all rules, amendments to rules, or suspensions or repeals of rules become effective after all requirements described in Minn. Stat. § 15.0412, subd. 4 have been met and five working days after publication in the *State Register*, unless a later date is required or specified.

If the rule as adopted does not differ from the proposed rule as previously published in the *State Register*, a notice of adoption as proposed and a citation to the previous publication is considered sufficient as publication of the adopted rule, suspension or repeal.

If the rule as adopted differs from the proposed rule, the adopted rules or subdivisions thereof which differ from the proposed rule are published along with a citation to the *State Register* publication of the proposed rule.

Pursuant to Minn. Stat. § 15.0412, subd. 5, temporary rules take effect upon approval of the Attorney General. As soon as practicable, notice of the Attorney General's decision and the adopted temporary rule are published in the *State Register*, as provided for adopted rules. Temporary rules are effective for only 90 days and may be reissued for 90 days.

Department of Health
Commissioner of Health
Adopted Rules Regarding Procedures for Determining Regulations of Human Service Occupations

The rules published at the *State Register*, volume 1, number 36, page 1311, March 14, 1977 (1 S.R. 1311) are adopted and are identical in every respect to their proposed form, with the following amendments:

Chapter Thirty: Human Services Occupations

Part I: Rules of Procedures ~~and Criteria~~ for Determining ~~Credentialing~~ Regulation of Human Services Occupations

MHD 536 General.

A. Declaration of purpose and scope. Minnesota Rules MHD 536-540 establish the process to be used by the ~~State~~ ~~Board~~ Commissioner of Health and ~~its~~ the Human Services Occupations Advisory Council in carrying out the charges of ~~Minn. Laws 1976, Chapter 222, Sections 1,~~ 8 ~~and~~ 9 Minn. Stat. §§ 214.001, 214.13 and 214.14 (1976). ~~It specifies~~ They specify the procedures by which human services occupations are identified and decisions are made regarding the State's need to regulate persons in specific occupations. This rule applies to all human services occupations that are not now credentialed by the State. Determination of a mode of regulation, if any, for an occupational group shall be based on the factors contained in Minn. Stat. § 214.001, subd. 2, at all levels of the recommendations-decision process, to wit: subcommittee, Council and Commissioner.

MHD 536

B. Definitions. For the purposes of Minnesota Rules MHD 536 to 540, the words, terms and phrases listed below in this subdivision shall have the meaning stated herein, unless the language or context clearly indicates that a different meaning is intended.

1. "Administrative authority" means the state agency responsible for administering the law and rules establishing a credential for a human services occupation.

2. "Applicant group" means an occupational group that has submitted a letter of intent to begin the credentialing process.

~~3. "Board" means the Minnesota State Board of Health.~~

~~4.~~ 3. "Career progression" means opportunity to move up a career ladder or enter a related profession without loss of credit for previous education and experience.

4. "Commissioner" means the Commissioner of Health.

5. "Competence" means possession of requisite abilities to fulfill work obligations.

6. "Conflict of interest" means

~~a. A direct financial or self-serving interest in the matter under consideration.~~

~~b.~~ a. ~~An~~ A direct or indirect financial or self-serving interest in the matter under consideration so that the member is not so free from personal bias, prejudice or preconceived notion as to make it possible for the member to ~~objectively~~

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MHD 536

~~consider~~ consider objectively the evidence presented and base a decision solely on such evidence.

~~c.~~ b. Circumstances such that a member finds it difficult, if not impossible to devote himself or herself to a consideration of the matter with complete energy, loyalty, and singleness of purpose to the general public interest.

7. "Continuing education" means education or training beyond the individual's pre-credentialing preparation for an occupation.

8. "Council" means the Human Services Occupations Advisory Council.

9. "Credentialing" means licensure or registration and the processes by which they are obtained and administered.

~~10. "Criteria approval" means evaluation, by the administrative agency, of the qualifications of an individual already licensed or registered by a state other than Minnesota to determine whether the individual's past practice and/or preparation meet Minnesota requirements for licensing or registration.~~

~~11.~~ 10. "Department" means Minnesota Department of Health.

~~12.~~ 11. "Function" means a special task, duty or performance required in the course of work or activity.

~~13.~~ 12. "Functional differentiation" means those functions carried out by a particular occupational group that distinguish that group from others.

~~14.~~ 13. "Letter of intent" means an applicant group's written expression of aim to pursue credentialing.

~~15.~~ 14. "Licensure" means a system whereby a practitioner must receive recognition by the state that he or she has met predetermined qualifications, and persons not so licensed are prohibited from practicing.

~~16.~~ 15. "Not now credentialed" means those occupations whose members are not currently licensed or registered by the state and those occupations whose members are currently licensed or registered by the state but who seek to expand or specialize their functions within that licensed or registered occupation such that the group members seek further state recognition by new, expanded or specialty licensure or registration.

~~17.~~ 16. "Occupational group" means a group of human service workers that have common occupational functions, practices, and roles in the delivery of human ~~health~~ services.

~~18.~~ 17. "Public forum" means public meeting(s) called to obtain comments on an applicant group's questionnaire. The meeting is open to the public, but it is not a hearing and does not require the hearings notification procedures called for by Minnesota Statutes.

~~19.~~ 18. "Questionnaire" means document designed to provide information about an occupational group for ~~credentialing~~ purposes of aiding in making a regulatory determination.

~~20.~~ 19. "Registration" means a system whereby practitioners who will be the only persons permitted to use a designated title are listed on an official roster after having met predetermined qualifications.

C. Prohibition. A Council member may not be appointed to a subcommittee, may not participate in subcommittee or council discussions, and may not vote on any matter in which he or she has a conflict of interest.

MHD 537 Identification of Occupational Groups, Questionnaire Contents, and Processing Priorities.

A. Applicant initiated identification.

1. The applicant group shall submit a letter of intent to the ~~Board~~ Commissioner.

2. Upon receipt of the letter of intent the ~~Board~~ Commissioner shall send these rules and a Questionnaire to the applicant group.

3. The applicant group shall submit the completed Questionnaire to the ~~Board~~ Commissioner within six months or shall make a written request for an extension of the time period. Failure to comply with either of those conditions during the six month period voids the original letter of intent and discontinues the ~~credentialing~~ regulatory decision process. The applicant group shall submit a new letter of intent if it desires to pursue credentialing.

~~4. When the Questionnaire is deemed complete by the Department, the Board shall transmit the Questionnaire to the Council.~~

4. When the Questionnaire is deemed complete by the Department, the Commissioner shall transmit the Questionnaire to the Council. If the Department deems the Questionnaire to be incomplete, it shall return the Questionnaire to the applicant group with a report describing the deficiencies. If the applicant group considers the Questionnaire to be complete, it may request that the Questionnaire be submit-

ted to the Commissioner to determine whether the Questionnaire contains adequate data for the Commissioner to commence the process. Nothing in this rule shall prevent the Department from informally assisting the applicant group in the completion of the Questionnaire.

B. ~~Board~~ Commissioner initiated identification.

1. When the ~~Board~~ Commissioner, Council, other groups, or individuals have reasons to suspect that an occupational group exists or is emerging but has not applied for credentialing and the question of regulation should be addressed the ~~Board~~ Commissioner shall determine whether the need to ~~credential~~ regulate the group should be investigated. The determination shall be based upon evidence that raises the question of the need for occupational regulation. Such evidence may be derived from sources that include, but are not limited to court decisions, data collected by state and national regulatory agencies, federal law or rule, and information submitted by legislators, government or private agencies, or the public.

2. The ~~Board~~ Commissioner may direct staff to collect data substantially equivalent to that on the Questionnaire for evaluation in the manner specified in Minnesota Rules MHD 538.

C. Contents of the questionnaire. The Questionnaire shall direct an applicant group to submit information ~~on at least~~ related to the following matters:

1. Evidence that ~~the~~ an applicant group claiming to speak for an occupational group represents a significant portion of an occupational group and that other organizations representing members of that occupational group have been identified.

2. Evidence that the occupational group meets the ~~credentialing criteria~~ regulatory factors contained in ~~Minnesota Statute and these rules~~ Minn. Stat. § 214.001, subd. 2.

3. Such other and additional information or evidence consistent with the provisions of applicable statute and these rules as well as information necessary to clarify matters already contained in the application. Such information shall be requested for the sole purpose of enabling the ~~Board~~ Commissioner to fairly, adequately and completely evaluate the applicant Questionnaire to determine whether an occupational group should be ~~credentialed~~ regulated, and if an occupational group is credentialed, ~~if so by licensure or registration, and~~ under which administrative authority it will be regulated. The ~~Board~~ Commissioner may suspend or terminate the ~~credentialing~~ regulatory decision process for failure to supply the information requested ~~by the Board~~.

D. Questionnaire processing priorities. The ~~Board~~ Commissioner may determine the priority for processing Questionnaires. The priority of an applicant group will be based on evidence available in the Questionnaire, particularly that relating to the potential harm to the public that the continued practice of the unregulated group may cause. After a determination of priority for entering the ~~credentialing~~ regulatory decision process has been made, the ~~Board~~ Commissioner shall take the actions listed in Minnesota Rules 538.

MHD 538 ~~Credentialing~~ Regulatory decision process.

A. Delayed consideration. The ~~Board~~ Commissioner shall proceed to notify the applicant group of the date at which its application might reasonably expect to be considered under Minnesota Rules MHD 538 B. The notification will include the reasons for the delayed consideration.

B. Immediate consideration.

1. When a Questionnaire is received by the Council, the chairman of the Council shall appoint a subcommittee of at least five members, none of whom shall have a conflict of interest, and shall name one of the members as subcommittee chairman. Insofar as possible the subcommittee shall be broadly representative of the Council.

2. Subcommittee procedures.

a. The subcommittee will meet to ~~evaluate~~ study the Questionnaire as it addresses the factors contained in Minn. Stat. § 214.001, subd. 2, and materials available to the subcommittee and to raise any questions members feel ought to be addressed either in subcommittee meetings or at the public forum.

b. All written material related to the ~~credentialing~~ of regulatory decision for an occupational group will be available as part of a public file retained at the Minnesota Department of Health and other locations the ~~Board~~ Commissioner deems appropriate.

3. Public forum.

a. The subcommittee shall hold at least one public

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MHD 538

forum for the purpose of providing for public participation in the ~~credentialing~~ regulatory decision process, collecting information, raising and clarifying issues, and when possible, providing for the negotiation of differences.

b. The first public forum shall be held within four months of the subcommittee appointments.

c. The public forum shall be open to all persons.

d. Notification of the public forum shall be made in the following manner:

(1) All groups and persons identified by name as part of the occupational group by the Questionnaire and through Department study will be notified by mail.

(2) A news release will be sent out by the ~~Board~~ Commissioner.

(3) Notice will be published in the Department's monthly listing of health-related meetings.

(4) Notice will be sent to the public information offices of the Departments of Corrections and Public Welfare for inclusion in any bulletins they use for public notification of meetings.

(5) Notice will be published in the *State Register*.

e. The conduct of the public forum(s) will be in accordance with procedures adopted by the Council and available in writing to the public at the public forum. All interested persons will be given an opportunity to make a presentation although time limits may be imposed.

4. Subcommittee recommendations. The Subcommittee shall make recommendations to the Council with respect to: the need for regulation, the type of regulation, whether any recommended credential be licensure or registration and the administrative authority for any recommended credential. The Department shall also make separate recommendations which accompany those of the subcommittee. Each recommendation shall be accompanied by the rationale/justification used in arriving at the decision. ~~Approval or denial of credentialing for~~ Regulation of an occupational group shall be based on ~~Minn. Laws 1976, Chapter 222, Section 1, subdivision 2~~ the factors contained in Minn. Stat. § 214.001, subd. 2.

5. Council action. The Council will review the subcommittee recommendation and approve or modify them as necessary. A Council final report and recommendations, along with supporting documents, will be sent to the ~~Board~~ Commissioner for action. The Department report and recommendations, with supporting documents, will accompany the Council report.

6. ~~Board~~ Commissioner actions. The ~~Board~~ Commissioner, upon review of the Council report and recommendations, will take one of ~~the following~~ actions listed below. The Commissioner's action will be accompanied by a report giving the reason for the decision. Notification of the action will be made in the same manner as that of the public forum as called for in Minnesota Rules MHD 538 B.3.d.

a. If the ~~Board~~ Commissioner determines that an occupational group shall be credentialed by registration with an existing health related licensing board acting as the administrative authority, ~~it~~ the Commissioner will establish procedures and adopt rules in cooperation with the identified board. The rules shall include, if appropriate, but not be limited to the following:

(1) Functional differentiation of the group.

(2) Qualifications for registration for all entry routes.

(3) Requirements for different levels of registered titles corresponding to steps in the occupation's career progression.

(4) Organizational structure of any advisory councils to the administrative authority.

(5) Procedures for registration.

(6) Requirements for registration renewal, including but not limited to provisions attempting to assure continued competency.

(7) Disciplinary procedures.

(8) Fee setting for initial application for registration and for renewal application.

(9) Such other information that the ~~Board~~ Commissioner deems necessary for the regulation of the occupational group.

b. If the ~~Board~~ Commissioner determines that an occupational group should be credentialed by licensure, with either an existing health related licensing board, the ~~Board itself~~ Commissioner, or a new and separate licensing board, acting as administrative authority, the ~~Board~~ Commissioner shall promptly so report to the legislature.

c. If the ~~Board~~ Commissioner determines that an

occupational group shall be credentialed by registration, with the ~~Board~~ Commissioner acting as the administrative authority, ~~it~~ the Commissioner shall establish procedures and adopt rules to implement the decision. The rules will include, if appropriate, but not be limited to, the items contained in Minnesota Rules MHD 538 B.6.a. (1) through (9).

d. If the ~~Board~~ Commissioner determines that an occupational group should be regulated pursuant to ~~Minnesota Laws 1976, Chapter 222, Section 1, subdivision 3(a) (b) or (d)~~ Minn. Stat. § 214.001, subd. 3 (a) (b) or (d) or any combination thereof or in combination with credentialing under these rules, the ~~Board~~ Commissioner shall promptly so report to the legislature.

e. If the ~~Board~~ Commissioner determines that ~~credentialing~~ regulating the occupational group is not in the public interest, the applicant group (if the application was initiated by the group) or the Council (if the application was initiated by the ~~Council~~ Commissioner) shall be so notified.

f. If the ~~Board~~ Commissioner determines that further study of the occupational group is required, the ~~Board~~ Commissioner shall refer the recommendation back to the Commissioner's instructions. The instructions shall include a specified time in which to complete this study. Extensions of time may be granted if needed to complete adequately the further study.

C. Reconsideration process.

1. If an interested person or the applicant group is dissatisfied with the decision of the ~~Board~~ Commissioner, the person or applicant group may request, within 60 days of notification of that decision, that the ~~Board~~ Commissioner reconsider the application. The person or applicant group shall submit in writing, along with ~~its~~ the request for reconsideration, ~~its~~ arguments detailing why the decision of the ~~Board~~ Commissioner was not supported by the evidence presented or why new or changed evidence does not support the earlier decision of the ~~Board~~ Commissioner.

2. The ~~Board~~ Commissioner may ~~choose to~~ reconsider the ~~credentialing~~ regulatory decisions ~~itself~~ or remand them, along with all reports, recommendations, and supporting documents to the Council. If the matter is remanded, the Council shall reconsider the application and recommend either no change or appropriate changes to the ~~Board~~ Commissioner. The Council may refer the matter to the subcommittee which initially considered the application. The

recommendation of the Council shall include substantiating documentation. Reconsideration by the Council may include new public forums if new or changed evidence warrants it.

3. The ~~Board~~ Commissioner shall notify the person or applicant group of the results of the request ~~to reconsider the application~~ to reconsider the regulatory decisions.

MHD 539, 540 Reserved for future use.

Department of Labor and Industry

Notice of Emergency Temporary Standard for Workers Exposed to Acrylonitrile (AN) Also Known as Vinyl Cyanide

Please take notice that E. I. Malone, commissioner, Department of Labor and Industry, has determined that a grave danger currently exists for workers exposed to acrylonitrile (AN) (also known as vinyl cyanide). The commissioner has therefore determined that an Emergency Temporary Standard (ETS) must be adopted to protect workers from this grave danger. This decision to adopt an ETS is based upon information published in the *Federal Register* on Tuesday, January 17, 1978.

In March 1977, the Manufacturing Chemists Association (MCA) reported the interim results after one year of a planned two-year study being conducted by Dow Chemical Company's laboratories on the chronic toxicity of ingestion of acrylonitrile by rats. Sacrifice of some of the animals after one year showed the development of various tumors including central nervous system and ear canal tumors; the tumors were found in animals exposed to 100 and 300 ppm. Later reports from MCA in April indicated that similar tumors had been found in the lowest exposure group — 35 ppm. In May 1977, E. I. duPont de Nemours and Company reported preliminary results of an epidemiological study demonstrating an excess of cancer among workers exposed to acrylonitrile at a duPont textile fibers plant in Camden, South Carolina. A December 1977 report from the National Institute for Occupational Safety and Health (NIOSH) stated that . . . "although the preliminary results of the duPont

epidemiologic study are inconclusive by themselves. . . , when viewed in light of the preliminary rat data the conclusion with regard to acrylonitrile is clear — the chemical must be viewed as a proven animal carcinogen and suspect human carcinogen."

The ETS reduces the permissible exposure level from 20 parts acrylonitrile per million parts of air (20 ppm) as an 8-hour time-weighted average concentration, to 2 ppm with a ceiling level of 10 ppm for any 15-minute period during the 8-hour day. In addition, the ETS includes an action level of 1 ppm as an 8-hour time-weighted average. Provision is also made for specific exemptions in the standard for plant operations involving the processing, use and handling of products fabricated from polyacrylonitrile (PAN). In addition, the ETS requires the measurement and control of employee exposure, personal protective equipment and clothing, employee training, medical surveillance, work practices and recordkeeping.

Therefore, the following Rule is promulgated pursuant to Minn. Stat. § 182.655, subd. 11 (1976), as an Emergency Temporary Occupational Safety and Health Standard:

Part 1910 Emergency Temporary Occupational Safety and Health Standard as publishedin *Federal Register*, Volume 43, No. 11, pages 2600 to 2607, January 17, 1978 which contains a new standard, Section 1910.1045, for occupational exposure to acrylonitrile. This new standard issued as an Emergency Temporary Standard will take effect March 13, 1978. It applies to all occupational exposures to acrylonitrile in Minnesota except that it does not apply to certain instances of processing, use, and handling of products fabricated from polyacrylonitrile (PAN).

Within thirty (30) days of the effective date of this ETS or within fifteen (15) days following the introduction of AN into the workplace, every employer who has a work place where AN is present shall report the following information to the Director, Occupational Safety and Health Division, Department of Labor and Industry, 444 Lafayette Road, St. Paul, Minnesota 55101: (1) The address and location of each workplace in which AN is present; (2) A brief description of each process or operation which may result in employee exposure to AN; (3) The number of employees engaged in each process or operation who may be exposed to AN and an estimate of the frequency and degree of exposure that occurs; and (4) A brief description of the employer's safety and health program as it relates to limitation of employee exposure to AN.

A complete copy of the above standard is available by writing Deputy Commissioner, Minnesota Department of Labor and Industry, 500 Space Center Building, 444 Lafayette Road, St. Paul, Minnesota 55101.

Department of Natural Resources

Designation, Classification and Management of the Rum River in Mille Lacs, Sherburne, Isanti and Anoka Counties

The rules published at *State Register* Vol. 1, No. 48, pp. 1755-1783, June 6, 1977 (1 S.R. 1755-1783), are adopted and are identical in every respect to their proposed form, with the following amendments.

Chapter Twenty-~~Four~~ Seven: Designation, Classification and Management of the Rum River in Mille Lacs, Sherburne, Isanti and Anoka Counties

NR 2700 Designation.

A. The River. That portion of the Rum River from the Ogechie Lake spillway to a line crossing the river between the center lines of Rice Street and Madison Street in the city of Anoka is hereby designated a component of the Minnesota Wild, Scenic and Recreational Rivers System.

B. Authority. This designation is made by the commissioner of natural resources pursuant to the authority of the Minnesota Wild and Scenic Rivers Act (Minn. Stat. §§ 104.31 to 104.40).

C. Shoreland Included. The designation and these rules apply to the river and the adjacent lands as provided for in the Land Use District Descriptions of these Regulations.

A. That portion of the Rum River and adjacent lands (excluding the shoreland of Shakopee Lake), from the Ogechie Lake spillway to the river's northernmost confluence with Lake Onamia is classified Wild.

B. Those portions of the Rum River and adjacent lands from the Mille Lacs CSAH 20 bridge to the Mille Lacs CSAH 9 bridge, and from the Mille Lacs CSAH 13 bridge to the T31N-T32N line on the southern border of the Anoka County Fairgrounds in the City of Anoka, are classified Scenic.

C. Those portions of the Rum River and adjacent lands from the State Highway 27 bridge to Onamia to the Mille Lacs CSAH 20 bridge, from the Mille Lacs CSAH 9 bridge to the Mille Lacs CSAH 13 bridge, and from the T31N-T32N line on the southern border of the Anoka County Fairgrounds in the City of Anoka to a line crossing the river between the center lines of Madison Street and Rice Street are classified Recreational, in accordance with the provi-

sions of Minn. Stat. § 104.33, subd. 2, and Minnesota Regulations NR 78 (f).

NR 2720 Management.

A. Land use provisions.

1. The commissioner of natural resources hereby adopts the Wild, Scenic and Recreational land use districts as identified in the Land Use District Descriptions of these Regulations. The land use districts were derived in accordance with NR 78 (g) (2) (bb).

a. Minnesota Regulations NR 78-81 shall apply to all lands in the Wild, Scenic and Recreational land use districts, except as specified in NR 2720 ~~D.~~ A. 4. g.

b. If land is annexed, incorporated or in any other way transferred to another jurisdiction, a moratorium shall exist on all construction, grading and filling, and vegetative cutting until the newly responsible unit of government adopts zoning for that land. The zoning shall meet the provisions of this management plan which applied to the land before the transfer. This provision does not apply to work for which lawful permits were previously issued.

2. Minnesota Regulations NR 79 (c) (3) (bb) (iii), NR 79 (d) (2) and NR 79 (g) (1) specify regulations concerning designated tributaries. Designated tributaries along the Rum River shall be:

a.	Bradbury Brook
b.	Tibbets Brook
c.	Vandell Brook
d.	Bogus Brook
~~e.~~	~~Estes Brook~~
~~f.~~ e.	West Branch of Rum River
~~g.~~ f.	Spencer Brook
~~h.~~ g.	Green Lake Brook
~~i.~~ h.	Stanchfield Creek
~~j.~~ i.	Lower Stanchfield Brook
~~k.~~ j.	Isanti Brook
~~l.~~ k.	Seelye Brook
~~m.~~ l.	Cedar Creek
~~n.~~ m.	Trott Brook

3. The grading and filling provision (Minnesota Regulations NR 79 (h) shall be enforced by local ordinance which shall require a grading and filling permit.

4. Certain provisions of Minnesota Regulations NR 78-81 are modified for purposes of the management plan, as follows:

a. Because of the erosive nature of soils along much of the Rum River, Minnesota Regulations NR 79 (c) (3) (cc) (i) is modified to read: Structures shall not be located on slopes greater than 12 percent, unless such structures are screened from the river view with natural vegetation where practicable, the Sanitary Provisions of this plan are compiled with, and the building permit applicant can prove to the local zoning authority that any potential erosion or sedimentation problems related to locating a structure either do not exist or that adequate measures will be taken to prevent any of these problems through special construction methods.

b. Because of land forms and high groundwater levels encountered on lands adjacent to much of the Rum River and to help further the enforcement of Minnesota Department of Health and Minnesota Pollution Control Agency (PCA) standards relating to on-site sewage disposal systems, Minnesota Regulations NR 79 (d) and NR 83 (d), Sanitary Provisions, ~~is~~ are modified by adding a new subdivision reading: (3) Local units of government shall require that both percolation-rate tests and soils boring tests be done on any proposed sites prior to approval of an on-site sewage disposal system installation permit. When new on-site sewage disposal system standards are officially adopted by the PCA, those standards shall take precedence over those of this program.

c. Because of land forms and high groundwater levels found along the Rum River and to further the enforcement of the Sanitary Provisions and the Subdivision Regulations, Minnesota Regulations NR 79 (f) and NR 83 (e) (Subdivision Regulations) ~~is~~ are modified by adding the following sentence to subdivision (1) of these regulations: No plat or subdivision within the land use district shall be approved by a local unit of government until the applicant for the plat or subdivision has proven to the local zoning authority, through the methods described in Minnesota Regulations NR ~~79 (d), Sanitary Provisions,~~ 2720 A. 4b. as modified in this plan; that every newly platted lot found within the land use district has adequate area and a suitable location for the installation of a conforming septic tank and soil absorption system.

d. Because of the large number of existing plats along some sections of the Rum River, Minnesota Regulations NR 79 (c) (1) (bb) is clarified by replacing the final phrase, "or to the greatest extent practicable," with this clause: "except that such lots which ~~are~~ meet or exceed 60 percent or more of the lot width standards of these regula-

KEY: PROPOSED RULES SECTION: Underlining indicates additions to pre-existing rule language. ~~Strike outs~~ indicate deletions from pre-existing rule language. If all proposed rules in a set are totally new (i.e. non-amendatory) the entire set is printed in standard type face. **RULES SECTION:** Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

NR 2720

tions may be considered as a separate parcel of land for the purpose of sale or development, if on-site sewage disposal systems can be installed so as to comply with these regulations. This provision shall also apply in urban areas.

e. Because Minnesota Regulations NR 79 provides neither the necessary flexibility nor the control over the great recreational development potential of the Rum River, the table of land use district uses in Minnesota Regulations NR 79 (b) (2) is modified ~~as follows: (1). The uses specified in (aa), (bb), (cc), (dd) and (ff) are all made Conditional Uses in all land use districts. (2).~~ so that the uses specified in (aa), (bb), (cc), (dd), (ff) and (gg) are ~~modified~~ amended by adding to their descriptions the following phrase: "and approval by the commissioner of natural resources." This ~~requirement~~ provision shall ~~not~~ also apply ~~to the~~ in urban areas ~~and~~ but shall not apply to the areas and facilities noted in NR 2720 C. ~~5.~~ 4.

f. Because agricultural uses are permitted in the land use district area and because of the pre-existence of agricultural buildings along most of the Rum River's adjacent lands, the maximum building height restriction contained in Minnesota Regulations NR 79 (c) (3) (dd) shall not apply to buildings used primarily for agricultural purposes.

g. Because some areas along the Rum River have been considerably developed, have or soon will have public sewer and water available, and because the Wild and Scenic Rivers Act states that management plans shall be prepared "with no unreasonable restrictions upon compatible, pre-existing, economic uses of particular tracts of land . . .", the following areas are exempted from the provisions of Minnesota Regulations NR 2720 A. 1. a: Within the boundaries of the municipalities, at the time of designation, of Onamia, Milaca, Princeton, Cambridge, Isanti, Anoka, St. Francis (that portion located in the S½ of Section 29, T34N-R24W, west of river only; Section 32, T34N-R24W; and the N½ of Section, T33N-R24W) and Ramsey (that portion located in the S½ of Section 19, T32N-R24W; and Sections 25, 36, plus the S½ of Section 24, T32N-R23W). These areas shall be considered urban areas and the following regulations shall apply within the Wild, Scenic or Recreational land use districts of these areas, regardless of the classification of the river, as follows: Minnesota Regulations NR 78; NR 79 (b) (2) (aa), (bb), (cc), (dd), (ff) and (gg); NR 79 (g) (within the building setback areas required in urban areas); NR 79 (h) (1), (2), (3) and (5); NR 79 (j); NR 80; NR 81; NR 82 (d) (where certain terms are not defined in NR 78); NR 83 (a) and (b); NR 83 (c) (1) and (2) (For Recreational Development Waters); NR 83 (c) (3) (cc); NR 83 (c) (4); NR 83 (d) (For Recreational Development Waters) and (e) (1) and (4); and NR 84 (a) (1) and (3).

5. The proposed bridges across the Rum River located at about Section 25, T32N-R25W and at about Sections 13 and 24, T32N-R25W (Also referred to as the Anoka County Road #20 and #57 bridge proposals) and the three (3) proposed bridge crossings for U.S. Highway #169 in Mille Lacs County shall be considered pre-existing uses of riverside lands, because they have been included in existing long-range thoroughfare plans for the area or Environmental Impact Statements have been finalized. However, any development of these bridges shall comply with the construction and permit requirements of Minnesota Regulations NR 79 (j). In addition, reconstruction, replacement or upgrading of existing bridge crossings shall be considered in compliance with the policy of the Management Plan when the procedures of Minnesota Regulations NR 79 (j) are followed.

6. Replacement of substandard structures may be allowed, limited or prohibited by the local ordinance.

B. Land acquisition.

1. The commissioner of natural resources hereby adopts the fee title and scenic easement lands, as identified in the Fee Title Descriptions and Scenic Easement Descriptions, as priority areas for these types of acquisition.

a. Fee title acquisition is recommended in those areas where recreational sites are needed, and to consolidate existing blocks of public ownership, as identified in the Fee Title Descriptions.

b. Scenic easement acquisition is recommended in those areas having outstanding scenic, natural or similar values as identified in the Scenic Easement Descriptions.

c. Because acquisition of lands or interests in land is from willing sellers at market value, some lands recommended for scenic easement acquisition may be purchased in fee title and some lands recommended for fee title acquisition may be purchased as scenic easements. These changes from the recommended acquisition could only be done with the mutual agreement by and between the state of Minnesota and the landowner(s). Furthermore, additional land or interests in land other than those recommended may be purchased within the land use districts to further the policies established in Minnesota Statutes, Section 104.32 and the management plan.

d. Other forms of acquisition such as use easements or leases, may be substituted for the recommended acquisition or used to acquire interests in other lands within the land use districts, when such purchases further the policies of this plan and Minn. Stat. § 104.32.

2. Land or interests in land recommended to be acquired in the plan will be acquired from willing sellers when funds are available for such purposes as provided for in Minn. Stat. § 104.37.

3. Whenever feasible, land will be exchanged in a manner prescribed by state law to acquire land in the land use districts. Land will not be exchanged, however, if such exchanges would adversely affect this or other Department of Natural Resources (DNR) management programs.

4. All islands acquired by or transferred to the DNR shall be managed in a manner consistent with policy established in the Minnesota Wild and Scenic Rivers Act and this management plan.

C. Recreation management.

1. As provided for in this management plan, the recreation management policy is to provide for the orderly use of public lands and waters within the Wild, Scenic and Recreational river land use districts. The development of selected land- and river-oriented recreational facilities and the maintenance of these will help "protect the rights of private landowners, ensure quietude, prohibit trespassing, and maintain the essential quality of Wild and Scenic river land use districts," as provided for in Minnesota Regulations NR 80 (a) (1). A specific recreation management policy shall be the enforcement of the Statutes and regulations pertaining to littering (Minn. Stat. § 609.68 and Minnesota Regulations NR 80 (b) (1)) and the promotion and advertising of a "carry-in, carry-out" philosophy, that is, for river users to take their trash home with them.

2. The recreational use of the Rum Wild, Scenic and Recreational river and adjacent state lands will be regulated when and where considered necessary by the commissioner to insure that the use does not adversely affect the values which qualified the river for designation.

3. As provided for in Minnesota Regulations NR 79 (b) (2) and the management plan, the development of public or private recreational facilities within the Wild, Scenic and Recreational river land use districts shall conform to the design specification guidelines shown in 1 S.R. 365 and 366 and the management plan.

~~4. No public river-oriented camping facilities will be established in close proximity to existing private recreational developments which are designed to serve the same recreational needs.~~

~~5.~~ 4. Priority areas for recreational development include:

a. Certain privately owned lands, which may be acquired by the DNR from willing sellers. The proposed lands and proposed uses of these lands are shown in the Fee Title descriptions. The exact locations of these sites may vary, depending on the availability of willing sellers, however, the total numbers of priority sites shall remain constant.

b. Certain publicly owned lands should be developed for certain recreational uses as follows:

Location of Site	Recommended Facilities	Governmental Unit Involved
T41N-R26W, Sec. 6	Portage, Access Rest Area	Dept. of Transportation
T40N-R27W, Sec. 26	Rest Areas, Access Campsite, Other Open Space Recreational Uses	DNR, DOT or Mille Lacs County
T38N-R27W, Sec. 26	Access, Portage, Other Open Space Recreational Uses	City of Milaca
T36N-R23W, Sec. 32	Campsite, Other Open Space Recreational Uses	City of Cambridge
T34N-R24W, Sec. 32	Access, Campground, Campsite, Portage, Rest Area and Other Open Space Recreational Uses	Anoka County
T33N-R24W, Sec. 19	Rest Area, Access	Anoka County
T33N-R24W, Sec. 31 & T32N-R24W, Sec. 6	Campground, Campsite, Access, Rest Area and other Open Space Recreational Uses	Anoka County

~~6.~~ 5. The Division of Parks and Recreation shall allocate funds for maintenance of DNR recreational facilities within the Rum River land use districts from the department's river development and maintenance account.

~~7.~~ 6. The DNR's Enforcement Division shall discuss with the local units of government the delineation of responsibilities for the enforcement of Wild, Scenic and Recreational river user regulations (Minnesota Regulations NR

NR 2720

80). The Division of Enforcement shall also take appropriate action, within the limits of available funding and personnel, to insure expeditious enforcement of wild, scenic and recrational river user regulations.

~~8.~~ 7. ~~Additional public snowmobile trails may be established within the land use district through the DNR's grants-in-aid program.~~ Snowmobile use on lands in the Wild, Scenic and Recreational land use district shall be allowed:

a. On private lands, only with the permission of the appropriate landowner.

b. On public trails specifically designated for snowmobile use.

~~9.~~ 8. The Division of Parks and Recreation of the DNR shall arrange for a recreational use study of the Rum River, when funds are appropriated for such a purpose.

~~10.~~ 9. Any recreational development proposed in Mille Lacs Kathio State Park shall not be subject to the provisions of NR 2720, A. 4. e. or C. ~~5.~~ 4. but shall comply with the terms of any plan approved in accordance with the Outdoor Recreation Act.

D. Administration.

1. Mille Lacs County shall enact or amend such ordinances and maps as necessary to:

a. Establish the Wild, Scenic and Recreational river land use districts in Mille Lacs County according to Minnesota Regulations NR 2710, to include the lands identified in the Land Use District Descriptions.

b. Conform to the provisions of Minnesota Regulations NR 78-81 and this management plan, as applicable.

2. Sherburne and Isanti counties shall enact or amend such ordinances and maps as necessary to:

a. Establish the Scenic river land use district in Sherburne and Isanti counties identified in the Land Use District Descriptions.

b. Conform to the provisions of Minnesota Regulations NR 78-81 and this management plan, as applicable.

3. Anoka County shall enact or amend such ordinances and maps as necessary to:

a. Establish the Scenic and Recreational river land use districts in Anoka County according to Minnesota Regulations NR 2710, to include lands identified in the Land Use District Descriptions.

b. Conform to the provisions of Minnesota Regulations NR 78-81 and this management plan, as applicable.

4. ~~The municipalities of Onamia, Milaca, Princeton, Cambridge, Isanti, Anoka and St. Francis (that portion located in the S½ of Section 29, T34N-R24W, west of river only; Section 32, T34N-R24W; and the N½ of Section 5, T33N-R24W shall enact or amend such ordinances and maps as necessary to:~~

~~a. Establish the Scenic or Recreational land use district, in each municipality according to Minnesota Regulations NR 2710, to include lands identified in the Land Use District Descriptions.~~

~~b. Conform to the provisions of Minnesota Regulations NR 82-84 for Recreational Development Waters within the applicable land use district area.~~

~~c. Conform to the provisions and administrative procedures of Minnesota Regulations NR 78, NR 79 (b), (2), (aa)-(gg) and (g) (within Building Setback areas only), (h), (i), NR 80 and NR 81; and this management plan, as applicable.~~

The municipalities which are listed in NR 2720 A. 4. g. as urban areas shall enact or amend such ordinances and maps as necessary to establish the land use district as identified in the Land Use District Descriptions and conform to the provisions required in NR 2720 A. 4. g.

5. The municipalities of St. Francis, (all, except the S½ of Section 29, T34N-R24W, west of river only; Section 32, T34N-R24W; and the N½ of Section 5, T33N-R24W), Ramsey (all, except the S½ of Section 19, T32N-R24W; and Sections 25, 36 and the S½ of Section 24, T32N-R23W) and Andover shall enact or amend such ordinances and maps as necessary to:

a. Establish the Scenic river land use district in each municipality according to Minnesota Regulations NR 2710, to include lands identified in the Land Use District Descriptions for each.

b. Conform to the provisions of Minnesota Regulations NR 78-81, and this management plan.

6. Any of the involved counties or cities may retain or adopt regulations which are more restrictive than those required by this plan.

7. The DNR shall assist local units of government in implementing Minnesota Regulations NR 82-84, NR 78-81

and this management plan, in accordance with the provisions of Minn. Stat. § 104.36.

8. The DNR shall delineate the land use district boundaries on the appropriate zoning maps for the affected local units of government.

~~1. It is recommended that the PCA be appropriated sufficient funds to continue an ongoing analysis and monitoring of water quality information, to help insure that water quality regulations and standards will be maintained for the Rum River.~~

~~2. It is recommended the PCA reevaluate its ranking system for distribution of funding used for upgrading municipal sewage treatment systems and that an additional ten (10) points be added to the Rum River's ranking because of its statewide significance and the large amount of recreational water contact activities taking place in the Rum.~~

~~3. To further the purposes of the Minnesota Wild and Scenic Rivers Act, it is recommended that all Minnesota Department of Transportation lands within the land use district be administered in accordance with Minnesota Regulations NR 78-81 and this management plan.~~

~~4. It is recommended that the State Planning Agency, Office of Local and Urban Affairs, give priority to any local funding requests for recreational land acquisition within the land use district consistent with the goals of the State Comprehensive Outdoor Recreation Plan.~~

~~5. It is recommended that each involved local unit of government have its grading and filling permit applications reviewed by the appropriate Soil and Water Conservation District.~~

~~6. It is recommended that the Legislative Commission on Minnesota's Resources appropriate funds to the state archaeologist to conduct an inventory of the archaeological sites in the Rum River land use districts. It is also recommended that funds be appropriated for the preservation of those sites having outstanding scientific significance.~~

~~7. To insure that the historical heritage of the Rum River will be protected for the enjoyment of present and future generations, it is recommended that the Minnesota Historical Society conduct an inventory of all historically important sites within the land use districts and recommend appropriate methods of preservation of those sites having outstanding significance.~~

~~8. It is recommended that the Agricultural Stabilization and Conservation Service give high priority to providing funds to alleviate severe siltation and erosion problems on the Rum River.~~

~~9. It is recommended that funds be appropriated by the legislature so that a study of the recreational use of the Rum River be initiated by the DNR.~~

~~10. It is recommended that the Department of Transportation and the involved county highway departments cooperate with the DNR by placing no-parking signs along any bridge crossing right-of-ways that are determined to be inadequate or dangerous as river access points.~~

~~11. It is recommended that the Anoka County Board of Commissioners maintain and continue to enforce the 10-horsepower limitation they now have on all county-administered access points on the Rum River.~~

~~12. It is recommended that each involved County Assessor consider assessment procedures which would give property tax relief to individuals who have sold scenic easements.~~

~~13. It is recommended that each involved local unit of government adopt erosion and sediment control ordinances in order to help alleviate these problems along the Rum River.~~

Board of Optometry

Adopted Rules for the Establishment of General Provisions, Definitions, and Fees, and to the Amendment or Repeal of Certain Existing Rules

The above-subject matter came on for hearing before an independent hearing examiner on August 23, 1977, in Room 105, at the State Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota. On November 21, 1977, and again on January 26, 1978, the Minnesota Board of Optometry met and considered the matter. After reviewing the entire record in the proceeding, including data, statements and arguments submitted by interested parties, the Board adotped the rules as originally

OPT 1

proposed and published at volume 2, number 1, page 44, July 11, 1977 (2 S.R. 44) with the following exceptions:

OPT 1

B. Applicability. These rules shall be applicable to all persons licensed to practice optometry in the State of Minnesota pursuant to the provisions of Minn. Stat. § 148.52 *et seq.* and, in pertinent part, to those persons applying to the ~~State of~~ Minnesota Board of Optometry for a license to practice optometry in the State of Minnesota.

OPT 2

B. "Board" means the ~~State of~~ Minnesota Board of Optometry.

~~C. "Prescription" means a spectacle lens correction as formulated by a licensed optometrist.~~

OPT 3

A. When using the title "Doctor" or its abbreviation "Dr.", the abbreviation "O.D." ~~should~~ shall not be used as a suffix to the name. However, when using the title or abbreviation before the name, the name may be followed by the explanatory term "Optometrist."

~~B. For an optometrist to advertise the practice of optometry with any business properly considered foreign to the subject of eyes and refraction is considered misleading and constitutes unprofessional conduct.~~

OPT 4

B. Any and all patient records required at A, above, shall be maintained for at least ~~seven~~ five years.

OPT 6

Incorporating under the professional corporation act. One or more licensed optometrists may form a corporation under the professional corporation act as stated in Minn. Stat. § ~~319A.21~~ § 319A.01 *et seq.* With reference to the formation and maintenance of such professional optometric corporation, the following rules shall apply:

B. Either the abbreviation "O.D." or the word "Optometry," ~~or~~ "Optometric," or "Optometrist(s)" shall appear in the corporate name. Where the word "Doctor" or its abbreviation is used as a prefix with the name of the optometrist, the abbreviation "O.D." shall not be used as a suffix.

OPT 7

C. ~~Spectacle~~ Prescriptions furnished to the patient shall be signed by the examining optometrist.

D. No licensed optometrist shall sign or cause to be signed a prescription ~~for an ophthalmic lens~~ without first making a personal examination of the eyes of the person for whom the prescription is made.

OPT 8 Fees.

B. License examination.

~~2. As provided at Minn. Stat. 148.56, subd. 1, said fee and a completed application form shall be filed with the board at least two weeks prior to the date of the examination. However to facilitate processing, assure the availability of sufficient examination space, equipment and testing personnel, and provide the applicant with a reasonable opportunity to remedy any deficiencies in his application, it is recommended that the application form and fee be received by the board sixty (60) days before examination.~~

~~3.~~ 2. In the event the applicant fails to pass a part of the examination, upon application and the payment of an additional fee of $35.00, he may retake the examination at the time for which the board next schedules such examinations.

D. Individual annual license renewal.

1. On or before March 31 of each year, the board shall receive a license renewal fee from every licensed optometrist who desires to continue to be entitled to practice in this state. The amount of said fee to be received by the board not later than March 31, 1978, for licensure between April 1, 1978, and March 31, 1979, shall be $65.00. Thereafter, subject to the approval of the State Commissioner of Finance under Minn. Stat. §§ 16A.128 and 214.06, subd. 1, the amount of said fee shall be as determined by the board ~~, not to exceed 115% of the renewal fee for the immediately preceding licensure year.~~ at open meetings for which not less than 30 days advance notice is published in the *State Register* and at which meetings any affected persons shall be given an opportunity to present pertinent oral or written statements. No renewal fee determined by the board pursuant to this subsection for licensure subsequent to March 31, 1979, shall exceed 115% of the renewal fee of the immediately preceding licensure year nor, in conjunction with all other authorized board fees, result in the collection of amounts not approximately equal to anticipated board expenditures. Such anticipated expenditures may include only reasonable or required costs associated with a. the board's necessary purchase of or payment for those services and staff required by Minn. Stat. § 214.04, b. authorized board member compensation, and c. the economical administration of the act.

E. Reciprocity.

~~Any qualified person seeking licensure in this state by reciprocity shall, in accordance with Minn. Stat. § 148.57, subd. 2, file a completed and sworn application for such licensure with the board at least two weeks prior to the regular meeting at which the Board considers such applications. To assure sufficient time for processing, however, it is recommended that all such applications be received by the board sixty (60) days prior to the board's consideration thereof.~~ A fee of $100.00 shall accompany every application for licensure by reciprocity.

OPT 8

~~F. Professional corporations.~~

~~Pursuant to Minn. Stat. § 319A.21, every professional optometrie corporation holding a certificate to do business in this state shall file annually with the board on or before January 1 a corporate report accompanied by a fee. Until otherwise provided by law, this fee shall be $100.00 for filing the first of such reports and $25.00 for filing each successive report.~~

Minnesota Board of Optometry
Leo A. Meyer, O.D.
Executive Secretary

KEY: PROPOSED RULES SECTION: Underlining indicates additions to pre-existing rule language. ~~Strike outs~~ indicate deletions from pre-existing rule language. If all proposed rules in a set are totally new (i.e. non-amendatory) the entire set is printed in standard type face. **RULES SECTION:** Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

PROPOSED RULES

Pursuant to the provisions of Minn. Stat. § 15.0411 to 15.052, the *State Register* publishes notices of hearing on proposed new or amended rules, including the full text of the new or amended rules, including the full text of the new or amended rule proposed for adoption, at least 30 days before the date set for the hearing.

Pursuant to Minn. Stat. § 15.0412, subd. 4, an agency may, with approval of the chief hearing examiner, incorporate by reference into the text of a rule, provisions of federal law, or rule, or other material which are 3000 words or more in length or would require five or more pages of print in the *State Register* and which are conveniently available to interested persons.

Pursuant to Minn. Stat. § 15.0412, subd. 5, when a statute, federal law or court order to adopt, suspend, or repeal a rule does not allow for the usual rulemaking process, temporary rules may be proposed. Proposed temporary rules are published in the *State Register*, and for at least 20 days thereafter, interested persons may submit data and views in writing to the proposing agency.

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Department of Commerce Insurance Division

Proposed Temporary Rules Governing the Minnesota Comprehensive Health Insurance Act

Notice of Public Opinion Sought

The Department of Commerce, Insurance Division has proposed that the following temporary rules governing the implementation, administration and enforcement of the Minnesota Comprehensive Health Insurance Act of 1976 (Minn. Stat. §§ 62E.01 et seq.), be adopted. These rules are promulgated pursuant to Minn. Stat. § 62E.09(i).

All interested persons are hereby afforded the opportunity to submit data and views on the proposed rules for 20 days immediately following publication of this material in the *State Register* by writing to John T. Ingrassia, Supervisor Life & Health Section, Insurance Division, Department of Commerce, 500 Metro Square Building, St. Paul, Minnesota 55101. Any written material received by the Insurance Division shall become part of the hearing record in the final adoption of the temporary rule.

Such publication is hereby ordered.

Temporary Rules as Proposed

INS 200 — Authority, scope and purpose. These rules are promulgated pursuant to Minn. Stat. § 62E.09(i) relating to qualified comprehensive health insurance plans and the operations of the Minnesota comprehensive health association in particular, and Minn. Stat. § 15.0411 to 15.052, as amended, relating generally to the promulgation of administrative rules and regulations. These rules and all future changes herein apply to all insurers, (including non-profit health service plan corporations), self-insurers, fraternals, health maintenance organizations and other organizations which are at the time of adoption of these rules, or at any time in the future, licensed or authorized to do business in or otherwise doing business in this state and are subject to the provisions of the Minnesota comprehensive health insurance act of 1976, as amended. These rules are promulgated to carry out the act, as amended, and to facilitate its full and uniform implementation and enforcement.

INS 201 — Definitions. All terms used herein which are defined in Minn. Stat. ch. 62E shall have the meanings attributed to them therein. For the purpose of Minn. Stat. ch. 62E and these regulations, the terms defined herein shall have the meaning given to them.

A. Accident only coverage. "Accident only coverage" means a policy designed to provide coverage solely upon the occurrence of an accidental injury or death.

B. Act. "Act" means Minn. Stat. §§ 62E.01 ot 62E.17, as amended, which are cited as the Minnesota comprehensive health insurance act of 1976.

C. Actuarial equivalence. "Actuarial equivalence" shall be recognized for two plans where, employing the same set of assumptions for the same population, the expected value of benefits provided by the plans is equal. Expected value of benefits will be measured by the probability of the claim for each benefit multiplied by the average expected amount of each of those benefits.

D. Administrative expenses of the pool. "Administrative expenses of the pool" means the actual operating and administrative expenses of the association incurred directly in the operation of the reinsurance plan including fees to a reinsurance administrator.

E. Association. "Association" means the Minnesota comprehensive health association.

F. Board. "Board means the board of directors of the association.

G. Calendar year. "Calendar year" means a twelve month period from January 1, to and including December 31.

H. Certificate of eligibility. "Certificate of eligibility" or "certificate of eligibility and application" means the document entitled "certificate of eligibility and application" or any other document which is used to apply for coverage under the state plan.

I. Claims expenses. "Claims expenses" or "payment of benefits" means all payments to covered persons or providers including payments for hospital surgical and medical care, and reasonable estimates (as determined by the association and approved by the commissioner) of the incurred but not reported claims of the state plan.

J. Close relative. "Close relative" means the insured person's spouse, brother, sister, parent or child.

K. Commercial reinsurance. "Commercial reinsurance" or "excess of loss reinsurance" means reinsurance arranged by the association under which the pool pays premiums to a reinsurer which assumes part of the risk of the reinsurance plan.

L. Covered expenses. "Covered expenses" means the usual and customary charges for the services and articles listed in Minn. Stat. § 62E.06, or the actuarial equivalence thereof, when prescribed for a covered person by a physician and when such expenses are incurred during a period in which the state plan policy or contract is in effect.

M. Covered person. "Covered person" means the insured person or an insured dependent.

N. Dental care. "Dental care" means those services which a person licensed to practice dentistry may provide as defined in Minn. Stat. § 105.05, subd. 1.

O. Disabled child. "Disabled child" or a "dependent child of any age who is disabled" means a child, married or unmarried, who is and has been continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap and is financially dependent upon the insured, provided proof of such incapacity and dependency is furnished to the insurer or to the association within 31

days of the child's attainment of the limiting age and subsequently as may be required by the insurer or the association but not more frequently than annually after the two year period following the child's attainment of the limiting age.

P. Employee welfare benefit plan. "Employee welfare benefit plan" means any plan, fund, or program through which an employer provides, directly or indirectly, accident and health benefits to its employees through a trust, through the purchase of insurance, or through the provision of benefits for medical, surgical or hospital care.

Q. Financially dependent. A person shall be considered "financially dependent" if that person is chiefly dependent upon the insured person for support and maintenance.

R. Free standing ambulatory surgical center. "Free standing ambulatory surgical center" or "free standing ambulatory medical center" means a surgical or medical center approved as such by the state of Minnesota.

S. Home health agency. "Home health agency" means a public or private agency that specializes in giving nursing service and other therapeutic services in the insured person's home and is approved as such by the state of Minnesota.

T. Hospital. "Hospital" means:

1. An institution which is operated pursuant to law and which is primarily engaged in providing on an inpatient basis for the medical care and treatment of sick and injured persons through medical, diagnostic, and surgical facilities, under the supervision of a staff of physicians and with twenty-four a day nursing service, or

2. An institution not meeting all the requirements of 1., but which is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.

3. In no event shall the term "hospital" include a nursing home or any institution or part thereof which is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

U. Hospital indemnity coverage. "Hospital indemnity coverage" means coverage which provides a fixed dollar benefit on the occurrence of the condition precedent that the covered person was confined in a hospital.

V. Illness. "Illness" means disease, injury, or a condition involving bodily or mental disorder of any kind, and including pregnancy.

W. Independent contractor. "Independent contractor" means a person who exercises an independent employment and contracts to do certain work without being subject to the control of his employer except as to the results of the work.

X. Individual insured. "Individual insured" means the covered employee or surviving spouse or surviving dependent of a covered employee as those terms are used in Minn. Stat. § 62A.17, subd. 6.

Y. Insured dependent. "Insured dependent" means an eligible dependent originally named in the policy or contract schedule or otherwise insured subsequent to the effective date of the policy or contract.

Z. Insured person. "Insured person" means the person named in the policy or contract schedule.

AA. Interim reinsurance assessment. "Interim reinsurance assessment" means an assessment at any time other than at the end of a calendar year (or other fiscal year end as determined by the association) of participating members when pooling payments and payments by reinsurers for the year are not sufficient to fund paid and estimated obligations of the pool and administrative expenses of the pool.

BB. Licensed and tested insurance agent or solicitor. "Licensed and tested insurance agent or solicitor" means an agent or solicitor as defined in Minn. Stat. § 60A.02, subd. 7 or 8 and licensed by the commissioner under Minn. Stat. § 60A.17 to act as an agent or solicitor for accident and health insurance as defined in Minn. Stat. § 60A.06, subd. 1(5) (a).

CC. Losses. "Losses" means all claims expenses.

DD. Major medical expenses. "Major medical expenses" as used in Minn. Stat. § 62E.04 means the covered expenses for services listed in Minn. Stat. § 62E.06, subd. 1 or the actuarial equivalence thereof, provided that the maximum lifetime benefit limit shall not be less than $250,000.

EE. Net gains. "Net gains" means the excess of premiums or contract charges over claims expenses, after the writing carrier's expenses and agent referral fees (not to exceed 12½% of premiums or contract charges) have been paid as provided in INS 233.B. 4.

FF. Non-qualified policy. "A non-qualified policy" or "unqualified policy" or "unqualified plan" means a policy, contract, or plan which has not been certified by the commissioner as qualified pursuant to the terms of the act.

GG. Nursing home. "Nursing home" means an institution meeting the following requirements:

1. it is operated pursuant to law and is primarily engaged in providing the following services for persons con-

valescing from illness: room, board, and twenty-four hour a day nursing service by one or more professional nurses and such other nursing personnel as are needed to provide adequate medical care;

2. it provides such services under the full-time supervision of a proprietor or employer who is a physician or a registered nurse; and

3. it maintains adequate medical records and has available the services of a physician under an established agreement if not supervised by a physician.

HH. Operating and administrative expenses of the association. "Operating and administrative expenses of the association" means expenditures reasonably necessary to the operation and administration of the association including but not limited to rents, stationery, telegraph and telephone charges, salaries and expenses of office employees, investigators or adjusters, and legal expenses, as well as expenses of directors of the board of the association relating to the conduct of or attendance at meetings. The operating and administrative expenses of the association do not include the operating and administrative expenses of the writing carrier.

II. Out-of-pocket expenses. "Out-of-pocket expenses" means any cost or charge in a calendar year for a health service or article which is included in the list of covered services under the qualified plan, qualified medicare supplement plan, policy or contract of major medical coverage, or state plan policy or contract under which the person is a covered person, and which is not paid or payable if claim were made under any plan of health coverage, medicare, or other governmental program.

JJ. Participating members. "Participating members" means insurer and fraternal members of the association which elect to reinsure risks of issuing certain coverages required under the act through the association under its reinsurance plan.

KK. Per diem policies. "Designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis" means policies which provide benefits upon the occurrence or existence of a condition precedent, without reference to expenses incurred or services provided, for hospital, surgical or medical care.

LL. Policies or contracts of accident and health insurance. "Policies or contracts of accident and health insurance" means accident and health insurance policies as defined by Minn. Stat. § 62E.02, subd. 11.

MM. Pooling payment. "Pooling payment" means the amount each participating member pays the association or its reinsurance administrator during a given period of time as determined by the association or its reinsurance administrator based on pooling rates and volume of policies and contracts reinsured by the participating member in each category.

NN. Pooling rates. "Pooling rates" means unit rates approved by the association and used as the basis for pooling payments.

OO. Pre-existing conditions limitation. "Pre-existing conditions limitation" means a limitation excluding coverage for a physical or mental condition of a covered person which existed prior to the issuance of the covered person's policy or contract, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk.

PP. Professional services. "Professional services" means only services rendered by a physician or at the physician's direction by a private duty, licensed, registered nurse or an allied health professional. Professional services shall not include a service rendered by a close relative.

QQ. Reasonable benefits in relation to the cost of covered services. "Reasonable benefits in relation to the cost of covered services" means reasonable benefits in relation to premium charged for coverage under a policy as determined by the minimum anticipated loss ratio requirement of Minn. Stat. § 62A.02, subd. 3.

RR. Reimbursable services. "Reimbursable services" means eligible services under medicare.

SS. Reinsurance administrator. "Reinsurance administrator" means an entity with which the association contracts for administration of its reinsurance plan.

TT. Reinsurance assessment. "Reinsurance assessment" means a calendar year end (or other fiscal year end as determined by the association) assessment of participating members when pooling payments and payments by reinsurers for the year are not sufficient to fund paid and estimated obligations of the pool and administrative expenses of the pool.

UU. Reinsurance plan. "Reinsurance plan" means any mechanism by which the association undertakes to rein-

sure the risks which Minn. Stat. § 62E.10, subd. 7 authorizes the association to reinsure.

VV. Reinsurance pool. "Reinsurance pool" or "pool" means the pool or fund into which the association or the reinsurance administrator deposits pooling payments, interim reinsurance assessments and reinsurance assessments paid to the association or its reinsurance administrator by insurer or fraternal members wishing to reinsure certain risks, as well as claims paid by reinsurers under contract for commercial reinsurance with the association, and other receipts, and from which the association or its reinsurance administrator pays premiums for commercial reinsurance, administrative expenses of the pool, and reimbursement for claims paid by insurer or fraternal members which have reinsured all or any portion of risks covered under policies or contracts which have been reinsured pursuant to a reinsurance pooling agreement with the association.

WW. Reinsurance pooling agreement. "Reinsurance pooling agreement" means the agreement between the association and participating members which establishes a reinsurance plan.

XX. Reinsurer. "Reinsurer" means the commercial reinsurance company which contracts with the association to provide excess of loss coverage for the risks which participating members reinsure through the association.

YY. Rejection. "Rejection" means refusal by any association member to issue a qualified plan to a person who completes an application for coverage under such qualified plan, as determined by the board.

ZZ. Renewal date. "Renewal date" means the date specified in a policy or contract on which renewal occurs. In the absence of a specified renewal date in a policy or contract renewal date shall be determined in reference to the anniversary date specified in the policy or contract and shall occur in intervals of no greater than 12 months duration as determined in reference to the date on which the policy or contract became effective. Renewal of a policy or contract shall be deemed to occur upon the expiration of a renewal date if coverage under the policy or contract is continued.

AAA. Resident of Minnesota. "Resident of Minnesota" means a person who is an actual resident of Minnesota, having there his or her principal and permanent abode.

BBB. Restrictive rider. "Restrictive rider" means a document or contractual provision adding certain conditions to the policy's or contract's coverage, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk.

CCC. Student. "Student" means any unmarried child under the age of 25 who during the calendar year is enrolled in and attends an educational institution as a full-time student and who is financially dependent upon an insured person.

DDD. Total cost of self insurance. "Total cost of self insurance" includes any direct and indirect administrative expenses incurred which are related to the operation of a plan of self-insurance, plus the sum of any payment made to or on behalf of Minnesota residents for costs or charges for health benefits by an employer which is a self-insurer under a plan of health coverage, regardless of the amount incurred or relationship of the cost to an insured or partially insured plan of health coverage, which is not counted as premium by an insurer, except to the extent of such payments made for coverage of the types described in clauses 1 through 8 of Minn. Stat. § 62E.02, subd. 11.

EEE. Usual and customary charge. "Usual and customary charge" for the purpose of the state plan means the normal charge, in absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a like service or supply. A "like service" is of the same nature and duration, requires the same skill and is performed by a provider of similar training and experience. A "like supply" is one which is identical or substantially equivalent. "Area" means the municipality (or, in the case of a large city, a subdivision thereof) in which the service or supply is actually provided or such greater area as is necessary to obtain a representative cross-section of charges for a like service or supply.

Part I — Qualified Comprehensive Health Insurance Plan

INS 202 — Duties of employers.

A. Duty to make available a qualified plan. An employer shall be deemed to have made available a qualified plan to its employees as required in Minn. Stat. § 62E.03, subd. 1 when participation under a number 2 or number 3 qualified plan or a health maintenance plan is offered to the employee directly or through an insurer or health maintenance organization and without regard to whether the cost of such participation is paid directly or indirectly by the employer or by the employee or by their joint payment.

B. Effect of collective bargaining on duty to make available a qualified plan. An employer whose employees are represented by one or more exclusive bargaining representatives shall be deemed to have complied with the provisions of Minn. Stat. § 62E.03, subd. 1 with respect to all employees within each unit for collective bargaining if the employer makes available qualified plans of health coverage to the exclusive bargaining representatives.

1. Such employers shall be deemed to have complied with requirements of Minn. Stat. § 62E.03, subd. 1 for each

accounting period utilized by the employer for Minnesota income tax purposes during the entire term of any collective bargaining agreement executed after an offer of qualified health coverage has been made.

2. Nothing in this section shall require the employer to renegotiate any collectively bargained agreement solely for the purposes of compliance with this act.

C. Frequency of required offer. Except as provided in INS 202 B., an employer shall be deemed to have complied with the requirements of Minn. Stat. § 62E.03, subd. 1 of the act if he makes available to his employees a plan of health coverage which is certified as a number 2 or number 3 qualified plan or a health maintenance plan at least once during each accounting period utilized by the employer for Minnesota income tax purposes.

INS 203 — Duties of insurers and fraternals.

A. Exception to definition of "accident and health insurance policy." The exception provided by Minn. Stat. § 62E.02, subd. 11(4), shall apply with respect to hospital indemnity coverage sold by an insurer to an applicant who is, at the time of application for hospital indemnity coverage, covered by a qualified plan, notwithstanding the possibility that the applicant may subsequently terminate coverage under a qualified plan.

1. The exclusion of Minn. Stat. § 62E.02, subd. 11(4) shall also apply to a hospital indemnity coverage which is sold by an insurer to an applicant who is then currently covered by a health maintenance plan.

2. Insurers shall be entitled to conclusively rely upon the written statement of an applicant for hospital indemnity coverage that such applicant is, at the time of the application, covered by a qualified plan or a health maintenance plan.

B. Timing of required offer of a qualified plan or qualified medicare supplement plan.

1. The offer of each type of qualified plan (that is a number 1, number 2, and number 3 qualified plan) which is required when an insurer or fraternal is offering an individual policy of accident and health insurance shall occur no later than the date of delivery of such polciy to the applicant.

2. The offer of a qualified medicare supplement plan which is required when an insurer or fraternal is offering a medicare supplement policy shall occur no later than the date of delivery of such policy to the applicant.

3. The offer of each type of qualified plan (that is a number 1, number 2, or number 3 qualified plan) required when an insurer or fraternal is offering a group policy of accident and health insurance shall occur no later than the date of delivery of such policy to the applicant.

4. "Each person who applies" and "applicant" for the purposes of Minn. Stat. § 62E.04 and this section of the rules shall be deemed to be only the individual making an initial application for an individual policy or in the case of a group policy, the corporation, partnership, proprietorship, association or other qualified entity making application for a group policy.

5. Minn. Stat. § 62E.04, subds. 1, 2 and 3 shall not be deemed to require an insurer or fraternal to offer a qualified plan or qualified medicare supplement plan at the time a policy is subject to renewal.

C. No duty to offer a particular category of insurance. For the purposes of the act, individual accident and health insurance, group accident and health insurance, individual medicare supplement plans and group medicare supplement plans are recognized as separate and distinct categories of insurance. Nothing in Minn. Stat. § 62E.04, subds. 1, 2 and 3 shall be construed as requiring an insurer or fraternal to engage in the business of offering or issuing a particular category of accident and health insurance policy or medicare supplement plan which it does not otherwise offer or issue in this state.

D. Duty to offer major medical coverage. Each insurer and fraternal shall affirmatively offer, subject to its underwriting standards, coverage of major medical expenses to every applicant for a new unqualified policy at the time of application and annually thereafter to every holder of an unqualified policy of accident and health insurance as required by Minn. Stat. § 62E.04, subd. 4. "Affirmatively offer" shall mean written advice to the applicant for, or the holder of, an unqualified policy of accident and health insurance, of the availability of coverage for major medical expenses. Such written advice of the availability of the coverage for major medical expenses may be satisfied by a contractual provision in the unqualified policy which gives the insured the contractual right to apply to the insurer or fraternal for a policy or rider which provides coverage for 80% of the covered expenses for services listed in Minn.

INS 203

Stat. § 62E.06, subd. 1 or the actuarial equivalence thereof subject to a $5,000 deductible for out-of-pocket expenses, subject to the insurer's or fraternal's underwriting requirements.

E. Effect on foreign contracts. No provision of the act shall be construed to require any insurer or fraternal to alter or amend any policy or contract issued outside the state of Minnesota.

F. Exclusion of certain foreign conversion policies. The issuance of individual group conversion policies or contracts in Minnesota pursuant to Minn. Stat. § 62A.17 or Minn. Stat. § 62E.16 shall not, in and of itself, constitute the transaction of accident and health insurance business by an insurer or fraternal which has relinquished prior authority to transact such business in Minnesota and which is not otherwise currently issuing policies or contracts in Minnesota.

G. Exceptions to duties for certain policies and contracts.

1. The continuation in force of a policy or contract under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend or change the terms, conditions or premium rate of the policy or contract in any way, shall not be considered a renewal for the purposes of Minn. Stat. § 62E.04 and INS 225 A.1. if the policy or contract:

a. was issued prior to July 1, 1976, or

b. was designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis and was issued prior to June 3, 1977.

2. The issuance or renewal by an insurer or fraternal on or after June 3, 1977, of a policy or contract which is designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis, shall not be subject to Minn. Stat. § 62E.04, except for policies and contracts sold by an insurer to provide payments on a hospital indemnity basis if such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenace plan at the time of issue.

H. Sanction for failure to comply with duties of insurers and fraternals. Any insurer or fraternal not in compliance with Minn. Stat. § 62E.04 shall cease and desist from transacting accident and health insurance business in the state of Minnesota. Nothing in this section shall prohibit such an insurer or fraternal no longer meeting the definition of insurer in Minn. Stat. § 62E.02, subd. 10 or fraternal in Minn. Stat. § 62E.02, subd. 19 from continuing to maintain in force any policies or contracts described in INS 203 G.1.

INS 204 — Qualified plan pre-existing conditions. A qualified plan may include provisions consistent with generally accepted underwriting practices which provide that any pre-existing condition for any person covered under the policy which was diagnosed prior to the effective date of the policy, and for which medical care or treatment was rendered or prescribed during the 90 days immediately prior to the application for such policy, shall not be covered or eligible for the payment of any benefits for care or treatment rendered during a period of time beginning on the effective date of the policy and ending 24 months after the policy has been continuously in force.

INS 205 — Minimum benefits of qualified medicare supplement plans. The minimum benefits of qualified medicare supplement plans shall be as provided in Minn. Stat. § 62E.07 and as described for the purposes of the state plan in INS 230 C.

INS 206 — Certification of qualified plans.

A. Application for certification. The application of an insurer, fraternal, or employer for certification by the commissioner of insurance of a plan of health coverage as a qualified plan or a qualified medicare supplement plan under Minn. Stat. § 62E.05 shall include the qualification number of the plan for which certification is sought pursuant to the procedures specified in the actuarial equivalence table set forth in table I of these regulations.

B. Certification by the commissioner. An accident and health insurance policy or plan is deemed certified as a qualified plan or qualified medicare supplement plan for the purposes of Minn. Stat. § 62E.05 if it meets the requirements of these regulations and other relevant laws of this state upon the expiration of 90 days after receipt of the request for certification by the commissioner, unless earlier rejected or certified by the commissioner. In the event the commissioner rejects such request, he shall give written notice of the grounds for rejection to the person submitting the plan, and the insurer, fraternal or employer has the same rights in the event of such rejection as provided in Minn. Stat. § 62A.02.

C. Required benefits under the act. On or after June 3, 1977, each plan of health coverage in order to be certified as a number 1, number 2 or number 3 qualified plan, shall provide a limitation of $3,000 per person on total annual out-of-pocket expenses and a maximum lifetime benefit of not less than $250,000, and shall provide all other benefits required under the act which are not subject to substitution of actuarially equivalent benefits, under Minn. Stat. § 62E.06.

D. Certification of an employer's plan of health coverage. For purposes of certification of an employer's plan of health coverage pursuant to Minn. Stat. § 62E.03, any plan

of health coverage which constitutes a qualified plan at the time of issue shall continue to be a qualified plan until the later of the next renewal date of the plan of health coverage or the expiration of an applicable collective bargaining agreement, if any.

INS 207 — Termination of coverage: Conversion privileges.

A. Eligibility for conversion upon termination. A person whose employment has terminated may elect to exercise the right provided by Minn. Stat. § 62A.17 for continued coverage under the group insurance policy, group subscriber contract, health maintenance contract, or plan of health coverage which is self insured or, at the employee's option, may exercise the right provided by Minn. Stat. § 62E.16, to convert to an individual coverage qualified plan. If the employee elects to continue coverage under Minn. Stat. § 62A.17, such employee may not exercise the right of conversion under Minn. Stat. § 62E.16 until the continuation coverage obtained pursuant to Minn. Stat. § 62A.17 is terminated, and if the employee elects to convert to an individual qualified plan, the employee may not elect to continue group coverage pursuant to Minn. Stat. § 62A.17.

B. Duty to offer conversion policy or contract.

1. For the purposes of Minn. Stat. § 62E.16 and Minn. Stat. § 62A.17, an insurer, health maintenance organization, or self insurer shall not be required to offer a conversion policy or contract to a person who is then covered by a qualified plan or eligible for medicare.

2. An insurer, health maintenance organization, or self insurer shall not be required to renew a conversion policy or contract issued to a person who, during the prior policy or contract year, became covered by a qualified plan or became eligible for medicare.

3. An insurer, health maintenance organization or self insurer which is required to offer conversion coverage to a terminated employee must offer, at the employee's option, a number 1, number 2 or number 3 qualified plan. A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, spouse or a dependent in lieu of the optional coverage otherwise required by Minn. Stat. §§ 62A.17, subd. 6 and 62E.16.

C. Due notice of cancellation or termination. An insurer, health maintenance organization or self insurer shall be deemed to have provided "due notice of cancellation or

termination" as required in Minn. Stat. § 62E.16 if the insurer, health maintenance organization or self insurer notifies in writing those employees at their repsective addresses as provided the insurer, health maintenance organization or self insurer by the employer pursuant to the terms of Minn. Stat. § 62E.16.

INS 208–224 Reserved for Future Use

PART II — Minnesota Comprehensive Health Association

INS 225 MCHA — Membership in the association.

A. Mandatory membership. As a condition of doing accident and health insurance business, self insurance business or health maintenance organization business in Minnesota, all insurers, self insurers, fraternals and health maintenance organizations licensed or authorized to do business in this state shall become members of the association and maintain their membership therein.

1. "Accident and health insurance business" means the issuance or renewal of any accident and health insurance policy as defined in Minn. Stat. § 62E.02, subd. 11.

a. An insurer is engaged in accident and health insurance business during the period in which any policy or contract which has been issued or renewed remains in effect.

b. Such business shall not include the issuance or renewal of policies or contracts providing coverage which is:

(1) Limited to disability or income protection coverage for a specified period of time;

(2) Limited to automobile insurance which provides coverage for medical payments as defined and authorized under Minn. Stat. § 60A.06, subd. 1(12);

(3) Supplemental to liability insurance, as defined and authorized in Minn. Stat. § 60A.06, subd. 1(13);

(4) Limited to policies or contracts issued prior to July 1, 1976 under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend or change the terms, conditions or premium rate of the policy or contract in any way; provided that all policies and contracts designed solely to provide payments on a per diem, fixed

indemnity or non-expense incurred basis issued prior to June 3, 1977 under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend or change the terms, conditions or premium rate of the policy or contract in any way, are also excluded.

(5) Designed solely to provide payment on a per diem, fixed indemnity or non-expense incurred basis except that all policies and contracts designed solely to provide payments on a hospital indemnity basis issued or renewed by an insurer on or after June 3, 1977 are included to the extent that such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue.

(6) Limited to credit accident and health insurance, meaning insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy, as authorized by Minn. Stat. ch. 62B;

(7) Designed solely to provide dental or vision care;

(8) Limited to blanket accident and sickness insurance as defined in Minn. Stat. § 62A.11; or

(9) Limited to accident only coverage issued by a licensed and tested insurance agent or solicitor and which provides reasonable benefits in relation to the cost of covered services.

2. "Self insurance business" means the provision, directly or indirectly, of a plan of health coverage by a self insurer. "Self insurance business" does not include the direct provision of health care services to employees at no charge to them by an employer engaged in the business of providing health care services to the public, nor does it include provision of benefits which, if provided by an insurer doing accident and health insurance business, would be excluded under INS 225 A.1.b.(1)-(9) of these rules. "Directly or indirectly" for the purposes of this section of the rules means that the employer or employee welfare benefit plan funds the plan of health coverage in any amount or collects any employee contributions which are used to pay for the plan of health coverage.

3. "Health maintenance organization business" means the operation of a nonprofit corporation licensed and operated as provided in Minn. Stat. ch. 62D.

4. "Licensed or authorized to do business" means:

a. licensed by the commissioner to conduct business under Minn. Stat. chs. 62A, 62C, or 64A, or by the commissioner of health under Minn. Stat. ch. 62D, or

b. authorized by the secretary of state to carry on any business in the state of Minnesota or otherwise doing business in this state and acting as an insurer, self insurer, fraternal or health maintenance organization.

B. Assessment agreement. Each member shall enter into an assessment agreement with the association for a one year term, renewable annually thereafter as required by the act. Signing this assessment agreement shall fulfill the requirement that members enter into a reinsurance contract with the association under Minn. Stat. § 62E.10, subd. 5. The agreement shall be signed by an officer of the member who is authorized to enter into contracts on behalf of the member, shall be in a form adopted by the board of directors of the association and approved by the commissioner, and shall include but not be limited to provisions regarding the members' obligation to:

1. Share proportionately in funding the operating and administrative expenses of the association in accordance with INS 225 C. and D. below;

2. Share proportionately in the losses of the association in accordance with INS 225 C. and D. below;

3. Pay all fiscal year-end assessments which shall be due within 30 days after the end of the association's fiscal year (December 31 unless the association establishes a different fiscal year end) and shall be payable 30 days after receipt of a written assessment notice.

C. Assessments. Members, according to the assessment agreement, will be assessed for their proportionate share of the operating and administrative expenses of the association, incurred or estimated to be incurred, together with losses, if any, incurred by the association as a result of operation of the state plan. The total amount of operating and administrative expenses and losses:

1. Shall be determined annually by the board at each fiscal year end;

2. May, at the recommendation of the board, subject to the approval of the commissioner, consist of a reasonable estimate of the operating and administrative expenses of the association for the succeeding fiscal year, which amount shall be adjusted at the end of the succeeding fiscal year to the amount of actual operating and administrative expenses, and members shall be entitled to credit for any excess or shall be assessed for any deficit in these expenses in the next annual fiscal year end assessment.

D. Levy of assessments. The association may levy assessments following each fiscal year end.

1. The association may also, upon approval of the commissioner, levy interim assessments when deemed

necessary to assure the financial capability of the association to meet the incurred or estimated operating and administrative expenses of the association and losses resulting from the state plan. Interim assessments shall be due and payable within 30 days of receipt by a member of a written interim assessment notice.

2. The association shall levy each member's share of the total assessment based on the ratio of:

a. The member's total accident and health insurance premium, subscriber contract charges or health maintenance organization contract charges (the preceding defined as charges for business defined in INS 225A.1. and 3. above) received from or on behalf of residents of Minnesota, or total cost of self insurance, as determined by the commissioner to

b. total for all members of premiums, contract charges and benefit plan costs reported in INS 225 D.2.a.

3. The costs and charges referred to in the ratio in INS 225 D.2.a. and b. shall, to the extent possible, be determined by reference to a form issued by the association or the commissioner which all members shall submit to the commissioner annually for the preceding calendar year.

a. If the required information is not available to the commissioner when necessary to levy an assessment the commissioner may estimate the member's share based on other available information relative to its experience, including but not limited to the annual statement which all insurers are required to transmit to the commissioner under Minn. Stat. § 60A.13.

b. The commissioner shall have the authority to audit the accounts and records of any member and any agent, trust, third party administrator or other entity administering all or any portion of a plan of health coverage with or on behalf of a self insurer for the purpose of obtaining information necessary to levy an assessment.

4. The board may, in its discretion, decline to levy assessments against members which owe up to $5.00 or less in a given year.

E. Failure to execute assessment agreement or to pay assessments. The names of all insurers, self insurers, fraternals and health maintenance organizations which are required under the act to be members of the association, but which fail to execute an assessment agreement, will be forwarded by the association to the commissioner for appropriate action within the discretion of the commissioner. Any members which fail to pay annual or interim assessments when such assessments become payable will be reported by the association to the commissioner for appropriate action within the discretion of the commissioner.

INS 226 MCHA — Organization and approval.

A. Creation. The association was incorporated on October 14, 1976, under the Minnesota nonprofit corporation act (Minn. Stat. ch. 317) and the articles of incorporation were submitted to and approved by the commissioner and are deemed effective.

1. The association operates and shall continue to operate under the provisions of Minn. Stat. ch. 62E, with all the powers of a corporation formed under Minn. Stat. ch. 317, except that if the provisions of the two chapters conflict, ch. 62E shall govern.

2. Amendments to the articles of incorporation as filed with the secretary of state of the state of Minnesota on October 14, 1976 shall, after approval in accordance with Minn. Stat. ch. 317 and the articles of incorporation and by-laws of the association, be submitted to and approved by the commissioner before filing with the secretary of state.

B. By-Laws. The first board of the association adopted the initial by-laws, and those which were submitted to and approved by the commissioner are deemed effective. All amendments shall be approved by the association in accordance with Minn. Stat. ch. 317 and with the articles of incorporation and by-laws of the association and shall be submitted to and approved by the commissioner before they become effective.

C. Operating rules. The board is authorized to adopt and to amend from time to time reasonable operating rules which are not inconsistent with the act and these regulations for the operation of the association, and upon submission to and approval by the commissioner, these operating rules shall become effective.

INS 227 MCHA — Board of directors.

A. Composition. The management of the association shall be vested in a board of seven directors who shall be representative of the membership of the association, and be officers, employees or agents of members of the association during their terms of office, and shall automatically be removed for failure to meet this qualification.

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B. Election. The board shall be elected by members at the annual meeting of the association in accordance with the by-laws of the association, to the extent that such by-laws are consistent with the provisions of Minn. Stat. chs. 317 and 62E, and in accordance with the provisions relating to voting rights as outlined in INS 228.

1. Prior to the election, the association may submit the names of proposed board members to the commissioner for approval, which may be granted according to criteria as determined by the commissioner.

2. After the annual meeting, the results of the election shall be certified and submitted to the commissioner for approval.

C. Duties. The duties of the board shall include management of the association in furtherance of its purposes as provided in the act, and as authorized in the articles of incorporation and by-laws of the association.

1. Members of the board may be reimbursed by the association for expenses incurred by them in attending board or board committee meetings and for other reasonable expenses incurred within the scope of their activities as directors and within guidelines established by the board and approved by the commissioner, but shall not otherwise be compensated for their services.

D. Officers and committees. The board may elect officers and establish committees as provided in the by-laws of the association. These officers and committees shall be charged with such duties as authorized by the board in accordance with the by-laws of the association.

INS 228 MCHA — Determination of members' voting rights.

A. Meetings. Every member is entitled to vote at the annual meeting and at any special meeting of the members.

B. Weighted vote. A member's vote shall be a weighted vote based on the member's cost of self-insurance, accident and health insurance premiums, subscriber contract charges or health maintenance contract charges derived from or on behalf of residents of Minnesota in the previous calendar year, as determined by the commissioner.

1. To the extent possible, this figure shall be determined by reference to the annual reporting form submitted to the commissioner in accordance with INS 225 D.3.

2. If the necessary information is not available to the commissioner on the form described in INS 228 B. at the time that voting rights must be determined, the commissioner may estimate the member's weighted vote based on other information available to the commissioner.

C. Voting procedures. Members are entitled to vote in person, by proxy, or by mail as determined by the board.

1. When a member elects to vote in person at a members' meeting, the representative casting the vote shall present credentials as may be required by the board.

2. When a member elects to vote by proxy, the proxy statement, as approved by the board and by the commissioner, shall be returned on or before the date indicated in the meeting notice sent to the members.

3. Voting by mail may be permitted as authorized by the board, provided that the meeting notice to members so indicates.

INS 229 MCHA — Meetings of the association.

A. Annual meeting. An annual meeting of the members shall be held for the purpose of electing directors as provided in INS 227 B. and for the purpose of transacting any other appropriate business of the membership of the association.

1. The meeting shall be held in the second calendar quarter of each year unless otherwise determined by the board, and shall occur at such date, time and place as the board determines.

2. "Appropriate business" includes any activities related to the powers and duties of the association under Minn. Stat. chs. 62E or 317.

3. Notice and quorum requirements shall be as provided in the articles of incorporation or by-laws of the association or as otherwise authorized by the board.

B. Special meetings. Special meetings of the members shall be held at the request of the commissioner and may otherwise be held as provided by the articles of incorporation or by-laws of the association for the purpose of conducting any appropriate business of the association.

1. A special meeting may be held at such date, time and place designated in the notice of the meeting.

2. Notice and quorum requirements shall be as provided in the articles of incorporation or by-laws of the association or as otherwise authorized by the board.

C. Open meetings. All meetings of the association membership, board and any committees established in accordance with INS 227 D. shall be held in compliance with the provisions of the open meeting law (Minn. Stat. § 471.705).

INS 230 MCHA — Minimum benefits of comprehensive health insurance plans.

A. Duty to offer. The association shall offer a number 1 and number 2 qualified plan, and a qualified medicare supplement plan to eligible persons. The association shall offer health maintenance plans in areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier in accordance with INS 233 A. The association may provide coverage for eligible dependents.

B. Benefits. Benefits of a number 1 and number 2 qualified plan shall meet or exceed the requirements of Minn. Stat. § 62E.06 or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence table set forth in table I of these rules, except where substitution of an actuarially equivalent benefit is not permissible under the act.

1. The minimum benefits shall be equal to at least 80% of the charges for covered expenses in excess of the annual deductible which shall not exceed:

a. $500.00 for a number 2 qualified plan,

b. $1,000.00 for a number 1 qualified plan.

2. Coverage under a number 1 or a number 2 qualified plan shall include an annual (calendar year) limitation of not more than $3,000.00 per covered person on total out-of-pocket expenses, which out-of-pocket expenses shall include the deductible under the state plan policy or contract, and which benefit (copayment) is not subject to substitution of an actuarially equivalent benefit (copayment).

3. Coverage shall be subject to a maximum lifetime benefit of not less than $250,000.00 per covered person, less any amount paid to or on behalf of the covered person under any other state plan policy or contract. This benefit is not subject to substitution of an actuarially equivalent benefit.

C. Benefits of a qualified medicare supplement plan. Benefits of a qualified medicare supplement plan shall meet or exceed the following minimum standards or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence table set forth in table I of these tables.

1. The plan shall provide benefits to covered persons who are 65 years of age or older by supplementing medicare through provision of 50% of the deductible and copayment required under medicare;

2. The plan shall provide 80% of the covered charges for expenses as provided in Minn. Stat. § 62E.06 or the actuarial equivalence thereof, which charges are not paid or payable under medicare or would not have been paid or payable had the covered person who is or was entitled or eligible to enroll in medicare been so enrolled.

3. Coverage shall include an annual limitation of $1,000.00 total out-of-pocket expenses per covered person for covered expenses.

4. Coverage may not be subject to a maximum lifetime benefit of less than $100,000.00.

D. Benefits of a health maintenance plan. Benefits of a health maintenance plan shall include those comprehensive health maintenance plan shall include those comprehensive health maintenance services required by Minn. Stat. ch. 62D and MHD 369(c).

E. Pre-existing conditions limitation. No person who obtains coverage under a policy or contract of the state plan shall be covered for any pre-existing condition during the first six months of coverage under the state plan if such covered person was diagnosed or treated for that condition during the 90 days immediately preceding the filing of a completed certificate of eligibility.

INS 231 MCHA — Approval of state plan.

A. Submission of proposed state plan. Members of the association may submit to the association policies or contracts which have been approved by the commissioner for selection by the association as the state plan.

B. Approval of policies or contracts by the association. The association shall select policies or contracts to constitute the state plan from among the proposals submitted by the members or from proposals developed by the association or others. These policies and contracts, or parts thereof, may be used to develop specification sfor bids from members which wish to be selected as a writing carrier to administer the state plan.

C. Approval of the state plan. The policies or contracts approved by the association as the state plan shall be approved by the commissioner prior to issuance.

INS 232 MCHA — Solicitation, application and enrollment of eligible persons in the state plan.

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A. Open enrollment. The state plan shall be open for enrollment by eligible persons at all times.

1. "Eligible person" means a resident of Minnesota who submits or on whose behalf is submitted a complete certificate of eligibility and application to the association or its writing carrier and who is not already covered by another state plan policy or contract.

a. A complete certificate of eligibility and application may, at the discretion of the association, provide:

(1) name, address, age, sex, and length of time as a resident of Minnesota,

(2) name, address, and age of eligible dependents, if any, if they are to be insured;

(a) "eligible dependent" means the insured person's spouse who has not reached age 65 or unmarried child, excluding:

(i) a legally separated spouse;

(ii) a child who is nineteen years old or older unless that child is a student or disabled child;

(iii) a spouse or child who has applied for an individual state plan policy or contract pursuant to any conversion privilege granted to such eligible dependent under the insured person's state plan policy or contract, and

(iv) a spouse or child on active duty in any military, naval or air force of any country.

(3) Evidence of rejection, or a requirement of a restrictive rider or pre-existing conditions limitation on a qualified plan the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, by at least two association members within six months of the date of application. "Substantially reduce coverage from that received by a person who is considered a standard risk" includes any restriction on coverage as a result of an illness, condition, or risk which the association deems substantial, any increase in rates for an applicant based on an illness, condition or risk, which the association deems substantial; and any pre-existing conditions limitation which the association deems substantial.

b. Before a person is determined to be an eligible person, the board may, in its discretion, require that any items listed in INS 232 A.1.a., or other information deemed necessary by the board be submitted to the association or its writing carrier and may also investigate the authenticity of information submitted as a part of the certificate of eligibility.

c. If a covered person, upon reaching age 65, wishes to purchase a state plan qualified medicare supplement plan, the requirement that the person obtain two rejections from members of the association within the preceding six months may be waived by the board.

d. A person who is age 65 or older shall be eligible for coverage only under the state plan's qualified medicare supplement plan and when an insured person under a qualified plan reaches age 65, the board may, in its discretion, terminate or refuse to renew coverage under the qualified plan.

e. An applicant or any person proposed to be covered under the state plan who has previously been covered by a state plan policy or contract and who has exhausted the maximum lifetime benefit under the state plan shall not be an eligible person for coverage under the state plan, and if such person has exhausted $100,000.00 of the maximum lifetime benefit under the state plan, such person shall not be an eligible person for coverage under a qualified medicare supplement policy or contract of the state plan.

f. When a covered person under the state plan no longer meets one or more of the requirements for eligibility for coverage under the state plan, the board may, in its discretion, terminate or refuse to renew coverage under the state plan.

B. Association's response. Within 30 days of receipt of a complete certificate of eligibility and application pursuant to INS 232 A.1.a. and b., the association or the writing carrier shall accept the certificate of eligibility or shall reject the certificate of eligibility for failure to meet the eligibility requirements.

1. If the association or its writing carrier accepts the certificate of eligibility, it shall forward a notice of acceptance, billing information and a policy or contract (or certificate) which shall evidence coverage under the state plan.

a. Such policy or contract (or certificate) of coverage shall include but not be limited to:

(1) a statement that the person is covered under the state plan from the effective date contained therein.

(2) specification of the type of state plan under which the person is covered,

(3) a statement that the plan is provided by the association,

(4) a description of the benefits provided by the plan, conditions for eligibility, and exclusions and limitations of coverage, and

(5) provision for an identification card for each covered person indicating the type of state plan and also that coverage is being provided by the association.

b. When the state plan premium is received by the association or its writing carrier for the first billing period (and accepted in accordance with INS 232 B.), the coverage shall be effective retroactive to the date of receipt by the association or its writing carrier of the completed certificate of eligibility pursuant to INS 232 A.1.a. and b. unless otherwise requested by the insured person and approved by the board.

2. If the association does not accept the certificate of eligibility the applicant shall be informed of the reason for the rejection and shall have the opportunity to submit additional information to substantiate eligibility for coverage under the state plan and to request reconsideration of the decision. The board may establish a review mechanism for reviewing requests for reconsideration of rejected certificates of eligibility.

C. Solicitation of eligible persons.

1. The association shall develop a plan for use by the association, upon approval by the commissioner, to publicize the existence of the state plan, the eligibility requirements and procedures for enrollment, and to maintain public awareness of and participation in the state plan.

a. The association may prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance solicitors, agents and brokers, and to the general public in Minnesota.

b. The association shall require the writing carrier to pay a referral fee of $25.00 for any certificate of eligibility accepted by the association or its writing carrier. The referral fee shall be paid to the licensed agent whose signature appears as the agent on the accepted certificate of eligibility. The referral fee shall be paid from the premium received for the state plan.

INS 233 MCHA — Selection, approval and operations of writing carrier(s).

A. Selection and approval of a writing carrier(s).

1. The association may select a writing carrier or writing carriers on the basis of criteria for selection which shall include but not be limited to:

a. The member's proven ability to handle large group accident and health insurance cases,

b. The efficiency of the member's claim paying capacity,

c. An estimate of total charges for administering the plan, and

d. Other criteria developed by the association or the commissioner.

2. The writing carrier selected by the association shall be approved by the commissioner prior to the establishment of a contract with the association and prior to the commencement of its duties pursuant to Minn. Stat. § 62E.13 and INS 233 B.

3. The writing carrier shall serve for a period of three years, unless the commissioner approves an earlier termination at the request of the writing carrier or the association in accordance with the terms of its contract with the writing carrier.

a. The commissioner shall approve or deny a request for termination within 90 days of receipt of such request.

b. Failure to make a determination within 90 days of receipt of such request shall be deemed to be an approval.

4. If termination is approved by the commissioner, the writing carrier shall serve for up to six months from the date of the writing carrier's request for termination, at the discretion of the association, to allow the association to select another writing carrier.

4. Six months prior to the expiration of each three year period of service by a writing carrier, the association shall invite insurer and health maintenance organization members, including the current writing carrier(s), to submit bids to serve as writing carrier for the succeeding three year period.

B. Operations of the writing carrier.

1. The writing carrier shall perform all administrative and claims payment functions relating to the state plan.

a. The writing carrier shall establish a premium

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billing procedure for collection of premiums from insured persons.

(1) Billings shall be made on a periodic basis as determined by the board.

(2) The amount of the premium shall be as determined from time to time by the board pursuant to Minn. Stat. § 62E.08.

b. The writing carrier shall perform all necessary functions to assure timely payment of benefits to covered persons under the state plan.

(1) The writing carrier shall make available information relating to the proper manner of submitting a claim for benefits under the state plan and shall distribute forms upon which submissions shall be made.

(2) The writing carrier shall evaluate the eligibility of the claim for payment under the state plan.

(3) The writing carrier shall determine the usual and customary charges for professional services, supplies or institutional care for which a claim is made under the state plan policy or contract.

(4) Within 15 working days of receipt by the writing carrier of a properly completed and executed proof of loss, the covered person shall, to the extent possible, be advised whether the claim was accepted or rejected by the writing carrier, unless already settled.

(5) The writing carrier shall establish an appeals procedure approved by the board to review claims which are denied in whole or in part. When a claim or any portion thereof is denied, the writing carrier shall inform the covered person of the existence of the procedure.

2. The writing carrier shall submit monthly reports to the commissioner and the board on the operation of the state plan. The content and form of the report shall be as determined by the board and approved by the commissioner.

3. The writing carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the state plan. If the writing carrier's payments for claims expenses exceed the portion of the state plan premiums allocated by the board for payment of claims expenses, the association shall provide to the writing carrier additional funds for payment of claims expenses. Not less than 87½ of the state plan premium as determined by the board, shall be used to pay claims expenses, and not more than 12½% of the state plan premium shall be used to pay agent referral fees (authorized by Minn. Stat. § 62E.15, subd. 3) and to pay the writing carrier's direct and indirect expenses (as defined and authorized in Minn. Stat. § 62E.13, subd. 7 and described in INS 233).

4. The writing carrier shall be paid from time to time as provided in the association's contract with the writing carrier for its direct and indirect expenses incurred in the performance of its services from the state plan premiums received in an amount not to exceed the lesser of:

a. 12½% of the state plan premium,

b. Direct and indirect operating and administrative expenses incurred in the performance of its services, and

c. An amount agreed upon by the board and the writing carrier.

5. "Direct and indirect expenses" shall include that portion of the carrier's actual administrative, printing, claims administration, management, building overhead expenses and other actual operating and administrative expenses approved by the board as allocable to the administration of the state plan.

6. The board shall approve cost accounting methods of the writing carrier, which shall be consistent with generally accepted accounting principles.

7. The board shall have the authority to conduct periodic audits to verify the accuracy of financial data and reports submitted by the writing carrier.

INS 234 MCHA — Reinsurance.

A. Authority to make available reinsurance. The association may provide for reinsurance of risks incurred by insurer or fraternal members resulting from such members' issuance of all or any of the following categories of coverage as provided in the act:

1. Individual qualified plans (but not including group conversions),

2. Individual qualified medicare supplement plans (but not including group conversions),

3. Group conversions on qualified plans,

a. "group conversions" means the conversion policies or contracts required to be issued under Minn. Stat. §§ 62A.16-62A.17 or § 62E.16.

4. Group qualified plans which cover fewer than 50 employees or insured persons.

5. Group qualified medicare supplement plans with fewer than 50 employees or insured persons,

6. Individual major medical coverage, and

7. Group major medical coverage.

A member may make a separate election to reinsure each of the above categories of coverage.

B. Reinsurance plan. The association may enter into reinsurance pooling agreements with insurer and fraternal members to establish a reinsurance plan for risks of categories of coverage described in INS 234 A. The reinsurance plan may provide for a reinsurance pool.

1. Insurer or fraternal members wishing to participate in the pool shall apply to the association for participation in the pool, specifying the categories of coverage which the member desires to reinsure.

a. Members entering into a reinsurance pooling agreement for a particular category or categories of coverage shall offer to place in the pool all policies and contracts that it issues in the category or categories listed in INS 234 A. which it wishes to reinsure.

b. Only policies and contracts acceptable to the association or its reinsurance administrator may be accepted for reinsurance. The association is under no obligation to accept any but standard risks in the reinsurance plan.

2. The association may obtain commercial reinsurance to reduce the risk of loss through the pool to insurer or fraternal members entering into reinsurance pooling agreements. Any contract for commercial reinsurance entered into between the association and a commercial reinsurer shall be binding on any insurer or fraternal member entering into a reinsurance pooling agreement.

3. The association may administer the pool directly or through a reinsurance administrator.

a. The association or its reinsurance administrator may establish underwriting standards with which participating members shall comply and may perform reinsurance underwriting on all policies or contracts submitted for reinsurance.

b. The association or its reinsurance administrator may perform benefit calculation (claims processing) for all claims eligible for reimbursement to participating members. Only claims paid by participating members and approved by the association or its reinsurance administrator shall be eligible for reimbursement by the association or its reinsurance administrator in accordance with the reinsurance pooling agreement.

c. Except for underwriting and claims processing functions, the association or the reinsurance administrator shall have no responsibility for other administration functions for any member's reinsured policies or contracts unless otherwise agreed to by the association.

4. Participating members shall have the duties established in the reinsurance pooling agreement, including but not limited to:

a. Submitting reports which provide all information deemed necessary by the association or its reinsurance administrator for performance of reinsurance, underwriting, and claims processing functions;

b. Paying all pooling payments; and

c. Paying all reinsurance assessments and interim reinsurance assessments as required by the board.

C. Pooling payments. The association may require pooling payments from all participating members, to provide for reimbursement to participating members for claims paid under reinsured policies and contracts and for payment of administrative expenses of the pool incurred or estimated to be incurred during the period for which the pooling payment is made. Pooling payments shall be established by the association to provide at least 110% of total anticipated expenses for reinsurance and for administration of the policies or contracts which are reinsured.

D. Assessment of participating members.

1. At the end of each calendar year (or other fiscal year end established by the association) the board may assess participating members on the basis of the formula established in or as a part of the reinsurance pooling agreement.

2. The board may also levy interim reinsurance assessments to assure the financial ability of the association to reimburse participating members for claims paid under reinsured policies and contracts and operating and administrative expenses incurred or estimated to be incurred in the operation of the reinsurance plan until the calendar year end (or other fiscal year end established by the association) reinsurance assessment.

a. Interim reinsurance assessments shall be due and

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payable within 30 days of receipt by a participating member of an interim reinsurance assessment notice.

b. Interim reinsurance assessments shall be credited to each participating member in the year end reinsurance assessment calculation.

3. Each participating member's reinsurance assessment (net after credit for any interim reinsurance assessment) shall be billed to the member by the association following each calendar year end (or other fiscal year end established by the association) and shall be due and payable within 30 days of receipt by the member of the reinsurance assessment notice.

E. Excess receipts. If pooling payments, reinsurance assessments and other receipts by the association or its reinsurance administrator as a result of the reinsurance plan exceed actual reinsurance losses and administrative expenses of the pool, such excess shall be held at interest and used by the association to offset losses (including but not limited to reserves for incurred but not reported claims) due to claims expenses of the state plan or allocated to reduce state plan premiums.

INS 235 MCHA — Severability. If any section or provision of these rules is declared unconstitutional or void by any court of competent jurisdiction or its applicability to any person or circumstances is held invalid, the constitutionality or validity of the remainder of the rules and applicability to other persons and circumstances are not affected, and to this end, the sections and provisions of these rules are declared to be severable.

INS 236–250 Reserved for Future Use

TABLE I
Actuarial Equivalence Table

The regulations adopted by the Insurance Division should incorporate the actuarial equivalence table developed by the actuarial advisory committee (dated August 10, 1976) and distributed to association members, modified as appropriate to conform to proper regulation form.

TABLE I

Minnesota Comprehensive Health Insurance Act of 1976
Actuarial Equivalence
of Qualified Plans

A. How to Use the Test

1. Follow this outline of procedure:

A. Basic and Comprehensive Major Medical Plans.

1. List the Plan benefits, ignoring deductibles and coinsurance.

2. For each benefit, find the appropriate Table of Equivalent Points for Basic and Major Medical Plans.

3. Extract the appropriate point value for the benefit from the Table, interpolating as necessary or indicated, and place it opposite the listed benefit.

4. Ignore benefits for which no Table exists.

5. List deductible, coinsurance and plan maximum if, the Plan is a Comprehensive Major Medical Plan.

6. Find Table(s) of points for deductible, coinsurance and plan maximum.

7. Extract the appropriate point values for deductible, coinsurance and plan maximum, usually negative, interpolating as necessary, and place the values in the list of points.

8. Add algebraically the list of points.

9. Refer the result to the Test For Actuarial Equivalence to determine Qualification.

B. Superimposed Major Medical Plans.

1. Follow steps A.1. through A.4. for Basic Health Plan Benefits.

2. Total the points for the Basic Plan.

3. Enter Tables 21, 22 and 23 of the Tables of Equivalent Points to determine the point value of a Minnesota Qualified Plan superimposed over the Basic Plan with the Deductible and Benefit Period of the Plan at hand, interpolating as necessary. Put the pionts in the point column.

4. Compare the benefits in the Superimposed Major Medical Plan with the benefit structure of a Minnesota Qualified Plan:

a. $250,000 Lifetime Maximum.

b. 80/20 Coinsurance

c. $3,000 annual per person out-of-pocket maximum.

d. Eligible Expenses are Usual and Customary Expenses For:

(i) Hospital Services.

(ii) Physician Care.

(iii) Prescription Drugs.

(iv) Nursing-Home Care of up to 120 days in one year commencing within 14 days of hospitalization of at least three days.

(v) Home Health Care.

(vi) Radium and Radioactive Therapy.

(vii) Oxygen.

(viii) Anesthetics.

(ix) Prostheses.

(x) Rental or purchase of durable medical equipment.

(xi) Diagnostic X-Rays and laboratory tests.

(xii) Oral surgery on impacted teeth, teeth roots and gums and tissues, not in connection with tooth extraction.

(xiii) Physical therapy.

(xiv) Maternity same as any illness.

(xv) Minnesota statutorily mandated benefits.

(xvi) Coordination of Benefits.

5. Consult the Tables for point adjustments (usually negative) for Minnesota Qualified Plan benefits not in the Superimposed Major Medical Plan being tested. Put the adjustments in the point column.

6. Add algebraically the points for the Basic Plan (B.2.), the Superimposed Major Medical Plan (B.3.) and the adjustments (B.5.).

7. Refer the result to the Test for Actuarial Equivalence to determine Qualification.

C. Medicare Supplement Plans

1. Follow the rules for Basic and Comprehensive Major Medical Plans but use the Tables of Equivalent Points for Medicare Supplement Plans and the Medicare Supplement Table of Actuarial Equivalence.

II. Benefit Variations Not Covered by Tables.

The Committee recognized only those plan variations that are most common. For instance, Comprehensive Plan coinsurance was assumed to normally not exceed 20%. Therefore, no points are shown for 25%. However, points for such missing benefit variations can be extrapolated or estimated.

III. Use Tables.

Any insurer, self insurer or policyholder may use the Test for Actuarial Equivalence as a Guide. However, to obtain certification of any plan of health benefits as "Qualified", it must be submitted to the Minnesota Commissioner of Insurance. If an uninsured plan description or a policy form member or policy identification number is sent to the Commissioner, together with a statement of its total Equivalent Point Value from the Tables, and with a certification by a principle or officer of an insurer, or by a Member of the Academy of Actuaries for plans submitted by employers, that the plan is Qualified by virtue of the Test of Actuarial Equivalence as either a Plan 1, 2 or 3 or a Medicare Supplement Plan, the plan will be deemed certified as filed. If the Test does not qualify a plan or does not result in qualification for the Plan (i.e., 1, 2 or 3) desired by the insurer or self insurer, the filing must include the plan document or policy, the Equivalent Point Calculation and a statement of specific reasons for the desired qualification. Such plan will not be qualified until and unless so certified by the Commissioner.

IV. Update of Tables.

Periodically, the Tables may be revised as health care costs change. The Commissioner may re-evaluate actuarial equivalence of any plan or policy at any time as he believes appropriate. Also, as health care costs or Medicare deductibles and coinsurance change, a plan may automatically lose or change its Qualification. Annual re-evaluation of plans is required. When a plan is re-evaluated and its qualification status changes, the filing procedures in III, above, will be followed.

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V. Mis-Use of Tables.

The tables of Equivalent Points are not intended for any other use, especially not for premium calculations. They represent a composite of data received by the Committee, adjusted to be useable for testing actuarial equivalence. No other use is contemplated.

B. How the Test was Developed

I. Statute.

Minnesota Statute 62E.02 defines Qualified Plans as health benefit plans that provide the benefits required in Statutes 62E.06 and 62E.07 "or the actuarial equivalent to those benefits." 62E.06 describes three Qualified Plans and 62E.07 describes a Qualified Medicare Supplement Plan.

The law requires all plans of health coverage to be labelled as Qualified or Non-Qualified. The Commissioner of Insurance may be requested to determine whether a plan is qualified and he may take up to 90 days to make that determination.

II. Actuarial Advisory Committee.

In order to provide guidance to policyholders, self insurers, insurers and consulting actuaries desiring to measure plans of health coverage for qualification, and to provide the Commissioner with a standard that can be used by him, a test for actuarial equivalence was desired.

The Commissioner asked that the industry form an Actuarial Advisory Committee to find a way to test for actuarial equivalence. The Committee's efforts resulted in the attached Tables of Equivalent Points and Test For Actuarial Equivalence.

III. Method Development of Tables of Equivalent Points.

The Committee mailed a questionnaire to over thirty-five insurers, one uninsured plan and one consulting actuary. Approximately twenty replies were received. Each respondent was asked to assume that the claim cost of a Minnesota Qualified Plan Number 3 was 1,000 points and to assign proportionate points to each specific benefit mandated in the law for Plan Number 3. Then, each benefit was listed separately and the questionnaire asked for point values for variation of that benefit (e.g., 365 days, 70 days or 31 days of hospital room and board instead of the unlimited days provided by Plan Number 3).

The results of all the questionnaires were analyzed objectively and subjectively by the Committee. The composite point values for Minnesota Qualified Plan 3 are shown in Appendix A. and the point values for the Minnesota Qualified Medicare Supplement as shown in Appendix B.

Composite Point Values For
Minnesota Qualified Plan No. 3
Arbitrary Radix = 1,000 Points

Points	Benefit
395	Hospital Room and Board — unlimited days, semi-private.
485	Hospital Extras (i.e., Hospital Services, Hospital Miscellaneous, Hospital Special Services, or Ancillary Services) including anesthesia.
210	Surgery, including oral surgery but no tooth repair or extraction.
220	Home and Office Physician Care — unlimited.
55	Physician Care in Hopsital — unlimited.
75	Obstetrics — unlimited.
125	Hospital maternity — unlimited.
90	X-Rays and Laboratory tests — outpatient and out of hospital.
90	Prescription Drugs and Medicine — outpatient and out of hospital.
20	Emergency Accident Care.
15	Radioactive Therapy — outpatient and out of hospital.
20	Nursing or Convalescent Facility.
10	Home Health Agency Care.
10	Physical Therapy.
20	$3,000 annual "out of pocket" expense limit.
−75	Coordination of Benefits.
−45	Non-Duplication with No-Fault.
−430	$150 Deductible.
−290	20% Coinsurance.
1,000	Total

Note: When setting up the above table, some minor benefits (e.g., student dependents to age 25, oxygen, etc.) specified in the Statute were overlooked. All have extremely nominal point value so no re-calculation has been made for them at this time.

Composite Point Values For
Minnesota Qualified Medicare Supplement Plan
Arbitrary Radix = 100 Points

Points	Benefit
26.13	Hospital Room and Board — unlimited days, semi-private, reasonable and customary — Net of Medicare payments.
3.90	Skilled Nursing Home — Net of Medicare Payments.
.15	Blood and Blood Plasma (In Hospital) — Not provided by Medicare.

Points	Benefit
45.78	*Surgery, including oral surgery but no tooth repair or extraction.
104.66	*Home and Office Physician Care — unlimited.
22.70	*Physician Care in Hospital — unlimited.
57.58	*X-Rays and Laboratory tests — outpatient and out of hospital.
5.00	*Radioactive Therapy — outpatient and out of hospital.
3.75	*Home Health Agency Care.
1.48	*Miscellaneous.
48.67	Drugs and Medicine — outpatient and out of hospital.
5.00	Private duty nursing.
−158.89	Part B Medicare payments credit.
−54.64	50% of Medicare Coinsurance and Deductibles.
−11.27	20% of expenses not covered by Medicare.
100.00	Total

*Gross expense — before Medicare payment under Part B.

Plan Name _____ Plan No. _____

WORKSHEET
Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976
A. Other than Medicare Supplement Plans

Table	Benefit	Basic	Major Medical: Superimposed	Major Medical: Comprehensive
21-23	Superimposed Major Medical	XXX		XXX
1.	Hospital Room and Board			
2.	Hospital Extras			
3.	Surgery			
4.	Physician Care — Home, Office			
5.	Physician Care — Hospital			
15-18	Benefits In Full			
6.	Maternity			
7.	Diagnostic X-Ray and Lab			
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident			
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility			
13.	Home Health Care			
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents			
24.	Limit on Out of Pocket			
25.	Maximum Benefit	XXX		
XX.	Subtotal			
26.	COB/No-Fault			
19-20	Coinsurance/Deductible	XXX		
XX.	Total			
XX.	Combined Basic and Superimposed		XXX	XXX

Equivalent to Minnesota Qualified Plan Number _____ Non-Qualified ☐

Date _____ By _____

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WORKSHEET
Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

B. Medicare Supplement Plan

Table	Benefit	Days	Daily Benefit	Factor	Product	
27.	Hospital — Defined daily benefit	1		9.59		
		2-60		83.56		
		61-90		1.50		
		91-150		.61		
		151 & Over		1.02		
		Total	XXX			
		Divisor				
		Quotient				
		Multiplier			23.78	
		Product				
27.	Hospital — Usual and customary charges not paid by Medicare					
	A. Medicare Deductible and Coinsurance					
	B. Benefits not covered by Medicare					
28.	Silled Nursing Facility					
29.	Blood					
30.	Surgery					
31.	Physician Care — Home and Office					
32.	Physician Care — Hospital					
33.	Home Health Care					
34.	Diagnostic X-Ray and Laboratory					
35.	Radioactive Therapy					
36.	Drugs and Medicine					
37.	Private Duty Nursing					
38.	Miscellaneous					
41.	Comprehensive Major Medical					
XX.	Subtotal					
39.	Medicare Part B Payments					
40.	Medicare Part B Deductible not Eligible.					
XX.	Total					

Equivalent to Minnesota Qualified Medicare Supplement Plan: Yes ☐ No ☐

Date _____ By _____

Test For
Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. For Plans Other Than Medicare Supplement Plans

If the Point Value of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualified Plan No. :
1,000 + points	3
700 + points	2
550 + points	1
Less than 550 points	Non-Qualified

B. For Medicare Supplement Plans

If the Point Value of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualified Plan No. :
100 + points	Minnesota Medicare Supplemental Plan

Location of Tables
of
Equivalent Points

A. Basic and Major Medical Health Plans

Table	Name
1.	Hospital Room and Board
2.	Hospital Extras
3.	Surgery
4.	Home and Office Physician Care
5.	In Hospital Physician Care
6.	Maternity
7.	Diagnostic X-Ray and Laboratory
8.	Drugs and Medicine
9.	Emergency and Supplemental Accident
10.	Radioactive Therapy
11.	Student Dependents
12.	Nursing or Convalescent — Home Care
13.	Home Health Care Agency Service
14.	Physical Therapy
14.	Oxygen
14.	Prostheses
14.	Durable Medical Equipment
15.	Hospital Room and Board in Full
16.	All Hospital Charges in Full

17. All Hospital and Surgical Charges in Full
18. All Hospital, Surgical and In-Hospital Physicians Care in Full
19. Coinsurance and Deductibles
20. Combined Dental and Health Insurance Deductible
21. Superimposed Major Medical
22. Superimposed Major Medical
23. Superimposed Major Medical
24. Limit on "Out of Pocket" Expenses
25. Major Medical Maximums
26. Coordination and Non-Duplication of Benefits

B. Medicare Supplement Plans

27. Hospital Room and Board and Extras
28. Skilled Nursing Facility
29. Blood
30. Surgery
31. Home and Office Physician Care
32. In-Hospital Physician Care
33. Home Health Care
34. Diagnostic X-Ray and Laboratory
35. Radioactive Therapy
36. Drugs and Medicines
37. Private Duty Nursing
38. Physical Therapy
38. Oxygen
38. Prostheses
38. Durable Medical Equipment
39. Medicare Part B Payments
40. Medicare Part B Deductible
41. Comprehensive Major Medical

Table of Equivalent Points For Basic and Major Medical Health Plans
(Not To Be Used For Medicare Supplement Plans)

1. Hospital Room and Board.

Maximum Days	Semi-Private Room at $81.00 Per Day	Deduct for Each $10/Day Less than Semi-Private
31	330	40
70	370	46
120	380	48
365	390	49
Unlimited	395	50
Additional Points Per $1.00 Excess of Private over Semi-Private	2	—

2. Hospital Extras (i.e., Hospital Services, Special Hospital Services, Ancillary Services, Hospital Therapeutics, etc.)

Maximum	Anesthesia	
Amount	Included	Not Included
$ 250	250	245
500	335	305
1,000	410	265
2,000	450	400
5,000	475	415
Unlimited	485	425

3. Surgery

Limit	Assistant Surgeon Included	Anesthesia	
		Included	Not Included
1957 Intercompany			
a. $420 Maximum	No	100	85
b. $900 Maximum	No	195	170
Prevailing Fee*	No	230	200
Deduct for each "$1.00 per 1964 CRVS Unit" lsss than Prevailing Fee		25	22
Prevailing Fee*	Yes	240	210
Deduct for each "$1.00 per 1964 CRVS Unit" less than Prevailing Fee		25	22

*Equivalent to $9.00 per 1964 CRVS Unit.

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4. Home and Office Physician Care.

Annual Maximum	First Visit Accident	
	First Visit Sickness	Third Visit Sickness
$ 100	115	65
200	140	75
500	170	95
Unlimited	220	120

5. In-Hospital Physician Care.

Maximum Number of Visits	Prevailing Fee at Average $15.50/Day/Visit	Deduct for Each $1.00 Per Day Per Visit Less Than Prevailing Fee
31	40	3
70	46	3
120	49	3
365	52	4
Unlimited	55	4

6. Maternity.

A. Complications only:

a. Limited to some specified list	20
b. Any complications	25

B. Full Maternity (including complications):

Limit	Deductible	Flat Maternity	Obstetrics	Hospital Maternity
$ 150	None	—	25	30
300	None	55	50	60
500	None	90	70	90
1,000	None	170	—	—
Unlimited	None	200	75	125
Unlimited	$500	100	—	—
Unlimited	$1,000	30	—	—

7. X-Rays and Laboratory Tests (Out of Hospital)

Maximum	Scheduled (Any Schedule)	Unscheduled
$ 50	40	50
100	55	70
200	60	80
Unlimited	65	90

8. Prescription Drugs and Medicine (Out of Hopsital).

Deductible Per Prescription	
$ 2.00	60
1.00	75
None	90

9. Emergency and Supplemental Accident (Basic Plans Only).

Maximum	Emergency	Supplemental
$ 25	10	—
50	15	20
150	—	30
300	—	35
500	—	40
Unlimited	20	—

10. Radioactive Therapy (Out of Hopsital).

Scheduled (Any Schedule)	10
Unscheduled	15

11. Student Dependents.

Student Extension Beyond Age 19	
None	0
To Age 21	2
To Age 23	4
To Age 25	5

12. Nursing or Convalescent Home Care (Within 14 days of hospital confinement of at least three days).

Maximum Days	
120 or More	20
Less than 120	0

13. Home Health Care Agency Services

Maximum Visits/Year	
180 or More	10
Less than 180	0

14. Miscellaneous (Out of Hospital)

A. Physical Therapy	10
B. Oxygen	5
C. Prostheses	5
D. Durable Medical Equipment Rental or Purchase	5

15. Hospital Room and Board in Full to Indicated Limit (Basic and Comprehensive Major Medical Plans) — Use in Lieu of Room and Board point sin Number 1, above.

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Limit $1,000	Limit $2,000	Limit $5,000	Limit Unlimited
Basic	0	100%	300	325	365	395
Comprehensive	0	20%	455	460	470	475
Comprehensive	$ 50	20%	480	485	500	505
Comprehensive	100	20%	495	505	520	530
Comprehensive	150	20%	510	520	535	550

16. All Hospital Charges In Full to Indicated Limited (Basic and Comprehensive Major MEDICAL Plans) — Use in lieu of Room and Board and Hospital Extras in Numbers 1 and 2, above.

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Limit $1,000	Limit $2,000	Limit $5,000	Limit Unlimited
Basic	0	100%	615	710	805	880
Comprehensive	0	20%	1005	1025	1045	1060
Comprehensive	$ 50	20%	1050	1080	1100	1130
Comprehensive	100	20%	1090	1125	1150	1180
Comprehensive	150	20%	1120	1160	1195	1225

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17. All Hospital and Surgical Charges In Full to Indicated Limit (Basic and Comprehensive Major Medical Plans) — Use in lieu of Room and Board, Hospital Edtras and Surgery points in Numbers 1, 2 and 3, above.

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Hospital Surgery	$1,000 $5 CRVS	$2,000 $6 CRVS	$5,000 $8 CRVS	Unlimited Unlimited
Basic	0	100%		740	855	995	1090
Comprehensive	0	20%		1240	1265	1295	1310
Comprehensive	$ 50	20%		1295	1330	1370	1400
Comprehensive	100	20%		1340	1385	1440	1465
Comprehensive	150	20%		1375	1425	1480	1515

18. All Hospital, Surgical and In Hospital Physicians Care In Full to Indicated Limit (Basic and Comprehensive Major Medical Plans) — Use in lieu of Room and Board, Hospital Extras, Surgical and In Hospital Physician Care points in Numbers 1, 2, 3 and 5, above.

Plans	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Hospital Surgical Physician	$1,000 $5 CRVS $5/Day	$2,000 $6 CRVS $6/Day	$5,000 $8 CRVS $8/Day	Unlimited Unlimited Unlmited
Basic	0	100%		750	865	1015	1145
Comprehensive	0	20%		1290	1320	1350	1375
Comprehensive	$ 50	20%		1355	1390	1430	1465
Comprehensive	100	20%		1400	1440	1490	1530
Comprehensive	150	20%		1440	1485	1540	1585

19. Coinsurance and Deductibles (Comprehensive Major Medical Plans).

Deductible	Coinsurance: Insured Pays Designated Percent of Expense in Exess of Deductible 0%	10%	20%
$ 0	0	-170	-375
50	-170	-325	-520
100	-310	-455	-630
150	-410	-520	-720
200	-520	-640	-790
500	-820	-910	-1020
1,000	-1010	-1080	-1170

20. Combined Dental and Health Insurance Deductible (Comprehensive Major Medical Plans).

Deductible	Added Points
$ 50	90
100	75
150	65
200	40
500	35
1,000	15

21. Superimposed Major Medical Plans — Over Basic Health Plans With Less than 500 Points.
    1. Calculate point value of a Comprehensive Major Medical Plan using deductibel $100 greater than actual.
    2. Add Basic Health Plan points.

22. Superimposed Major Medical Plans — 80/20 Coinsurance — Over Basic Health Plans With 500-799 Points.

Deductible:	Add to Basic Plan Points: Calendar Year Plan Individual	Calendar Year Plan 2 x Family	2 Year Benefit Period Plan Individual	2 Year Benefit Period Plan 2 x Family
A. Corridor				
$ 50	740	780	745	765
100	665	705	680	700
150	615	655	630	650
200	575	615	590	610
500	365	405	380	400

B. Integrated				
$ 500	615	635	650	670
1,000	515	525	535	545

NOTE: Points assume Major Medical contains Minnesota Qualified Plan Number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

23. Superimposed Major Medical Plans — 80/20 Coinsurance — Over Basic Health Plans With 800 or More Points.

	Add to Basic Plan Points			
	Calendar Year Plan		2 Year Benefit Period Plan	
Deductible:	Individual	2 x Family	Individual	2 x Family
A. Corridor				
$ 50	505	535	515	525
100	445	475	455	465
150	405	435	415	425
200	365	395	375	385
500	205	235	215	225
B. Integrated				
$ 500	505	525	530	550
1,000	405	415	420	430

NOTE: Points assume Major Medical contains Minnesota Qualified Plan Number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

24. Limited on "Out of Pocket" Expenses (i.e., maximum Co-payment and Deductible per benefit year) — Comprehensive and Superimposed Major Medical Plans.

Out of Pocket Limit	Deductible: Coinsurance:	$50 20%	$150 20%	$500* 20%	$1,000 20%
$ 500		80	100	200	—
1,000		36	40	55	60
3,000		20	20	22	25
5,000		10	10	11	13
10,000		5	5	5	6

*Use this column for Superimposed Major Medical Plans

24. Major Medical Maximum (Comprehensive and Superimposed Plans).

Maximum	Add (+) or Subtract (−)
$ 10,000	−50
20,000	−40
50,000	−20
100,000	− 7
250,000	0
Unlimited	+ 5

26. Coordination and Non-Duplication of Benefits (All Plans)

	Deduct the Following Percentage of Total Points Before Crediting Points For Deductible and Coinsurance
a. With other health plans	4.0%
b. With No Fault	2.5%
c. With both a. and b.	6.5%
d. With neither	0

27. Hospital Room and Board and Extras

During a spell of illness, Medicare Part A pays all expenses except for the deductible and coinsurance amounts for hospital services during the first 90

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days of hospitalization. If hospitalization continues, Medicare will pay the expenses greater than the coinsurance amount until the lifetime reserve of 60 days is reached.

Use the following procedure to obtain the Equivalent Point value for a benefit which pays a certain amount if the individual is hospitalized a specified number of days:

a. Multiply the benefits provided by the policy by the appropriate adjustment factors given below and sum.

b. Calculate value of Medicare Deductible and Coinsurance — Multiply the current Medicare deductible and coinsurance amounts by the appropriate adjustment factors and sum. (Calculated below for July 1, 1976 deductible and coinsurance — recalculate each time Medicare changes deductible and coinsurance.)

c. Divide the value from step (a) by step (b).

d. Multiply step (c) by 23.78

Value of July 1, 1976 Medicare Deductible and Coinsurance

Days In Hospital	Adjustment Factor	Medicare Deductible and Coinsurance	Value
1	09.59	$104	997.36
2-60	83.56	0	0.00
61-90	1.50	26	39.00
91-50	.61	52	31.72
151	1.02	0	0.00
Total			1068.08

Since the Medicare Deductible and Coinsurance provisions change annually, policies using the defined Benefit approach should be re-evaluated annually.

If the policy does not pay a defined benefit during hospitalization but pays all usual and customary charges for hospital inpatient services not paid by Medicare, then use 23.78 and 2.35 as the Equivalent Point value for the benefits providing for the Medicare Deductible and Coinsurance amounts and for the benefits not covered by Medicare respectively.

28. Skilled Nursing Facility

Medicare Part A pays the usual and customary expenses of a qualified Skilled Nursing Facility exclusive of a coinsurance amount after twenty days of confinement up to a maximum of 100 days per spell of illness.

Payment of the Coinsurance Amount (currently $13) to 100 days	3.50
Payment of reasonable and customary expenses 100 to 120 days	.30
Payment of reasonable and customary expenses after the 120th day	.10

29. Blood

Medicare does not pay for the first 3 pints of blood while in the hospital. If the policy covers this, then the Equivlaent Point value is .15.

30. Surgery	Assistant Surgeon Included	Anesthesia Included	Not Included
Prevailing Fee*	No	48.70	43.60
Deduct for each "1.00 per 1964 CRVS Unit" less than Prevailing Fee		5.05	4.60
Prevailing Fee*	Yes	50.45	45.78
Deduct for each "$1.00 per 1964 CRVS Unit" less than Prevailing Fee		5.05	4.60

*Equivalent to $9.00 factor on the 1964 CRVS

31. Physician Care — Home and Office

	First Visit Accident	
	First Visit Sickness	Third Visit Sickness
Unlimited	104.46	74.50

32. Physician Care-Hospital

Maximum Number of Visits	Prevailing Fee at Average 14.50/Day/Visit	Deduct for each 1.00 Per Day Per Visit Less than Prevailing Fee
31	17.51	1.21
70	19.10	1.32
120	20.30	1.40
365	21.46	1.48
Unlimited	22.70	1.57

33. Home Health Care*

Maximum Visits/Year	
180 or More	3.75
Less than 180	0

*Excludes Home Health Care after individual is discharged from a hospital after a stay of at least 3 days.

34. Diagnostic X-Ray and Laboratory (Outpatient or out of hospital)

	Scheduled	Unscheduled
Unlimited	40.60	57.58

35. Radioactive Therapy (Outpatient or out of hospital)

Scheduled	3.00
Unscheduled	5.00

36. Drugs and Medicines (Outpatient or out of hospital)

Deductible Per Prescription	
2.00	30.00
1.00	38.75
None	48.67

37. Private Duty Nursing (Either RN or LPN) 5.00

38. Miscellaneous (In Clinic or as Outpatient) 1.48

a. Physical Therapy
b. Oxygen
c. Prostheses
d. Durable Medical Equipment (Rental or Purchase)

39. Medicare Part B Payments

Deduct 158.89

40. Medicare Part B Deductible ($60)

Deduct if not eligible 28.50

41. Comprehensive Major Medical Plans

Type	Equivalent Points
a. With C.O.B. against Medicare A and B, Maximum of $50,000 or more, Deductible of $100 or less, and Coinsurance of 20% or less	100
b. Other, including "Medicare Carve Out" Plans.	*

*File with Commissioner.

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EXAMPLE I

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesota Qualified Plan?

Deductible:	$100
Coinsurance:	80/20
Maximum:	$10,000
Maternity:	Any Complications
Student Dependents:	To 23
Limits on Specified Benefits:	Outpatient Mental limited to Minnesota Required Benefits
Excluded Care:	Home Health Care
Out of Pocket Limit:	$5,000 per year
Coordination of Benefits	Yes, but no COB with No-Fault

II. Answer (calculated January 1, 1977): Test result is 919 points

This Plan is a Minnesota Qualified Plan Number 2.

Plan Name Comprehensive Plan Plan No. Example I.

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

			Major Medical	
Table	Benefit	Basic	Superimposed	Comprehensive
21-23	Superimposed Major Medical	XXX		XXX
1.	Hospital Room and Board			395
2.	Hospital Extras			485
3.	Surgery			240
4.	Physician Care — Home Office			210
5.	Physician Care — Hospital			55
15-18	Benefits In Full			—
6.	Maternity			25
7.	Diagnostic X-Ray and Lab			90
8.	Drugs and Medicine			90
9.	Emergency/Supplemental Accident			0
10.	Radioactive Therapy			15
12.	Nursing/Convalescent Facility			20
13.	Home Health Care			0
14.	Physical Therapy			10
14.	Oxygen			5
14.	Prostheses			5
14.	Durable Medical Equipment			5
11.	Student Dependents			4
24.	Limit on Out of Pocket			10
25.	Maximum Benefit	XXX		−50
XX.	Subtotal			1614
26.	COB/No-Fault			−65
19-20	Coinsurance/Deductible	XXX		−630
XX.	Total			919

				INS
XX.	Combined Basic and Superimposed		XXX	XXX

Equivalent to Minnesota Qualified Plan Number 2 Non-Qualified ☐

Date January 1, 1977 By JPS

EXAMPLE II

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesota Qualified Plan?

Hospital:	$70 per day, 365 days, $2,000 Extras
Surgery:	$7 CRVS, an assistant surgeon
In Hospital Physicians Calls:	$10 per day, 365 days
Maternity	Specified complications only
Coordination of Benefits	No

II. Answer (calculated January 1, 1977): Test result is 1016 points.

This Plan is a Minnesota Qualified Plan Number 3.
Plan Name Basic Plan Plan No. Example II

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

Table	Benefit	Basic	Superimposed	Major Medical Comprehensive
21-23	Superimposed Major Medical	XXX		XXX
1.	Hospital Room and Board	336		
2.	Hospital Extras	450		
3.	Surgery	180		
4.	Physician Care — Home Office	30		
5.	Physician Care — Hospital	20		
15-18	Benefits In Full			
6.	Maternity			
7.	Diagnostic X-Ray and Lab			
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident			
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility			
13.	Home Health Care			
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents			
24.	Limit on Out of Pocket			
25.	Maximum Benefit	XXX		

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INS

XX.	Subtotal			
26.	COB/No-Fault			
19-20	Coinsurance/Deductible	XXX		
XX.	Total	1016		
XX.	Combined Basic and Superimposed		XXX	XXX

Equivalent to Minnesota Qualified Plan Number 3 Non-Qualified ☐

Date January 1, 1977 By JPS

EXAMPLE III

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesota Qualified Plan?

Hospital:	$30 per day, 70 days, $500 Extras
Surgery:	$420 Intercompany
Superimposed Major Medical:	
Deductible:	$100 corridor
Coinsurance:	80/20
Maximum:	$10,000
Maternity	Any complications
Student Dependents:	No
Out of Pocket Limit:	None
Exclude Care:	Home Health Care Nursing Home Care
Limits on Specified Benefits:	Maximum Eligible Charges as follows:
1. Room & Board	$50, less Basic Benefit.
2. Hospital Extras:	$2,000 less Basic Benefit
3. Surgery:	$7.00 per CRVS unit.
Coordination of Benefits	yes, including No/Fault

II. Answer (calculated January 1, 1977): Test result is 611 points.

This Plan is a Minnesota Qualified Plan Number 1.

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

			Major Medical	
Table	Benefit	Basic	Superimposed	Comprehensive
21-23	Superimposed Major Medical	XXX	665	XXX
1.	Hospital Room and Board	135	−143 (3.1 times 46)	
2.	Hospital Extras	335	−95 (402 less 305)	
3.	Surgery	85	−50 (2 times 25)	
4.	Physician Care — Home, Office			
5.	Physician Care — Hospital			
15-18	Benefits in Full			
6.	Maternity		−175 (200 less 25)	
7.	Diagnostic X-Ray and Lab			

				INS
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident			
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility		−20	
13.	Home Health Care		−10	
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents		−4	
24.	Limit on Out of Pocket		−20	
25.	Maximum Benefit	XXX	-50	
XX.	Subtotal	555	98	
26.	COB/No-Fault	−36	−6	
19-20	Coinsurance/Deductible	XXX		
XX.	Total	519	92	
XX.	Combined Basic and Superimposed	611	XXX	XXX

Equivalent to Minnesota Qualified Plan Number 1

Non-Qualified ☐

Date January 1, 1977 By JPS

EXAMPLE IV

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesota Qualified Plan?

Hospital:	First $3,000 of all Hospital Charges in Full
Surgery:	$420 Intercompany
Emergency Accident:	$25
Superimposed Major Medical:	
Deductible:	$500 Integrated
Coinsurance:	80/20
Maximum:	$25,000
Maternity:	Full
Student Dependents:	No
Out of Pocket Limit:	None
Excluded Care:	Home Health Care
Coordination of Benefits:	Yes, Other Health and No Fault Plans

II. Answer: (Calculated January 1, 1977). Test result is 1290 points.

This Plan is a Minnesota Qualified Plan Number 3.

KEY: PROPOSED RULES SECTION: Underlining indicates additions to pre-existing rule language. ~~Strike outs~~ indicate deletions from pre-existing rule language. If all proposed rules in a set are totally new (i.e. non-amendatory) the entire set is printed in standard type face. **RULES SECTION:** Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

INS

Plan Name Basic With Benefits In Full and Comprehensive Plan No. Example IV

WORKSHEET

Test for Actuarial Equivalence

Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

Table	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
21-23	Superimposed Major Medical	XXX	615	XXX
1.	Hospital Room and Board			
2.	Hospital Extras			
3.	Surgery	85		
4.	Physician Care — Home, Office			
5.	Physician Care — Hospital			
15-18	Benefits In Full	741 (710 plus 33% of 95)		
6.	Maternity			
7.	Diagnostic X-Ray and Lab			
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident	10		
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility			
13.	Home Health Care		−10	
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents		−5	
24.	Limit on Out of Pocket		−22	
25.	Maximum Benefit	XXX	−35	
XX.	Subtotal	836	543	
26.	COB/No-Fault	−54	−35	
19-20	Coinsurance/Deductible	XXX		
XX.	Total	782	508	
XX.	Combined Basic and Superimposed	1290	XXX	XXX

Equivalent to Minnesota Qualified Plan Number 3 Non-Qualified ☐

Date January 1, 1977 By JPS

EXAMPLE V.

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to a Minnesota Qualified Medicare Supplement Plan?

Hospital Benefit	$100 first day $21 61 to 90 days
Skilled Nursing Home	$13 100 days
Blood	3 pints in hospital
Surgery	$1.50 CRVS with anesthesia, no assistant surgeon
Physician Care — In Hospital	$4 per day, 90 days

Drugs and Medicines	$2 deductible per prescription	

II. Answer: (calculated January 1, 1977): Test results is 72.1 points.

This Plan is not a Minnesota Qualified Medicare Supplement Plan.

Plan Name Medicare Supplement Plan No. Example V

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

B. Medicare Supplement Plan

Table	Benefit	Days	Daily Benefit	Factor	Product	
27.	Hospital — Defined daily benefit	1	100	9.59	959.00	
		2-60	0	83.56		
		61-90	26	1.50	39.00	
		91-150		.61		
		151 & Over		1.02		
		Total	XXX		998.00	
		Divisor			1068.08	
		Quotient			.9344	
		Multiplier			23.78	
		Product				22.22
27.	Hospital — Usual and customary charges not paid by Medicare					
	A. Medicare Deductible and Coinsurance					
	B. Benefits not covered by Medicare					
28.	Skilled Nursing Facility					3.50
29.	Blood					.15
30.	Surgery					10.82
31.	Physician Care — Home and Office					
32.	Physician Care — Hospital					5.41
33.	Home Health Care					
34.	Diagnostic X-Ray and Laboratory					
35.	Radioactive Therapy					
36.	Drugs and Medicine					30.00
37.	Private Duty Nursing					
38.	Miscellaneous					
41.	Comprehensive Major Medical					
XX.	Subtotal					72.10
39.	Medicare Part B Payments					
40.	Medicare Part B Deductible not Eligible					
XX.	Total					72.10

Equivalent to Minnesota Qualified Medicare Supplement Plan: Yes ☐ No ☒

Date January 1, 1977 By JPS

KEY: PROPOSED RULES SECTION: Underlining indicates additions to pre-existing rule language. ~~Strike outs~~ indicate deletions from pre-existing rule language. If all proposed rules in a set are totally new (i.e. non-amendatory) the entire set is printed in standard type face. **RULES SECTION:** Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

EXAMPLE VI

Use of Actuarial Equivalent Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to a Minnesota Qualified Medicare Supplement Plan?

Benefit: (a) 100% of reasonable and customary hospital and nursing home expenses in excess of Medicare Part A.

(b) 20% of reasonable and customary charges for medical services after $60 deductible applied to expenses eligible under Part B of Medicare.

II. Answer (Calculated January 1, 1977): Test result is 84.3 points.

The Plan is not Qualified.

Plan Name Medicare Supplement Plan No. Example VI

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

B. Medicare Supplement Plan

Table Benefit

27. Hospital — Defined daily benefit

Days	Daily Benefit	Factor	Product
1		9.59	
2-60		83.56	
61-90		1.50	
91-150		.61	
151 & over		1.02	
Total	XXX		
Divisor			
Quotient			
Multiplier			23.78
Product			

27. Hospital — Usual and customary charges not paid by Medicare	
A. Medicare Deductible and Coinsurance	23.78
B. Benefits not covered by Medicare	2.35
28. Skilled Nursing Facility	3.90
29. Blood	.15
30. Surgery.	10.09 (=20%)
31. Physician Care — Home and Office	20.89 (=20%)
32. Physician Care — Hospital	4.54 (=20%)
33. Home Health Care	.75 (=20%)
34. Diagnostic X-Ray and Laboratory	11.52 (=20%)
35. Radioactive Therapy	1.00 (=20%)
36. Drugs and Medicine	9.73 (=20%)
37. Private Duty Nursing	1.00 (=20%)
38. Miscellaneous	.30 (=20%)
41. Comprehensive Major Medical	
XX. Subtotal	90.00
39. Medicare Part B Payments	

	INS
40. Medicare Part B Deductible not Eligible	−5.70 (=20%)
XX. Total	84.30

Equivalent to Minnesota Qualified Medicare Supplement Plan: Yes ☐ No ☑

X

Date January 1, 1977 By JPS

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OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, when, in preparing to propose rules, an agency seeks to obtain information or opinion form sources outside of the agency, a notice of intent to solicit such information or opinion is published in the *State Register* and interested persons are afforded an opportunity to submit data and views on the subject.

The *State Register* also contains any other official notice requested to be published by an agency, pursuant to Laws of 1977, ch. 305 § 3.

Department of Personnel

Notice of Intent to Solicit Outside Opinions on Rules Governing the Taking of Official Action by State Employees in Matters Involving Businesses in Which They Have an Interest

Notice is hereby given that the Department of Personnel is drafting rules amending the code of ethics for employees in the executive branch of the State of Minnesota. The rules governing a code of ethics are authorized by Minn. Stat. § 43.05 subd. 2 (13) 1976. It is the intent of these new rules to define significant financial interest in outside businesses, and to specify the conditions when employees should not be involved in official actions involving businesses in which they have a significant financial interest.

The department invites all interested persons or groups to provide information or comment on the above subject in writing to:

Richard R. Cottrell
Department of Personnel
Third Floor Space Center
444 Lafayette Road
St. Paul, MN 55101

All statements of information or comment must be received by March 31, 1978. Any written material received by the department on or before this date will become part of the hearing record.

Energy Agency

Notice of Intent to Solicit Outside Opinion Regarding Preparation of Environmental Reports on Large Electric Generating Facilities and Large High Voltage Transmission Lines

Notice is hereby given that the Minnesota Energy Agency (hereinafter the "Agency") is seeking information or opinions from sources outside the Agency in preparing to write drafts of environmental reports for large electric generating facilities and large high voltage transmission lines.

The Agency, pursuant to 6 MCAR § 3.025 G, must prepare an environmental report in conjunction with the processing of an application for a certificate of need for an electrical power plant or transmission line. Because of the short time period for preparation of an environmental report after an application is received, the Agency intends to prepare outlines for the reports prior to the receipt of any application. The Agency also intends to prepare drafts of certain sections of the reports, to the extent possible without knowing the contents of applications for future electrical facilities which would require certificates of need.

Environmental reports prepared at the certificate of need stage must be limited to broad generic questions, since information on detailed design and plant location is unavailable at that stage. The aforementioned rule specifically states that such reports shall not be as exhaustive or detailed as an EIS. However, the rule specifies that each environmental report shall include:

A. a summary of the information provided in the application;

B. a brief analysis of alternatives to the proposed facility, which analysis shall include: a discussion of the economic and environmental feasibility of each alternative including the alternative of a different sized facility, an estimate of the time it would take to implement each alternative, the projected availability of each alternative, and the estimated reliability of each alternative;

C. an evaluation of the environmental and economic impact of the proposed facility, each reasonable alternative thereto, and the alternative of no facility;

D. an evaluation of:

1. the environmental impact of the proposed action, including any pollution, impairment, or destruction of the air, water, land, or other natural resources located within the site;

2. any direct or indirect adverse environmental, economic, and employment effects that cannot be avoided should the proposal be implemented;

3. alternatives to the proposed action;

4. the relationship between local short term uses of the environment and the maintenance and enhancement of long

term productivity, including the environmental impact of predictable increased future development of an area because of the existence of a proposal, if approved;

5. any irreversible and irretrievable commitments of resources which would be involved in the proposed action should it be implemented;

6. the impact on state government of any federal controls associated with proposed actions; and

7. the multi-state responsibilities associated with proposed actions.

Interested or affected persons or groups may submit statements of information and comment orally or in writing. Written statements may be addressed to:

David L. Jacobson
Minnesota Energy Agency
American Center Building
150 East Kellogg Boulevard
St. Paul, MN 55101

Oral statements will be received during regular business hours over the telephone at (612) 296-7502, or in person at the above address.

All statements of information and comment must be received by May 12, 1978.

Dated: March 6, 1978

David L. Jacobson
Acting Manager
Certificate of Need Program

Department of Human Rights

Settlement Agreements: January 31, 1978 through February 17, 1978

In addition to specific remedies, standard agreements reached prior to a hearing contain the following stipulations:

1. The agreement does not constitute an admission by the respondent of a violation of Minn. Stat. ch. 363.

2. The respondent agrees to abide by the provisions of Minn. Stat. ch. 363.

Department of Human Rights, Complainant, vs. Anderson Window Corporation, Respondent, E2710.

Charge.

A person (hereinafter "charging party") filed a charge alleging that Anderson Window Corporation (hereinafter "respondent") refused to hire him because of a disability that was not related to job performance. The charging party alleged that this was a violation of the Minnesota Human Rights Act. Following an investigation, the Commissioner of Human Rights found cause to credit the charging party's allegation.

Settlement.

The matter was settled in the following manner:

1. The respondent agreed to pay the charging party the sum of $75.00 as a total settlement of the charge filed.

Department of Human Rights, Complainant, vs. Pearson Candy Company, Respondent, E3637.

Charge.

A person (hereinafter "charging party") filed a charge alleging that Pearson Candy Company (hereinafter "respondent"), her employer, terminated her because of her race. The charging party alleged that she was told by her employer that she was not working according to standards and that she was too friendly. Following an investigation, the Commissioner of Human Rights found to credit the charging party's allegation.

Settlement.

The charging party and the respondent agreed to settle the matter in the following manner:

1. The respondent agreed to pay the charging party $1,750.00 minus standard payroll deductions as back pay.

2. The charging party was informed of and waived any reemployment with the respondent at any time in the future.

Department of Human Rights, Complainant, vs. Independent School District #308, Nevis, Minnesota, Respondent, E2441.

Charge.

A person (hereinafter "charging party") filed a charge alleging that her employer, Independent School District #308 (hereinafter "respondent"), discriminated against her because of her sex by paying her less as a coach of girls' athletics than coaches of boys' athletics were paid. Following an investigation, the Commissioner of Human Rights found cause to credit the charging party's allegation.

Settlement.

The parties agreed to settle the matter in the following manner:

1. The respondent agreed to implement a coaching salary schedule based on sex-neutral criteria, e.g.,

a. length of season;

b. maximum number of games which may be played during the season;

c. any other objective criteria approved by the department.

2. The respondent agreed to pay the charging party the sum of $1,250.00 in settlement of the charge.

Department of Human Rights, Complainant, vs. Bank Americard, Respondent, CR12.

Charge.

A person (hereinafter "charging party") filed a charge alleging that Bank Americard (hereinafter "respondent") discriminated against her by denying her credit because of her sex and marital status. The charging party alleged that the respondent discriminated against her because of her marital status by making her receipt of credit contingent upon her husband's signature. Following an investigation, the Commissioner of Human Rights found cause to credit the charging party's allegation.

Settlement.

The parties agreed to settle the matter in the following manner:

1. The respondent agreed to disseminate to all persons involved in processing an application for credit the following statement:

"It is understood that any willful breach or disregard of the Bank's equal credit opportunity policy regarding non-discrimination shall be grounds for disciplinary action".

2. The respondent agreed to accept a new application for credit from the charging party and to consider the application on a non-discriminating basis.

3. The respondent agreed to pay the sum of $300.00 to the charging party for expenses incurred by her in pursuing this matter.

4. The respondent agreed to provide written assurance to the charging party that the respondent's denial of credit was not reported to any credit bureau or agency and agreed to expunge any record or notation in its files indicating that the charging party was denied credit initially.

Department of Human Rights, Complainant, vs. Independent School District #347, Willmar, Minnesota, Respondent, E3687.

Charge.

A person (hereinafter "charging party") filed a charge alleging that Independent School District #347 (hereinafter "respondent"), her employer, discriminated against her because of her sex by refusing to allow her to use accumulated sick leave days when she was absent because of childbirth. Following an investigation, the Commissioner of Human Rights found probable cause to credit the charging party's allegation.

Settlement.

The parties agreed to settle the matter in the following manner:

1. The respondent agreed to treat childbirth and recovery from childbirth as a temporary disability analogous to disabilities resulting from illnesses or injuries.

2. The respondent agreed to revise the contract between the school district and the faculty so that employees absent from work because of childbirth would receive the same sick leave benefits as employees absent for illness or injury received.

3. The respondent agreed that the length of time that an employee is absent because of childbirth could receive benefits would be determined in the same manner as the length of time is determined for other absent employees who receive disability benefits for illness or injury.

4. The respondent agreed that sick leave time accrued during disability leaves due to illness or injury would be accrued in the same manner by employees who take leave due to maternity disabilities.

5. The respondent agreed to pay the charging party the sum of $362.13 in full financial settlement of the charge.

Pre-Determination Agreements: January 31, 1978 through February 17, 1978

A pre-determination agreement is an agreement reached prior to the Commissioner's finding of probable or no probable cause to credit the allegation(s) contained in a charge of discrimination. It is signed by the charging party, the re-

spondent, and the Commissioner. A pre-determination agreement may be reached through a departmental procedure called the 30-Day Waiver Process. Prior to a formal investigation by the department, a charging party and a respondent may mutually agree to request that the department waive investigation of a charge for 30 days while the parties attempt to settle the matter.

Department of Human Rights, Complainant, vs. Abbott-Northwestern Hospital, Respondent, E4769.

Charge.

A person (hereinafter "charging party") filed a charge alleging that her employer, Abbott-Northwestern Hospital (hereinafter "respondent"), discriminated against her because of her sex by refusing to allow her to use paid sick leave time she had accrued when she was unable to work because of pregnancy. Prior to a formal investigation, an agreement was reached.

Agreement.

The parties agreed to settle the matter in the following manner:

1. The respondent agreed to pay the charging party the sum of $382.44, representing 85.75 hours of sick pay.

Department of Human Rights, Complainant, vs. Sentry Insurance Company, a Mutual Company, Respondent, E3658.

Charge.

A person (hereinafter "respondent") filed a charge alleging that Sentry Insurance Company (hereinafter "respondent") refused to hire him as an insurance agent because of his race. Prior to a formal investigation, the matter was resolved.

Agreement.

The parties settled the matter in the following manner:

1. The respondent agreed to pay the charging party the sum of $1,050.00 as a negotiated settlement of the charge filed.

2. The respondent offered the charging party a job and it was agreed that the charging party's rejection of the job offer was solely his decision.

Department of Human Rights, Complainant, vs. Teamsters and Dairies Employees Union, Local #346, Respondent, E4632.

Charge.

A person (hereinafter "charging party") filed a charge alleging that his union, Local #346 (hereinafter "respondent") discriminated against him because of a disability. The charging party alleged that after recovery from a back injury, he tried to secure employment through the respondent and was unsuccessful even though his physician had certified his ability to work. Prior to a formal investigation, an agreement was reached.

Agreement.

The parties agreed to settle the matter in the following manner:

1. The respondent agreed to refer the charging party for available employment and to continue referral efforts until employment is obtained.

Department of Human Rights, Complainant, vs. Chicago, Milwaukee, St. Paul and Pacific Railroad Company, Respondent, E4147.

Charge.

A person (hereinafter "charging party") filed a charge alleging that her employer, Chicago, Milwaukee, St. Paul and Pacific Railroad Company (hereinafter "respondent"), discriminated against her because of her sex and disability. The charging party alleged that when she returned to work following absence because of a back injury, she was disqualified from a position because she lacked sufficient fitness and ability to perform the job. The charging party believed the disqualification was prompted by her sex and disability. She was forced to resign when she was disqualified. Prior to a formal investigation, an agreement was reached.

Agreement.

The parties agreed to settle the matter in the following manner:

1. The respondent agreed to pay the charging party disability payments from the Railroad Retirement Board.

2. The respondent agreed that the charging party would receive disability insurance.

Department of Human Rights, Complainant, vs. Data 100 Corporation, Respondent, E4376.

Charge.

A person (hereinafter "charging party") filed a charge alleging that her employer, Data 100 Corporation (here-

inafter "respondent"), discriminated against her because of her sex by paying her less than males were paid to perform the same job. Prior to a formal investigation, an agreement was reached.

Agreement.

The parties agreed to settle the matter in the following manner:

1. The respondent agreed to pay the charging party a monthly salary of $950.00.

Department of Human Rights, Complainant, vs. Ziegler Inc., Respondent, E4627.

Charge.

A person (hereinafter "charging party") filed a charge alleging that her employer, Ziegler Inc. (hereinafter "respondent") discriminated against her because of her age. The charging party believed that she was terminated by the respondent because of her age. The charging party believed that her termination was related to the upcoming vestiture in the company's retirement program. Prior to a formal investigation, an agreement was reached.

Agreement.

The parties settled the matter in the following manner:

1. The respondent agreed to reinstate the charging party.

2. The respondent agreed to treat the charging party's employment as continuous without interruption for purposes of fringe benefits and the retirement program.

Department of Human Rights, Complainant, vs. Hoerner Waldorf, A Division of Champion International, Respondent, E4417.

Charge.

A person (hereinafter "charging party") filed a charge alleging that her employer, Hoerner Waldorf (hereinafter "respondent") discriminated against her because of her race and disability. The charging party alleged that she was treated differently than other employees with regard to the use of fringe benefits. She also alleged that her supervisor told her to look for employment elsewhere because of her health. The charging party possessed verification from her physician that she was able to perform her job with proper medication. Prior to a formal investigation, an agreement was reached.

Agreement.

The parties settled the matter in the following manner:

1. The respondent agreed to transfer the charging party to a position that is under different supervision.

2. The respondent agreed that the charging party would be allowed 2 months to learn the duties of the new position and that counseling and appraisals to insure that the charging party is aware of her duties and responsibilities would be provided.

Department of Human Rights, Complainant, vs. Fabri-Tek, Respondent, E4298.

Charge.

A person (hereinafter "charging party") filed a charge alleging that his employer, Fabri-Tek (hereinafter "respondent"), discriminated against him because of his race when the respondent terminated him without proper warning or reprimand. Prior to a formal investigation, an agreement was reached.

Agreement.

The parties agreed to settle the matter in the following manner:

1. The respondent agreed to pay the charging party $400.00 in settlement of the charge.

2. The respondent agreed that no information pertaining to the charging party's employment would be given out other than the dates of his employment and the fact that he voluntarily quit.

Department of Human Rights, Complainant, vs. Hiawatha Children's Home, Respondent, E4746.

Charge.

A person (hereinafter "charging party") filed a charge alleging that Hiawatha Children's Home (hereinafter "respondent"), discriminated against her in that she believed that the respondent did not consider her for employment because of her age. Prior to a formal investigation, an agreement was reached.

Agreement.

The parties settled the matter in the following manner:

1. The respondent agreed to accept a new application for employment from the charging party.

2. The respondent agreed to give priority consideration to the charging party for future openings within the charging party's area of interest and expertise.

Pollution Control Agency

Order for Hearing and Notice Thereof in the Matter of the Application of the City of North Mankato for a Variance from Minn. Reg. APC 8(j) for the Establishment of a Diseased Shade Tree Open Burning Site

It is hereby ordered and notice is hereby given that a hearing concerning the above-entitled matter will be held on Thursday, April 13, 1978, at the City Hall in North Mankato, Minnesota, beginning at 1:00 p.m. and continuing until all persons can be heard.

The hearing will be held before Howard L. Kaibel, 1745 University Avenue, St. Paul, Minnesota 55104, (612) 296-8107, a Hearing Examiner appointed by the Chief Hearing Examiner of the State of Minnesota. The hearing will be conducted pursuant to the contested case procedures set out in Minn. Stat. §§ 15.0411 through 15.052 and Minn. Reg. HE 201 through 222. Questions concerning discovery or other matters concerning this proceeding may be directed to Special Assistant Attorney General Jocelyn Furtwangler Olson, (612) 296-7343 or Richard Sandberg, Division of Air Quality, (612) 296-7274, Minnesota Pollution Control Agency, 1935 W. County Road B2, Roseville, Minnesota 55113.

The purpose of this hearing will be to consider testimony and evidence bearing upon the application of the City of North Mankato, Minnesota, for a variance from the siting requirements of Minn. Reg. APC 8(j) concerning diseased shade tree open burning sites. The City desires to establish a diseased shade tree open burning site at the north end of Sherman Street in North Mankato, Minnesota. The proposed site does not conform to the requirements of Minn. Reg. APC 8(j) (1) (aa) and (bb), which state that a diseased shade tree open burning site shall be located not less than 1000 feet from an occupied building and not less than 1000 feet from a public roadway. The City seeks a variance from these distance requirements.

The Minnesota Pollution Control Agency is authorized to hold such hearing and grant such a variance by Minn. Stat. § 116.07, subd. 5 (1976) and pursuant to its regulation, Minn. Reg. MPCA 6.

Any person who desires to become a party to this case must submit a timely petition to intervene to the Hearing Examiner, pursuant to Minn. Reg. HE 210, showing how that person's legal rights, duties, and privileges may be affected by the decision in this case. The petition must also set forth the grounds and purpose for which intervention is sought. A party to a case has the right to present evidence and argument with respect to the issues and to cross-examine witnesses. Interested persons may present oral or written statements at the hearing without becoming parties.

Any person desiring to intervene as a party must submit to the Hearing Examiner a Petition to Intervene by March 31, 1978. At the present time the representatives of the proceeding who should be served with such a petition to intervene are:

Mr. Tom Bublitz
Office of the City Administrator
North Mankato, Minnesota 56001

Ms. Jocelyn F. Olson
Special Assistant Attorney General
Minnesota Pollution Control Agency
1935 W. County Road B2
Roseville, Minnesota 55113

A Notice of Appearance form, enclosed with this order, must be completed and returned to the Hearing Examiner at least ten days before the hearing date by any person admitted as a party.

The procedural rules HE 201 through HE 222 are available for inspection at the Office of Hearing Examiners or may be purchased from the Documents Section of the Department of Administration, 140 Centennial Building, St. Paul, Minnesota 55155 (296-2874). Copies of regulations and other documents pertinent to the proposed variance and application therefor are available for review by all interested persons during normal business hours at the Minnesota Pollution Control Agency, 1935 W. County Road B2, Roseville, Minnesota 55113.

State of Minnesota
Pollution Control Agency
Sandra S. Gardebring
Executive Director

Dated: March 10, 1978

Notice of Appearance

Date of Hearing: Thursday, April 13, 1978

Name and Telephone Number of Hearing Examiner:
Howard L. Kaibel, (612) 296-8107

TO THE HEARING EXAMINER:

You are advised that the party named below will appear at the above-entitled hearing.

Name of Party: _____

Address: _____

Telephone Number: _____

Party's Attorney or
Other Representative: _____

Office Address: _____

Telephone Number: _____

Signature of Party or Attorney: _____

Date: _____

NOTE : This form does not constitute a Petition to Intervene and should be filed only by persons who have been admitted as parties to this hearing. Interested persons may present oral or written statements at the hearing without filing this form.

Department of Transportation

Notice of Application and of Opportunity for Hearing In re Petition of the Chicago and North Western Transportation Company for authority to retire and remove approximately 450 feet from the westerly end of track No. 41 located at Chaska, Minnesota and of Opportunity for Hearing

Notice is hereby given that the Chicago and North Western Transportation Company with offices at 4200 IDS Center, 80 South 8th Street, Minneapolis, Minnesota (55402) has filed a petition with the Commissioner of Transportation pursuant to Minn. Stat. § 219.741 (1977 Supp.) and § 218.041, subd. 3 (10) (1977 Supp.) to retire and remove approximately 450 feet from the westerly end of track No. 41 located at Chaska, Minnesota. Said trackage is located generally within the boundaries of Sixth Street on the North, Fourth Street on the south, Cedar Street on the west, and Chestnut Street on the east, and crosses Pine Street.

The petition recites among other matters that: "The subject track is no longer needed for rail transportation service, and constitutes a continuing and burdensome maintenance expense. The track is not used at the present time, and there is no present prospect that the subject track will be needed in the future."

Any person may file a written objection to the proposed action by means of a letter addressed to the Commissioner of Transportation, Transportation Building, Saint Paul, Minnesota 55155, not later than the date specified below. An objection must be received on or before April 10, 1978. The objection should state specifically how the objector's interest will be adversely affected by the proposed action.

Upon receipt of a written objection, the Commissioner will, with respect to the named petitioner, set the matter down for hearing. If no objections are received, the Commissioner may grant the relief sought by the petitioner.

If this matter is set for hearing, any person who desires to become a party to this matter must submit a timely petition to intervene to the Hearing Examiner pursuant to Minn. Reg. HE 210, showing how the person's legal rights, duties and privileges may be determined or affected by the decision in this case. The petition must also set forth the grounds and purposes for which intervention is sought. All parties have the right to be represented by legal counsel or any other representative of their choice. In the event the objecting party does not do so, or otherwise does not participate in the hearing, the statements contained in the application filed may be taken as true.

Jim Harrington
Commissioner of Transportation

Dated this 6th day of March 1978.

Department of Transportation

Notice of Application and of Opportunity for Hearing In re Application of the Duluth, Winnipeg and Pacific Railway Company for authority to abandon and remove the entire House Track at Orr, Minnesota, which is approximately 1204 feet long and of Opportunity for Hearing

Notice is hereby given that the Duluth, Winnipeg and Pacific Railway Company with offices at 1808 South 8th Street, Virginia, Minnesota 55792 has filed a petition with

the Commissioner of Transportation pursuant to Minn. Stat. § 219.741 (1977 Supp.) and § 218.041, subd. 3 (10) (1977 Supp.) for authority to abandon and remove the entire House Track at Orr, Minnesota, which is approximately 1204 feet long. The petition recites among other matters that: "The Village of Orr has requested that we remove this trackage so that the parking area may be increased near the business district in Orr. . . ."

Any person may file a written objection to the proposed action by means of a letter addressed to the Commissioner of Transportation, Transportation Building, Saint Paul, Minnesota 55155, not later than the date specified below. An objection must be received on or before April 10, 1978. The objection should state specifically how the objector's interest will be adversely affected by the proposed action.

Upon receipt of a written objection, the Commissioner will, with respect to the named petitioner, set the matter down for hearing. If no objections are received, the Commissioner may grant the relief sought by the petitioner.

If this matter is set for hearing, any person who desires to become a party to this matter must submit a timely petition to intervene to the Hearing Examiner pursuant to Minn. Reg. HE 210, showing how the person's legal rights, duties and privileges may be determined or affected by the decision in this case. The petition must also set forth the grounds and purposes for which intervention is sought. All parties have the right to be represented by legal counsel or any other representative of their choice. In the event the objecting party does not do so, or otherwise does not participate in the hearing, the statements contained in the application filed may be taken as true.

Jim Harrington
Commissioner of Transportation

Dated this 6th day of March 1978.

Errata

1. 2 S.R. 1549: Change "throughout" to "throughput" at EA 701 R.

2. 2 S.R. 1550: Change "throughout" to "throughput" at EA 703 B.5.

3. 2 S.R. 1551: Change "eight" to "eighty" at EA 704 E.

4. 2 S.R. 1553: Change "throughout" to "throughput" at EA 731 A.3.

5. 2 S.R. 1555: Change "metholological" to "methodological" at EA 735 C.1.a.

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