STATE OF MINNESOTA

SEVENTY-SEVENTH SESSION—1992

SEVENTY-FIFTH DAY

SAINT PAUL, MINNESOTA, TUESDAY, MARCH 10, 1992

The House of Representatives convened at 12:00 noon and was called to order by Dee Long, Speaker of the House.

Prayer was offered by Monsignor James D. Habiger, House Chaplain.

The roll was called and the following members were present:

Abrams	Farrell	Kelso	Ogren	Simoneau
Anderson, I.	Frederick	Kinkel	Olsen, S.	Skoglund
Anderson, R.	Frerichs	Knickerbocker	Olson, E.	Smith
Anderson, R. H.	Garcia	Koppendrayer	Olson, K.	Solberg
Battaglia	Girard	Krambeer	Omann	Sparby
Bauerly	Goodno	Krinkie	Onnen	Stanius
Beard	Greenfield	Krueger	Orenstein	Steensma
Begich	Gruenes	Lasley	Orfield	Sviggum
Bertram	Gutknecht	Leppik	Osthoff	Swenson
Bettermann	Hanson	Lieder	Ostrom	Thompson
Bishop	Hartle	Limmer	Ozment	Tompkins
Blatz	Hasskamp	Lourey	Pauly	Trimble
Bodahl	Haukoos	Lynch	Pellow	Tunheim
Boo	Hausman	Macklin	Pelowski	Uphus
Brown	Heir	Mariani	Peterson	Valento
Carlson	Henry	Marsh	Pugh	Vanasek
Carruthers	Hufnagle	McEachern	Reding	Vellenga
Clark	Hugoson	McGuire	Rest	Wagenius
Cooper	Jacobs	McPherson	Rice	Waltman
Dauner	Janezich	Milbert	Rodosovich	Weaver
Davids	Jaros	Morrison	Runbeck	Wejcman
Dawkins	Jefferson	Munger	Sarna	Welker
Dempsey	Jennings	Murphy	Schafer	Welle
Dille	Johnson, R.	Nelson, S.	Schreiber	Wenzel
Dorn	Johnson, V.	Newinski	Seaberg	Winter
Erhardt	Kalis	O'Connor	Segal	Spk. Long

A quorum was present.

Johnson, A.; Kahn; Nelson, K., and Rukavina were excused.

The Chief Clerk proceeded to read the Journal of the preceding day. Winter moved that further reading of the Journal be dispensed with and that the Journal be approved as corrected by the Chief Clerk. The motion prevailed.

REPORTS OF STANDING COMMITTEES

Skoglund from the Committee on Financial Institutions and Insurance to which was referred:

H. F. No. 1791, A bill for an act relating to insurance; Minnesota comprehensive health association; increasing the maximum lifetime benefit amounts of certain state plan coverages; extending the effective date of the authorization of use of experimental delivery methods; amending Minnesota Statutes 1991 Supplement, sections 62E.10, subdivision 9; and 62E.12.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"ARTICLE 1

Section 1. Minnesota Statutes 1991 Supplement, section 62A.31, subdivision 1, is amended to read:

Subdivision 1. [POLICY REQUIREMENTS.] No individual or group policy, certificate, subscriber contract or other evidence of accident and health insurance the effect or purpose of which is to supplement Medicare coverage issued or delivered in this state or offered to a resident of this state shall be sold or issued to an individual covered by Medicare unless the following requirements are met:

(a) The policy must provide a minimum of the coverage set out in subdivision 2~~;~~ and section 62E.07.

(b) The policy must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage~~;~~.

(c) The policy must contain a provision that the plan will not be canceled or nonrenewed on the grounds of the deterioration of health of the insured~~;~~.

(d) Before the policy is sold or issued, an offer of both categories of Medicare supplement insurance has been made to the individual, together with an explanation of both coverages~~;~~.

(e) An outline of coverage as provided in section 62A.39 must be delivered at the time of application and prior to payment of any premium~~;~~.

(f)(1) The policy must provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period, not to exceed 24 months, in which the policyholder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder notifies the issuer of the policy within 90 days after the date the individual becomes entitled to this assistance;

(2) if suspension occurs and if the policyholder or certificate holder loses entitlement to this medical assistance, the policy shall be automatically reinstated, effective as of the date of termination of this entitlement, if the policyholder provides notice of loss of the entitlement within 90 days after the date of the loss;

(3) the policy must provide that upon reinstatement (i) there is no additional waiting period with respect to treatment of preexisting conditions, (ii) coverage is provided which is substantially equivalent to coverage in effect before the date of the suspension, and (iii) premiums are classified on terms that are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had coverage not been suspended;

(g) The written statement required by an application for Medicare supplement insurance pursuant to section 62A.43, subdivision 1, shall be made on a form, approved by the commissioner, that states that counseling services may be available in the state to provide advice concerning the purchase of Medicare supplement policies and enrollment under the Medicaid program;

(h) No issuer of Medicare supplement policies, including policies that supplement Medicare issued by health maintenance organizations or those policies governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., in this state may impose preexisting condition limitations or otherwise deny or condition the issuance or effectiveness of any Medicare supplement insurance policy form available for sale in this state, nor may it discriminate in the pricing of such a policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such insurance is submitted during the six-month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B;

(i) If a Medicare supplement policy replaces another Medicare supplement policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for ~~similar~~ benefits to the extent the time was spent under the original policy;

(j) The policy has been filed with and approved by the department as meeting all the requirements of sections 62A.31 to 62A.44~~;~~ ~~and~~.

(k) The policy guarantees renewability.

Only the following standards for renewability may be used in Medicare supplement insurance policy forms.

No issuer of Medicare supplement insurance policies may cancel or nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

If a group Medicare supplement insurance policy is terminated by the group policyholder and is not replaced as provided in this clause, the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder, provides for continuation of the benefits contained in the group policy; or provides for such benefits and benefit packages as otherwise meet the requirements of this clause.

If an individual is a certificate holder in a group Medicare supplement insurance policy and the individual terminates membership in the group, the issuer of the policy shall offer the certificate holder the conversion opportunities described in this clause; or offer the certificate holder continuation of coverage under the group policy.

(l) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(m) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with the changes.

As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. Such notice shall:

(1) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(2) inform each policyholder or certificate holder as to when any premium adjustment is to be made, due to changes in Medicare.

The notice of benefit modifications and any premium adjustments must be in outline form and in clear and simple terms so as to facilitate comprehension.

The notices must not contain or be accompanied by any solicitation.

(n) Termination by an issuer of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that began while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy or certificate was in force may be conditioned on the continuous total disability of the insured, limited to the duration of the policy or certificate benefit period, if any, or payment of the maximum benefits. The extension of benefits does not apply when the termination is based on fraud, misrepresentation, or nonpayment of premium. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days before discontinuing the availability of the form of the policy or certificate. An issuer that discontinues the availability of a policy form or certificate shall not file for approval a new policy form or certificate form of the same type for the same Medicare supplement benefit plan as the discontinued form for five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section. A change in the rating structure or methodology shall be considered a discontinuance under this section unless the issuer complies with the following requirements:

(1) the issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resulting rates differ from the existing rating methodology and resulting rates; and

(2) the issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

(o)(1) Except as provided in clause (2), the Minnesota experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section 62A.36;

(2) forms assumed under an assumption reinsurance agreement shall not be combined with the Minnesota experience of other forms for purposes of the refund or credit calculation.

(p) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy or certificate, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy or certificate, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy or certificate after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy or certificate shall require a signed acceptance by the insured. After the date of policy or certificate issue, a rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy or certificate term shall be agreed to in writing and signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, declaration page, or certificate. If a Medicare supplement policy or certificate contains limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "preexisting condition limitations."

Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person eligible for Medicare by reason of age shall provide to such applicants a Medicare Supplement Buyer's Guide in the form developed by the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the Buyer's Guide must be made whether or not such policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this section. Except in the case of direct response issuers, delivery of the Buyer's Guide must be made to the applicant at the time of application, and acknowledgment of receipt of the Buyer's Guide must be obtained by the issuer. Direct response issuers shall deliver the Buyer's Guide to the applicant upon request, but no later than the time at which the policy is delivered.

(q)(1) An issuer, directly or through its producers, shall:

(i) establish marketing procedures to assure that a comparison of policies by its agents or other producers will be fair and accurate;

(ii) establish marketing procedures to ensure that excessive insurance is not sold or issued;

(iii) establish marketing procedures that set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than the benefits under the replaced policy or certificate;

(iv) display prominently by type or other appropriate means, on the first page of the policy or certificate, the following:

"Notice to buyer: This policy or certificate may not cover all of your medical expenses";

(v) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of the insurance;

(vi) establish auditable procedures for verifying compliance with this paragraph;

(2) in addition to the practices prohibited in chapter 72A, the following acts and practices are prohibited:

(i) knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or issuers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer;

(ii) employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance;

(iii) making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company;

(3) the terms "Medicare supplement," "medigap," and words of similar import shall not be used unless the policy or certificate is issued in compliance with this subdivision.

(r) Each health maintenance organization, health service plan corporation, insurer, or fraternal benefit society that sells coverage that supplements Medicare coverage shall establish a separate community rate for that coverage. Beginning January 1, 1993, no

coverage that supplements Medicare or that is governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., may be offered, issued, sold, or renewed to a Minnesota resident, except at the community rate required by this paragraph.

For coverage that supplements Medicare and for the Part A rate calculation for plans governed by section 1833 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., the community rate may take into account only the following factors:

(1) actuarially valid differences in benefit designs or provider networks;

(2) geographic variations in rates if preapproved by the commissioner of commerce; and

(3) premium reductions in recognition of healthy lifestyle behaviors, including but not limited to, refraining from the use of tobacco. Premium reductions must be actuarially valid and must relate only to those healthy lifestyle behaviors that have a proven positive impact on health. Factors used by the health carrier making this premium reduction must be filed with and approved by the commissioner of commerce.

(s) Beginning January 1, 1993, a health maintenance organization that issues coverage that supplements Medicare or that issues coverage governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., must make available with each contract at least one option that includes coverage for at least 80 percent of the usual and customary charge for prescription drugs or the copayment equivalency. Each contract issued without prescription drug coverage by any insurer, health service plan corporation, health maintenance organization, or fraternal benefit society must contain, displayed prominently by type or other appropriate means, on the first page of the contract, the following:

"Notice to buyer: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs is available to you as an optional benefit."

Sec. 2. Minnesota Statutes 1990, section 62A.31, is amended by adding a subdivision to read:

Subd. 3. [DEFINITIONS.] (a) "Accident," "accidental injury," or "accidental means" means to employ "result" language and does not include words that establish an accidental means test or use words

such as "external," "violent," "visible wounds," or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under a workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(b) "Applicant" means:

(1) in the case of an individual Medicare supplement policy or certificate, the person who seeks to contract for insurance benefits; and

(2) in the case of a group Medicare supplement policy or certificate, the proposed certificate holder.

(c) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

(d) "Certificate" means a certificate delivered or issued for delivery in this state or offered to a resident of this state under a group Medicare supplement policy or certificate.

(e) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(f) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

(g) "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers. The expenses shall not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; and

(7) claims processing costs.

(h) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in the Medicare program.

(i) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery Medicare supplement policies or certificates in this state or offering these policies or certificates to residents of this state.

(j) "Medicare" shall be defined in the policy and certificate. Medicare may be defined as the Health Insurance for the Aged Act, title XVIII of the Social Security Amendments of 1965, as amended, or title I, part I, of Public Law Number 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as amended.

(k) "Medicare eligible expenses" means health care expenses covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

(l) "Medicare supplement policy or certificate" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy or certificate issued under a contract under section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., or an issued policy under a demonstration project authorized under amendments to the federal Social Security Act, which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.

(m) "Physician" shall not be defined more restrictively than as defined in the Medicare program or section 62A.04, subdivision 1, or 62A.15, subdivision 3a.

(n) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(o) "Sickness" shall not be defined more restrictively than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under a workers' compensation, occupational disease, employer's liability, or similar law.

Sec. 3. Minnesota Statutes 1990, section 62A.31, is amended by adding a subdivision to read:

Subd. 4. [PROHIBITED POLICY PROVISIONS.] A Medicare supplement policy or certificate in force in the state shall not contain benefits that duplicate benefits provided by Medicare.

Sec. 4. Minnesota Statutes 1990, section 62A.315, is amended to read:

62A.315 [EXTENDED BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.]

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

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

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

(3) coverage for the 20 percent copayment amount of Medicare eligible expenses excluding outpatient prescription drugs under Medicare part B regardless of hospital confinement for Medicare part B and coverage of the Medicare deductible amount;

(4) 80 percent of usual and customary hospital and medical expenses, supplies, and prescription drug expenses, not covered by Medicare's eligible expenses;

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

(6) 100 percent of the cost of immunizations~~.~~ and routine screening procedures for cancer, including mammograms and pap smears;

(7) preventive medical care benefit: coverage for the following preventive health services:

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

(ii) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

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

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinauria;

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

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

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

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

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

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

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

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

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

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

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

(ii) coverage requirements and limitations:

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

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

(C) coverage is limited to:

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

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

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

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

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

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

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

(iii) coverage is excluded for:

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

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

Sec. 5. Minnesota Statutes 1991 Supplement, section 62A.316, is amended to read:

62A.316 [BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.]

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

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

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

(3) coverage for the 20 percent copayment amount of Medicare eligible expenses excluding outpatient prescription drugs under Medicare part B regardless of hospital confinement for Medicare part B after the Medicare deductible amount;

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

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

(6) 100 percent of the cost of immunizations and routine screening procedures for cancer screening including mammograms and pap smears.

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

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

(2) a minimum of 80 percent of usual and customary eligible medical expenses, not to exceed any charge limitation established by the Medicare program, and supplies not covered by Medicare part B. This does not include outpatient prescription drugs;

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

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

~~Nothing in this section prohibits the plan from requiring that services be received from providers designated as preferred providers or participating providers in order to receive coverage under optional benefit riders.~~

(5) coverage for the following preventive health services:

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

(ii) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

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

(B) dipstick urinalysis for hematuria, bacteriuria, and proteinauria;

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

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

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

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

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

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

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

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

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

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

(ii) Coverage requirements and limitations:

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

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

(C) Coverage is limited to:

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

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

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

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

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

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

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

(iii) Coverage is excluded for:

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

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

Sec. 6. [62A.317] [STANDARDS FOR CLAIMS PAYMENT.]

(a) An issuer shall comply with section 1882(c)(3) of the federal Social Security Act, as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA), Public Law Number 100-203, by:

(1) accepting a notice from a Medicare carrier on duly assigned claims submitted by Medicare participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the Medicare participating physician or supplier and the beneficiary of the payment determination;

(3) paying the Medicare participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy or certificate name, number, and a central mailing address to which notices from a Medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(b) Compliance with the requirements in paragraph (a) shall be certified on the Medicare supplement insurance experience reporting form.

Sec. 7. [62A.319] [REPORTING OF MULTIPLE POLICIES.]

Subdivision 1. [ANNUAL REPORT.] On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

(1) the policy and certificate number; and

(2) the date of issuance.

Subd. 2. [NAIC REPORT FORMS.] The items in subdivision 1 must be grouped by individual policyholder and be on the National Association of Insurance Commissioners Reporting Medicare Supplement Policies form.

Sec. 8. Minnesota Statutes 1990, section 62A.36, subdivision 1, is amended to read:

Subdivision 1. [~~MINIMUM~~ LOSS ~~RATIOS~~ RATIO STANDARDS.] ~~Notwithstanding section 62A.02, subdivision 3, relating to loss ratios,~~ (a) A Medicare supplement ~~policies~~ policy form or certificate form shall not be ~~required~~ delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to ~~Minnesota~~ policyholders and certificate holders in the form of aggregate benefits ~~under the policy, for each year excluding the year of issuance and the first year thereafter, on the basis of incurred claims experience and earned premiums in Minnesota and in accordance with accepted actuarial principles and practices,~~ not including anticipated refunds or credits, provided under the policy form or certificate form:

~~(a)~~ (1) at least 75 percent of the aggregate amount of premiums ~~collected~~ earned in the case of group policies, and

~~(b)~~ (2) at least 65 percent of the aggregate amount of premiums ~~collected~~ earned in the case of individual policies~~.~~, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and prac-

tices. An insurer shall demonstrate that the third year loss ratio is greater than or equal to the applicable percentage.

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

(b) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the National Association of Insurance Commissioners Medicare Supplement Refund Calculating form, for each type of Medicare supplement benefit plan.

If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation must be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week treasury bills. A refund or credit against premiums due shall be made by September 30 following the experience year on which the refund or credit is based.

(c) An issuer of Medicare supplement policies and certificates in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy or certificate duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but before the effective date of enhance-

ments in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(1) a premium adjustment that is necessary to produce an expected loss ratio under the policy or certificate that will conform with minimum loss ratio standards for Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy or certificate other than the adjustments described herein shall be made with respect to a policy or certificate at any time other than on its renewal date or anniversary date;

(2) if an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits considered necessary to achieve the loss ratio required by this section;

(3) any appropriate riders, endorsements, or policy or certificate forms needed to accomplish the Medicare supplement insurance policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy or certificate forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(d) The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of a refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner considered appropriate by the commissioner.

Sec. 9. Minnesota Statutes 1990, section 62A.38, is amended to read:

62A.38 [NOTICE OF FREE EXAMINATION.]

Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded in full if, after examination of the policy or certificate, the insured person is not satisfied for any reason. Medicare supplement policies or certificates, issued pursuant to a direct response solicitation to persons eligible for medicare by reason of age, shall have a notice prominently printed on the first page or attached thereto stating in substance that the policyholder or certificate holder shall have the

right to return the policy or certificate within 30 days of its delivery and to have the premium refunded within ten days after receipt of the returned policy or certificate to the insurer if, after examination, the insured person is not satisfied for any reason.

Sec. 10. Minnesota Statutes 1990, section 62A.39, is amended to read:

62A.39 [DISCLOSURE.]

No individual Medicare supplement plan shall be delivered or issued in this state and no certificate shall be delivered ~~pursuant to~~ under a group Medicare supplement plan delivered or issued in this state unless an outline containing at least the following information in no less than 12-point type is delivered to the applicant at the time the application is made:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the exceptions, reductions, and limitations contained in the policy including the following language, as applicable, in bold print: "THIS POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THIS POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.";

(c) A statement of the renewal provisions including any reservations by the insurer of a right to change premiums. The premium and manner of payment shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated. If the premium is based on the increasing age of the insured, information specifying when premiums will change must be included;

(d) READ YOUR POLICY OR CERTIFICATE VERY CAREFULLY [Boldface type]. A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions. Additionally, it does not give all the details of Medicare coverage. Contact your local Social Security office or consult the Medicare handbook for more details; ~~and~~

(e) A statement of the policy's loss ratio as follows: "This policy provides an anticipated loss ratio of (..%). This means that, on the average, policyholders may expect that ($....) of every $100.00 in

premium will be returned as benefits to policyholders over the life of the contract.";

(f) When the outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.";

(g) RIGHT TO RETURN POLICY OR CERTIFICATE [Boldface type]. "If you find that you are not satisfied with your policy or certificate for any reason, you may return it to [insert issuer's address]. If you send the policy or certificate back to us within 30 days after you receive it, we will treat the policy or certificate as if it had never been issued and return all of your payments within ten days.";

(h) POLICY OR CERTIFICATE REPLACEMENT [Boldface type]. "If you are replacing another health insurance policy or certificate, do NOT cancel it until you have actually received your new policy or certificate and are sure you want to keep it.";

(i) NOTICE [Boldface type]. "This policy or certificate may not fully cover all of your medical costs."

A. [for agents:]

"Neither [insert company's name] nor its agents are connected with Medicare."

B. [for direct response:]

"[insert company's name] is not connected with Medicare."

(j) Notice regarding policies or certificates which are not Medicare supplement policies.

Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, or a policy or certificate issued pursuant to a contract under the federal Social Security Act, section 1833 or 1876 (United States Code, title 42, section 1395, et seq.), disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy; or other policy, issued for delivery in this state to persons eligible for Medicare shall

notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Medicare supplement buyer's guide available from the company."

(k) COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface type]. "When you fill out the application for the new policy or certificate, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy or certificate and refuse to pay any claims if you leave out or falsify important medical information." If the policy or certificate is guaranteed issue, this paragraph need not appear.

"Review the application carefully before you sign it. Be certain that all information has been properly recorded."

Include for each plan, prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments, and insured payments for each plan, using the same language, in the same order, using uniform layout and format.

Sec. 11. Minnesota Statutes 1990, section 62A.42, is amended to read:

62A.42 [RULEMAKING AUTHORITY.]

To carry out the purposes of sections 62A.31 to 62A.44, the commissioner may promulgate rules pursuant to chapter 14. These rules may:

(a) prescribe additional disclosure requirements for medicare supplement plans, designed to adequately inform the prospective insured of the need and extent of coverage offered;

(b) prescribe uniform policy forms in order to give the insurance purchaser a reasonable opportunity to compare the cost of insuring with various insurers and may prescribe reasonable measures as necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations; and

(c) establish other reasonable standards to further the purpose of sections 62A.31 to 62A.44.

Sec. 12. Minnesota Statutes 1990, section 62A.436, is amended to read:

62A.436 [COMMISSIONS.]

The commission, sales allowance, service fee, or compensation to an agent for the sale of a Medicare supplement plan must be the same for each of the first four years of the policy. The commissioner may grant a waiver of this restriction on commissions when the commissioner believes that the insurer's fee structure does not encourage deceptive practices.

In no event may the rate of commission, sales allowance, service fee, or compensation for the sale of a basic Medicare supplement plan exceed that which applies to the sale of an extended basic Medicare supplement plan.

For purposes of this section, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, awards, and finder's fees.

This section also applies to sales of replacement policies.

Sec. 13. Minnesota Statutes 1990, section 62A.44, is amended to read:

62A.44 [APPLICATIONS.]

Subdivision 1. [APPLICANT COPY.] No individual medicare supplement plan shall be issued or delivered in this state unless a signed and completed copy of the application for insurance is left with the applicant at the time application is made.

Subd. 2. [QUESTIONS.] (a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing the questions and statements may be used.

"(1) You do not need more than one Medicare supplement policy or certificate.

(2) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy or certificate.

(3) The benefits and premiums under your Medicare supplement policy or certificate will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy or certificate will be reinstated if requested within 90 days of losing Medicaid eligibility.

To the best of your knowledge:

(1) Do you have another Medicare supplement policy or certificate in force, including health care service contract or health maintenance organization contract? If so, with which company?

(2) Do you have any other health insurance policies that provide benefits that this Medicare supplement policy or certificate would duplicate? (a) If so, with which company?

(3) If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy or certificate?

(4) Are you covered by Medicaid?"

(b) Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold that are still in force.

(2) List policies sold in the past five years that are no longer in force.

(c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer on delivery of the policy or certificate.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, before issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy or certificate the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by paragraph (d) for an issuer shall be provided in substantially the following form in no less than 12-point type:

"NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy or certificate to be issued by [Company Name] Insurance Company. Your new policy or certificate will provide 30 days within which you may decide without cost whether you desire to keep the policy or certificate.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, AGENT, [BROKER OR OTHER REPRESENTATIVE]: I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy or certificate is being purchased for the following reason(s) (check one):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ Other (please specify)

_____

_____

_____

(1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under

the new policy or certificate. This could result in denial or delay of a claim for benefits under the new policy or certificate, whereas a similar claim might have been payable under your present policy or certificate.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent the time was spent (depleted) under the original policy or certificate.

(3) If you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy or certificate until you have received your new policy or certificate and are you sure that you want to keep it.

_____

(Signature of Agent, Broker, or Other Representative)*

_____

[Typed Name and Address of Issuer, Agent, or Broker]

_____

(Date)

_____

(Applicant's Signature)

_____

(Date)

*Signature not required for direct response sales."

(f) Paragraph (e), clauses (1) and (2), of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

Sec. 14. Minnesota Statutes 1990, section 62E.07, is amended to read:

62E.07 [QUALIFIED MEDICARE SUPPLEMENT PLAN.]

Any plan which provides benefits ~~to persons over the age of 65 years~~ may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 100 percent of the deductibles required under Medicare and 80 percent of the charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by Medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services. ~~The coverage may be subject to a maximum lifetime benefit of not less than $500,000.~~

Sec. 15. Minnesota Statutes 1991 Supplement, section 62E.10, subdivision 9, is amended to read:

Subd. 9. [EXPERIMENTAL DELIVERY METHOD.] The association may petition the commissioner of commerce for a waiver to allow the experimental use of alternative means of health care delivery. The commissioner may approve the use of the alternative means the commissioner considers appropriate. The commissioner may waive any of the requirements of this chapter and chapters 60A, 62A, and 62D in granting the waiver. The commissioner may also grant to the association any additional powers as are necessary to facilitate the specific waiver, including the power to implement a provider payment schedule.

This subdivision is effective until August 1, ~~1992~~ 1993.

Sec. 16. Minnesota Statutes 1991 Supplement, section 62E.12, is amended to read:

62E.12 [MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLAN.]

The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan, and a number two qualified plan, except that the maximum lifetime benefit on these plans shall be $1,000,000, and

~~basic and~~ an extended basic plan and a basic Medicare ~~supplement plans~~ plan as described in sections 62A.31 to 62A.44 and 62E.07. The requirement that a policy issued by the association must be a qualified plan is satisfied if the association contracts with a preferred provider network and the level of benefits for services provided within the network satisfies the requirements of a qualified plan. If the association uses a preferred provider network, payments to nonparticipating providers must meet the minimum requirements of section 72A.20, subdivision 15. They shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier. Notwithstanding the provisions of section 62E.06 the state plan shall exclude coverage of services of a private duty nurse other than on an inpatient basis and any charges for treatment in a hospital located outside of the state of Minnesota in which the covered person is receiving treatment for a mental or nervous disorder, unless similar treatment for the mental or nervous disorder is medically necessary, unavailable in Minnesota and provided upon referral by a licensed Minnesota medical practitioner.

Sec. 17. [FEDERAL CHANGES.]

If the federal government requires additions or changes for compliance with any provisions of this act that are required by the federal Omnibus Budget Reconciliation Act of 1990, Public Law Number 101-508, the commissioner may by order make those additions or changes. Before issuing an order, the commissioner shall notify the appropriate policy committees of the legislature of the additions or changes.

Sec. 18. [EFFECTIVE DATE.]

Sections 1 to 14 and 17 are effective the day following final enactment and apply to policies or certificates issued before and after that date. Sections 15 and 16 are effective the day following final enactment.

ARTICLE 2

Section 1. [62A.318] [MEDICARE SELECT POLICIES AND CERTIFICATES.]

(a) This section applies to Medicare select policies and certificates, as defined in this section, including those issued by health maintenance organizations. No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

(b) For the purposes of this section:

(1) "complaint" means any dissatisfaction expressed by an individual concerning a Medicare select issuer or its network providers;

(2) "grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare select issuer or its network providers;

(3) "Medicare select issuer" means an issuer offering, or seeking to offer, a Medicare select policy or certificate;

(4) "Medicare select policy" or "Medicare select certificate" means a Medicare supplement policy or certificate that contains restricted network provisions;

(5) "network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy or certificate;

(6) "restricted network provision" means a provision that conditions the payment of benefits, in whole or in part, on the use of network providers; and

(7) "service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare select policy or certificate.

(c) The commissioner may authorize an issuer to offer a Medicare select policy or certificate pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, Public Law Number 101-508, if the commissioner finds that the issuer has satisfied all of the requirements of this section.

(d) A Medicare select issuer shall not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(e) A Medicare select issuer shall file a proposed plan of operation with the commissioner, in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(i) the services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availabil-

ity of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

(ii) the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(A) to deliver adequately all services that are subject to a restricted network provision; or

(B) to make appropriate referrals;

(iii) there are written agreements with network providers describing specific responsibilities;

(iv) emergency care is available 24 hours per day and seven days per week; and

(v) in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against an individual insured under a Medicare select policy or certificate. This section does not apply to supplemental charges or coinsurance amounts as stated in the Medicare select policy or certificate;

(2) a statement or map providing a clear description of the service area;

(3) a description of the grievance procedure to be used;

(4) a description of the quality assurance program, including:

(i) the formal organizational structure;

(ii) the written criteria for selection, retention, and removal of network providers; and

(iii) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted;

(5) a list and description, by specialty, of the network providers;

(6) copies of the written information proposed to be used by the issuer to comply with paragraph (i); and

(7) any other information requested by the commissioner.

(f) A Medicare select issuer shall file proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner before implementing the changes. The changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

An updated list of network providers shall be filed with the commissioner at least quarterly.

(g) A Medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or condition; and

(2) it is not reasonable to obtain the services through a network provider.

(h) A Medicare select policy or certificate shall provide payment for full coverage under the policy or certificate for covered services that are not available through network providers.

(i) A Medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare select policy or certificate to each applicant. This disclosure must include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate with:

(i) other Medicare supplement policies or certificates offered by the issuer; and

(ii) other Medicare select policies or certificates;

(2) a description, including address, phone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are used;

(4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

(7) a description of the Medicare select issuer's quality assurance program and grievance procedure.

(j) Before the sale of a Medicare select policy or certificate, a Medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to paragraph (i) and that the applicant understands the restrictions of the Medicare select policy or certificate.

(k) A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure must be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances must be considered in a timely manner and must be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action must be taken promptly.

(5) All concerned parties must be notified about the results of a grievance.

(6) The issuer shall report no later than March 31 of each year to the commissioner regarding the grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of the grievances.

(l) At the time of initial purchase, a Medicare select issuer shall make available to each applicant for a Medicare select policy or certificate the opportunity to purchase a Medicare supplement policy or certificate otherwise offered by the issuer.

(m)(1) At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that

has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare supplement policy or certificate has been in force for six months. If the issuer does not have available for sale a policy or certificate without restrictive network provisions, the issuer shall provide enrollment information for the Minnesota comprehensive health association Medicare supplement plans.

(2) For the purposes of this paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for part B excess charges.

(n) Medicare select policies and certificates shall provide for continuation of coverage if the secretary of health and human services determines that Medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare select program to be reauthorized under law or its substantial amendment.

(1) Each Medicare select issuer shall make available to each individual insured under a Medicare select policy or certificate the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for part B excess charges.

(o) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare select program.

(p) Medicare select policies and certificates under this section shall be regulated and approved by the department of commerce.

(q) Medicare select policies and certificates must be either a basic

plan or an extended basic plan. The basic plan may also include any of the optional benefit riders authorized by section 62A.316. Preventive care provided by Medicare select policies or certificates must be provided as set forth in section 62A.315 or 62A.316, except that the benefits are as defined in chapter 62D.

(r) Medicare select policies and certificates are exempt from the requirements of section 62A.31, subdivision 1, paragraph (d). This paragraph expires January 1, 1994.

Sec. 2. [EFFECTIVE DATE.]

Section 1 is effective July 30, 1992, and applies to policies or certificates issued on or after that date."

Delete the title and insert:

"A bill for an act relating to insurance; regulating Medicare supplement; making various changes in state law required by the federal government; regulating coverages and practices; regulating the Minnesota comprehensive health association; increasing the maximum lifetime benefit amounts of certain state plan coverages; extending the effective date of the authorization of use of experimental delivery methods; amending Minnesota Statutes 1990, sections 62A.31, by adding subdivisions; 62A.315; 62A.36, subdivision 1; 62A.38; 62A.39; 62A.42; 62A.436; 62A.44; and 62E.07; Minnesota Statutes 1991 Supplement, sections 62A.31, subdivision 1; 62A.316; 62E.10, subdivision 9; and 62E.12; proposing coding for new law in Minnesota Statutes, chapter 62A."

With the recommendation that when so amended the bill pass.

The report was adopted.

Murphy from the Committee on Energy to which was referred:

H. F. No. 1931, A bill for an act relating to energy; providing incentives for the use of renewable sources of electric energy; exempting wind energy conversion systems from sales taxation; amending Minnesota Statutes 1990, section 297A.25, by adding a subdivision.

Reported the same back with the following amendments:

Page 1, line 14, delete "1991" and insert "1992"

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Taxes.

The report was adopted.

Skoglund from the Committee on Financial Institutions and Insurance to which was referred:

H. F. No. 2099, A bill for an act relating to insurance; auto; requiring insurers to fully reimburse insureds for deductible amounts before retaining subrogation proceeds; specifying related rights of insureds; amending Minnesota Statutes 1991 Supplement, section 72A.201, subdivision 6.

Reported the same back with the following amendments:

Page 1, before line 8, insert:

"Section 1. Minnesota Statutes 1990, section 72A.20, subdivision 23, is amended to read:

Subd. 23. [DISCRIMINATION IN AUTOMOBILE INSURANCE POLICIES.] (a) No insurer that offers an automobile insurance policy in this state shall:

(1) use the employment status of the applicant as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason.

(b) No insurer that offers an automobile insurance policy in this state shall:

(1) use the applicant's status as a tenant, as the term is defined in section 566.18, subdivision 2, as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason.

(c) No insurer that offers an automobile insurance policy in this state shall:

(1) use the failure of the applicant to have an automobile policy in force during any period of time before the application is made as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason.

This provision does not apply if the applicant was required by law to maintain automobile insurance coverage and failed to do so.

An insurer may require reasonable proof that the applicant did not fail to maintain this coverage. The insurer is not required to accept the mere lack of a conviction or citation for failure to maintain this coverage as proof of failure to maintain coverage.

(d) No insurer that offers an automobile insurance policy in this state shall use an applicant's prior no-fault claims history as an underwriting standard or guideline if the applicant was 50 percent or less negligent in the accident or accidents causing the claims."

Page 3, lines 19 to 24, reinstate the stricken language and delete the new language

Page 5, line 10, delete "Section 1 is" and insert "Sections 1 and 2 are" and delete "applies" and insert "apply"

Renumber the sections in sequence

Amend the title as follows:

Page 1, line 2, after "auto;" insert "prohibiting discrimination in automobile insurance policies;"

Page 1, line 5, after "amending" insert "Minnesota Statutes 1990, section 72A.20, subdivision 23;"

With the recommendation that when so amended the bill pass.

The report was adopted.

Anderson, I., from the Committee on Local Government and Metropolitan Affairs to which was referred:

H. F. No. 2115, A bill for an act relating to partition fences; providing for apportionment of cost of a partition fence; amending Minnesota Statutes 1990, sections 344.03, subdivision 1; and 344.06.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 1990, section 344.03, subdivision 1, is amended to read:

Subdivision 1. [ADJOINING OWNERS.] If all or a part of adjoining Minnesota land is improved and used, and one or both of the owners of the land desires the land to be partly or totally fenced, the land owners or occupants shall build and maintain a partition fence between their lands in equal shares, except that no landowner or occupant shall be required to pay any share of the construction or maintenance of a partition fence if that landowner or occupant has no need for a fence. If the landowners or occupants disagree about the need for a fence, it is a controversy under section 344.06.

Sec. 2. Minnesota Statutes 1990, section 344.06, is amended to read:

344.06 [CONTROVERSY; DECISION BY FENCE VIEWERS.]

If a controversy arises concerning the rights in partition fences of the respective occupants or their obligation to erect or maintain the fences, either party may apply to the fence viewers, who, after due notice to the parties, may assign to each a share, or no share, in the fence and direct the time within which the fence must be erected or repaired. If in the fence viewer's opinion an assignment of shares is appropriate the shares shall be assigned in accordance with the need and benefit of each party. The assignment, unless appealed, may be filed for record with the county recorder after which it is binding upon the parties and upon all succeeding occupants of the lands."

With the recommendation that when so amended the bill pass and be placed on the Consent Calendar.

The report was adopted.

Vellenga from the Committee on Judiciary to which was referred:

H. F. No. 2160, A bill for an act relating to family law; modifying provisions dealing with the administration, computation, and enforcement of child support; modifying visitation provisions; imposing penalties; appropriating money; amending Minnesota Statutes 1990, sections 257.67, subdivision 3; 357.021, subdivision 1a; 518.003, subdivision 3; 518.14; 518.171, subdivisions 1, 3, 4, 5, 6, 7, and 9; 518.175, subdivision 1; 518.54, subdivision 4; 518.551, subdivisions 1, 7, and 10, and by adding subdivisions; 518.57, subdivision 1, and by adding subdivisions; 518.611, subdivision 4; 548.091, subdivision 1a; 588.20; and 609.375, subdivisions 1 and 2; Minnesota Statutes 1991 Supplement, sections 214.101, subdivision 1; 357.021, subdivision 2; 518.551, subdivisions 5 and 12; and 518.64, subdivisions 1, 2, and 5; proposing coding for new law in Minnesota Statutes, chapters 16B and 518; repealing Minnesota Statutes 1990, section 609.37.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"ARTICLE 1

COMPUTATION AND ENFORCEMENT OF SUPPORT

Section 1. [16B.091] [CONTRACTS; COMPLIANCE WITH CHILD SUPPORT ORDERS.]

A state agency may not enter into, extend, or renew a contract with an individual unless the individual submits a verified statement that the individual is not under a court-ordered obligation to pay child support or that the individual is in good standing with respect to a court-ordered child support obligation. For purposes of this section, an individual is in good standing if:

(1) no arrearages are owed with respect to a child support obligation;

(2) the individual has a motion pending with respect to modification of child support and liability for arrearages; or

(3) the individual is complying with a court-ordered repayment plan for arrearages.

Sec. 2. Minnesota Statutes 1991 Supplement, section 214.101, subdivision 1, is amended to read:

Subdivision 1. [COURT ORDER; HEARING ON SUSPENSION.] (a) For purposes of this section, "licensing board" means a licensing board or other state agency that issues an occupational license.

(b) If a licensing board receives an order from a court under section 518.551, subdivision 12, dealing with suspension of a license of a person found by the court to be in arrears in child support payments, the board shall, within 30 days of receipt of the court order, provide notice to the licensee and hold a hearing. If the board finds that the person is licensed by the board and evidence of full payment of arrearages found to be due by the court is not presented at the hearing, the board shall suspend the license unless it determines that probation is appropriate under subdivision 2. The only issues to be determined by the board are whether the person named in the court order is a licensee, whether the arrearages have been paid, and whether suspension or probation is appropriate. The board may not consider evidence with respect to the appropriateness of the court order or the ability of the person to comply with the order. The board may not lift the suspension until the licensee files

with the board proof showing that the licensee is current in child support payments.

Sec. 3. Minnesota Statutes 1990, section 257.67, subdivision 3, is amended to read:

Subd. 3. Willful failure to obey the judgment or order of the court is a ~~civil~~ contempt of the court. All remedies for the enforcement of judgments apply including those available under chapters 518 and 518C and sections ~~518C.01 to 518C.36 and~~ 256.871 to 256.878.

Sec. 4. Minnesota Statutes 1990, section 518.14, is amended to read:

518.14 [COSTS AND DISBURSEMENTS AND ATTORNEY FEES.]

In a proceeding under this chapter, the court shall award attorney fees, costs, and disbursements in an amount necessary to enable a party to carry on or contest the proceeding, provided it finds:

(1) that the fees are necessary for the good-faith assertion of the party's rights in the proceeding and will not contribute unnecessarily to the length and expense of the proceeding;

(2) that the party from whom fees, costs, and disbursements are sought has the means to pay them; and

(3) that the party to whom fees, costs, and disbursements are awarded does not have the means to pay them.

Nothing in this section precludes the court from awarding, in its discretion, additional fees, costs, and disbursements against a party who unreasonably contributes to the length or expense of the proceeding. Fees, costs, and disbursements provided for in this section may be awarded at any point in the proceeding, including a modification proceeding under section 518.64. The court may adjudge costs and disbursements against either party. The court may authorize the collection of money awarded by execution, or out of property sequestered, or in any other manner within the power of the court. An award of attorney's fees made by the court during the pendency of the proceeding or in the final judgment survives the proceeding and if not paid by the party directed to pay the same may be enforced as above provided or by a separate civil action brought in the attorney's own name. If the proceeding is dismissed or abandoned prior to determination and award of attorney's fees, the court may nevertheless award attorney's fees upon the attorney's motion. The award shall also survive the proceeding and may be enforced in the same manner as last above provided.

Sec. 5. Minnesota Statutes 1990, section 518.171, subdivision 1, is amended to read:

Subdivision 1. [ORDER.] ~~Unless the obligee has comparable or~~ The court shall order the parent who has better group dependent health insurance coverage available ~~at a more reasonable cost, the court shall order the obligor,~~ after considering cost, to name the minor child as beneficiary on any health and dental insurance plan that is available to the ~~obligor~~ parent on a group basis or through an employer or union. If only one parent has such coverage available, the court shall order that parent to name the minor child as beneficiary. "Health insurance coverage" as used in this section does not include medical assistance provided under chapter 256, 256B, or 256D.

If the court finds that dependent health or dental insurance is not available to ~~the obligor~~ either parent on a group basis or through an employer or union, or that the group insurer is not accessible to the ~~obligee~~ custodial parent, the court may require ~~the obligor~~ either parent to obtain dependent health or dental insurance, ~~or to be liable for reasonable and necessary medical or dental expenses of the child~~.

~~If the court finds that the dependent health or dental insurance required to be obtained by the obligor does not pay all the reasonable and necessary medical or dental expenses of the child, or that the dependent health or dental insurance available to the obligee does not pay all the reasonable and necessary medical or dental expenses of the child, and the court finds that the obligor has the financial ability to contribute to the payment of these medical or dental expenses, the court shall require the obligor to be liable for all or a portion of the medical or dental expenses of the child not covered by the required health or dental plan.~~ If the court awards child support in the guidelines amount, the parents shall contribute equally to the cost of the premium for the child and the cost of medical or dental expenses of the child not covered by health or dental insurance. If the court awards child support in a lesser amount, the court shall allocate the cost of the premium for the child and the cost of any medical or dental expenses of the child not covered by health or dental insurance to each parent in proportion to the parent's share, after the transfer of child support, of the total combined net incomes of the parents.

Sec. 6. Minnesota Statutes 1990, section 518.171, subdivision 3, is amended to read:

Subd. 3. [IMPLEMENTATION.] (a) Upon the entry of an order for insurance coverage under this section, the court shall mail a copy of the ~~court~~ order ~~for insurance coverage shall be forwarded~~ to the ~~obligor's~~ employer or union ~~by the obligee or the public authority~~

~~responsible for support enforcement only when ordered by the court or when the following conditions are met:~~

~~(1) the obligor fails to provide written proof to the obligee or the public authority, within 30 days of receiving effective notice of the court order, that the insurance has been obtained or that application for insurability has been made;~~

~~(2) the obligee or the public authority serves written notice of its intent to enforce medical support on the obligor by mail at the obligor's last known post office address; and~~

~~(3) the obligor fails within 15 days after the mailing of the notice to provide written proof to the obligee or the public authority that the insurance coverage existed as of the date of mailing~~ of the parent who is responsible for the insurance coverage, if insurance is available to the parent on a group basis. The employer or union shall forward a copy of the order to the health and dental insurance plan offered by the employer.

Sec. 7. Minnesota Statutes 1990, section 518.171, subdivision 4, is amended to read:

Subd. 4. [EFFECT OF ORDER.] The order is binding on the employer or union and the health and dental insurance plan when service under subdivision 3 has been made. Upon receipt of the order, ~~or upon application of the obligor pursuant to the order,~~ the employer or union and its health and dental insurance plan shall enroll the minor child as a beneficiary in the group insurance plan and withhold any required premium from the obligor's income or wages. If more than one plan is offered by the employer or union, the child shall be enrolled in the insurance plan in which the obligor is enrolled or the least costly plan otherwise available to the obligor that is comparable to a number two qualified plan. An employer or union that fails to comply with the order for 30 or more days is subject to contempt of court. Failure of the obligor to execute any documents necessary to enroll the dependent in the group health and dental insurance plan will not affect the obligation of the employer or union and group health and dental insurance plan to enroll the dependent in a plan for which other eligibility requirements are met. Information and authorization provided by the public authority responsible for child support enforcement, or by the custodial parent or guardian, is valid for the purposes of meeting enrollment requirements of the health plan. The insurance coverage for a child eligible under subdivision 5 shall not be terminated except as authorized in subdivision 5.

Sec. 8. Minnesota Statutes 1990, section 518.171, subdivision 6, is amended to read:

Subd. 6. [INSURER REIMBURSEMENT; CORRESPONDENCE

AND NOTICE.] (a) The signature of the custodial parent of the insured dependent is a valid authorization to the insurer for purposes of processing an insurance reimbursement payment to the provider of the medical services. If a parent makes a payment for medical services for which reimbursement is required, the insurer shall pay the reimbursement directly to the parent who made the payment.

(b) The insurer shall send copies of all correspondence regarding the insurance coverage to both parents. When an order for dependent insurance coverage is in effect and the obligor's employment is terminated, or the insurance coverage is terminated, the insurer shall notify the obligee within ten days of the termination date with notice of conversion privileges.

Sec. 9. [518.173] [CHILD CARE EXPENSES.]

If, at the time a child support order is entered, joint physical custody of the child is not ordered and the party who has physical custody has work-related child care expenses, the court shall allocate the cost of work-related child care to each parent in proportion to each parent's share, after the transfer of child support, of the total combined net incomes of the parents.

Sec. 10. Minnesota Statutes 1990, section 518.175, subdivision 1, is amended to read:

Subdivision 1. In all proceedings for dissolution or legal separation, subsequent to the commencement of the proceeding and continuing thereafter during the minority of the child, the court shall, upon the request of either parent, grant such rights of visitation on behalf of ~~the~~ each child and noncustodial parent as will enable the child and the noncustodial parent to maintain a child to parent relationship that will be in the best interests of the child. In particular, the court shall consider the need of each child to spend time alone with each parent. If the court finds, after a hearing, that visitation is likely to endanger ~~the~~ any child's physical or emotional health or impair ~~the~~ any child's emotional development, the court shall restrict visitation by the noncustodial parent with that child as to time, place, duration, or supervision and may deny visitation entirely, as the circumstances warrant. The court shall consider the age of ~~the~~ each child and ~~the~~ each child's relationship with the noncustodial parent prior to the commencement of the proceeding. A parent's failure to pay support because of the parent's inability to do so shall not be sufficient cause for denial of visitation.

Sec. 11. Minnesota Statutes 1990, section 518.54, subdivision 4, is amended to read:

Subd. 4. [SUPPORT MONEY; CHILD SUPPORT.] "Support money" or "child support" means:

(1) an award in a dissolution, legal separation, ~~or~~ annulment, or parentage proceeding for the care, support and education of any child of the marriage or of the parties to the ~~annulment~~ proceeding; or

(2) a contribution by parents ordered under section 256.87.

"Support money" or "child support" includes interest on arrearages under section 23.

Sec. 12. Minnesota Statutes 1990, section 518.551, subdivision 1, is amended to read:

Subdivision 1. [SCOPE; PAYMENT TO PUBLIC AGENCY.] (a) This section applies to all proceedings involving an award of the child support.

(b) The court shall direct that all payments ordered for maintenance and support be made to the public agency responsible for child support enforcement so long as the obligee is receiving or has applied for public assistance, or has applied for child support and maintenance collection services. Public authorities responsible for child support enforcement may act on behalf of other public authorities responsible for child support enforcement. This includes the authority to represent the legal interests of or execute documents on behalf of the other public authority in connection with the establishment, enforcement, and collection of child support, maintenance, or medical support, and collection on judgments. Amounts received by the public agency responsible for child support enforcement greater than the amount granted to the obligee shall be remitted to the obligee.

Sec. 13. Minnesota Statutes 1991 Supplement, section 518.551, subdivision 5, is amended to read:

Subd. 5. [NOTICE TO PUBLIC AUTHORITY; GUIDELINES.] (a) The petitioner shall notify the public authority of all proceedings for dissolution, legal separation, determination of parentage or for the custody of a child, if either party is receiving aid to families with dependent children or applies for it subsequent to the commencement of the proceeding. After receipt of the notice, the court shall set child support as provided in this subdivision. The court may order either or both parents owing a duty of support to a child of the marriage to pay an amount reasonable or necessary for the child's support, without regard to marital misconduct. The court shall approve a child support stipulation of the parties if each party is represented by independent counsel, unless the stipulation does not meet the conditions of paragraph (h). In other cases the court shall determine and order child support in a specific dollar amount in accordance with the guidelines and the other factors set forth in paragraph (b) and any departure therefrom. The court may also

order the obligor to pay child support in the form of a percentage share of the obligor's net bonuses, commissions, or other forms of compensation, in addition to, or if the obligor receives no base pay, in lieu of, an order for a specific dollar amount.

(b) The court shall derive a specific dollar amount by multiplying the obligor's net income by the percentage indicated by the following guidelines:

Net Income Per Month of Obligor	Number of Children						
	1	2	3	4	5	6	7 or more
$400 and Below	Order based on the ability of the obligor to provide support at these income levels, or at higher levels, if the obligor has the earning ability.						
$401– 500	14%	17%	20%	22%	24%	26%	28%
$501– 550	15%	18%	21%	24%	26%	28%	30%
$551– 600	16%	19%	22%	25%	28%	30%	32%
$601– 650	17%	21%	24%	27%	29%	32%	34%
$651– 700	18%	22%	25%	28%	31%	34%	36%
$701– 750	19%	23%	27%	30%	33%	36%	38%
$751– 800	20%	24%	28%	31%	35%	38%	40%
$801– 850	21%	25%	29%	33%	36%	40%	42%
$851– 900	22%	27%	31%	34%	38%	41%	44%
$901– 950	23%	28%	32%	36%	40%	43%	46%
$951–1000	24%	29%	34%	38%	41%	45%	48%
$1001–4000 10,000	25%	30%	35%	39%	43%	47%	50%

Guidelines for support for an obligor with a monthly income of ~~$4,001~~ $10,000 or more shall be the same dollar amounts as provided for in the guidelines for an obligor with a monthly income of ~~$4,000~~ $10,000. The court may apply the guideline percentages for net monthly incomes of $1,001 to $10,000 to any portion of net monthly income in excess of $10,000, but the rebuttable presumption in paragraph (i) does not apply to this additional amount.

Net Income defined as:

Total monthly income less

*(i) Federal Income Tax

*(ii) State Income Tax

(iii) Social Security Deductions

(iv) Reasonable Pension Deductions

*Standard Deductions apply—use of tax tables recommended	(v)	Union Dues
	(vi)	Cost of Dependent Health Insurance Coverage
	(vii)	Cost of Individual or Group Health/ Hospitalization Coverage or an Amount for Actual Medical Expenses
	(viii)	A Child Support or Maintenance Order that is Currently Being Paid.

"Net income" does not include:

(1) the income of the obligor's spouse, but does include in-kind payments received by the obligor in the course of employment, self-employment, or operation of a business if the payments reduce the obligor's living expenses; or

(2) compensation received by a party for employment in excess of a 40-hour work week, provided that:

(i) support is nonetheless ordered in an amount at least equal to the guidelines amount based on income not excluded under this clause; and

(ii) the party demonstrates, and the court finds, that:

(A) the excess employment began after the filing of the petition for dissolution;

(B) the excess employment reflects an increase in the work schedule or hours worked over that of the two years immediately preceding the filing of the petition;

(C) the excess employment is voluntary and not a condition of employment;

(D) the excess employment is in the nature of additional, part-time or overtime employment compensable by the hour or fraction of an hour; and

(E) the party's compensation structure has not been changed for the purpose of affecting a support or maintenance obligation.

~~(b)~~ (c) In addition to the child support guidelines, the court shall take into consideration the following factors in setting or modifying child support:

(1) all earnings, income, and resources of the parents, including real and personal property, but excluding income from excess employment of the obligor or obligee that meets the criteria of paragraph ~~(a)~~ (b), clause (2)(ii);

(2) the financial needs and resources, physical and emotional condition, and educational needs of the child or children to be supported;

(3) the standards of living the child would have enjoyed had the marriage not been dissolved, but recognizing that the parents now have separate households;

(4) ~~the amount of the aid to families with dependent children grant for the child or children;~~

~~(5)~~ which parent receives the income taxation dependency exemption and what financial benefit the parent receives from it; ~~and~~

~~(6)~~ (5) the parents' debts as provided in paragraph ~~(c)~~ (d); and

(6) existing or anticipated extraordinary medical expenses of the child.

~~(c)~~ (d) In establishing or modifying a support obligation, the court may consider debts owed to private creditors, but only if:

(1) the right to support has not been assigned under section 256.74;

(2) the court determines that the debt was reasonably incurred for necessary support of the child or parent or for the necessary generation of income. If the debt was incurred for the necessary generation of income, the court shall consider only the amount of debt that is essential to the continuing generation of income; and

(3) the party requesting a departure produces a sworn schedule of the debts, with supporting documentation, showing goods or services purchased, the recipient of them, the amount of the original debt, the outstanding balance, the monthly payment, and the number of months until the debt will be fully paid.

~~(d)~~ (e) Any schedule prepared under paragraph ~~(c)~~ (d), clause (3), shall contain a statement that the debt will be fully paid after the number of months shown in the schedule, barring emergencies beyond the party's control.

~~(e)~~ (f) Any further departure below the guidelines that is based on a consideration of debts owed to private creditors shall not exceed 18 months in duration, after which the support shall increase automatically to the level ordered by the court. Nothing in this section shall be construed to prohibit one or more step increases in support to reflect debt retirement during the 18-month period.

~~(f) Where~~ (g) If payment of debt is ordered pursuant to this section, the payment shall be ordered to be in the nature of child support.

~~(g)~~ (h) Nothing shall preclude the court from receiving evidence on the above factors to determine if the guidelines should be exceeded or modified in a particular case.

~~(h)~~ (i) The guidelines in this subdivision are a rebuttable presumption and shall be used in all cases when establishing or modifying child support. If the court does not deviate from the guidelines, the court shall make written findings concerning the amount of the obligor's income used as the basis for the guidelines calculation and any other significant evidentiary factors affecting the determination of child support. If the court deviates from the guidelines, the court shall make written findings giving the reasons for the deviation and shall specifically address the criteria in paragraph ~~(b)~~ (c) and how the deviation serves the best interest of the child. The provisions of this paragraph apply whether or not the parties are each represented by independent counsel and have entered into a written agreement. The court shall review stipulations presented to it for conformity to the guidelines and the court is not required to conduct a hearing, but the parties shall provide the documentation of earnings required under subdivision 5b.

(j) Under no circumstances shall the fact that the obligee receives public assistance be grounds for the court to depart downward from the applicable child support amount calculated under paragraph (b).

Sec. 14. Minnesota Statutes 1990, section 518.551, is amended by adding a subdivision to read:

Subd. 5d. [EDUCATION TRUST FUND.] If the child support order provides the child with a reasonable standard of living, the parties may agree to designate a sum of money as a trust fund for the costs of post-secondary education. The court shall advise parties that this option is available and that they may wish to consult an attorney concerning the creation of a trust. The state court administrator, in consultation with attorneys experienced in trust law, shall prepare a

model trust instrument which the court administrator shall provide to parties who have minor children.

Sec. 15. Minnesota Statutes 1991 Supplement, section 518.551, subdivision 12, is amended to read:

Subd. 12. [OCCUPATIONAL LICENSE SUSPENSION.] Upon petition of an obligee or public agency responsible for child support enforcement, if the court finds that the obligor is in arrears in court-ordered child support payments, the court may provide for suspension of licenses as provided in this subdivision. If the court finds that the obligor is or may be licensed by a licensing board listed in section 214.01 and the obligor is in arrears in court-ordered child support payments or by any other state agency that issues an occupational license, the court may direct the licensing board or other licensing agency to conduct a hearing under section 214.101 concerning suspension of the obligor's license. If the obligor is a licensed attorney, the court may report the matter to the lawyers professional responsibility board for appropriate action in accordance with the rules of professional conduct.

The remedy under this subdivision is in addition to any other enforcement remedy available to the court.

Sec. 16. Minnesota Statutes 1990, section 518.57, subdivision 1, is amended to read:

Subdivision 1. [ORDER.] Upon a decree of dissolution, legal separation, or annulment, the court shall make a further order which is just and proper concerning the maintenance of the minor children as provided by section 518.551, and for the maintenance of any child of the parties as defined in section 518.54, as support money, and. The court may make the same any child support order a lien or charge upon the property of the parties to the proceeding, or either of them obligor, either at the time of the entry of the judgment or by subsequent order upon proper application.

Sec. 17. Minnesota Statutes 1990, section 518.57, is amended by adding a subdivision to read:

Subd. 4. [OTHER CUSTODIANS.] If a child resides with a person other than a parent and the court approves of the custody arrangement, the court may order child support payments to be made to the custodian regardless of whether the person has legal custody.

Sec. 18. [518.585] [NOTICE OF INTEREST ON LATE CHILD SUPPORT.]

Any judgment or decree of dissolution or legal separation containing a requirement of child support and any determination of

parentage, order under chapter 518C, order under section 256.87, or order under section 260.251 must include a notice to the parties that section 23 provides for interest to begin accruing on a payment or installment of child support whenever the unpaid amount due is greater than the current support due.

Sec. 19. Minnesota Statutes 1990, section 518.611, subdivision 4, is amended to read:

Subd. 4. [EFFECT OF ORDER.] (a) Notwithstanding any law to the contrary, the order is binding on the employer, trustee, payor of the funds, or financial institution when service under subdivision 2 has been made. Withholding must begin no later than the first pay period that occurs after 14 days following the date of the notice. In the case of a financial institution, preauthorized transfers must occur in accordance with a court-ordered payment schedule. An employer, payor of funds, or financial institution in this state is required to withhold income according to court orders for withholding issued by other states or territories. The payor shall withhold from the income payable to the obligor the amount specified in the order and amounts required under subdivision 2 and section 518.613 and shall remit, within ten days of the date the obligor is paid the remainder of the income, the amounts withheld to the public authority. The payor shall identify on the remittance information the date the obligor is paid the remainder of the income. The obligor is deemed to have paid the amount withheld as of the date the obligor received the remainder of the income. The financial institution shall execute preauthorized transfers from the deposit accounts of the obligor in the amount specified in the order and amounts required under subdivision 2 as directed by the public authority responsible for child support enforcement.

(b) Employers may combine all amounts withheld from one pay period into one payment to each public authority, ~~but~~ or one payment for all public authorities made to a public authority in a county designated by the commissioner of human services. The employer shall separately identify each obligor making payment in accordance with information required by the commissioner of human services. The combined payment must be accompanied by a fee of $1 for each obligor included in the payment, which must be deposited in the county treasury of the county designated by the commissioner of human services and credited to the county general fund. Amounts received by the public authority which are in excess of public assistance expended for the party or for a child shall be remitted to the party.

(c) An employer shall not discharge, or refuse to hire, or otherwise discipline an employee as a result of a wage or salary withholding authorized by this section. The employer or other payor of funds shall be liable to the obligee for any amounts required to be withheld. A financial institution is liable to the obligee if funds in any of the

obligor's deposit accounts identified in the court order equal the amount stated in the preauthorization agreement but are not transferred by the financial institution in accordance with the agreement. An employer or other payor of funds or a financial institution that fails to withhold or transfer funds in accordance with this section is:

(i) liable to the obligee for interest on the funds at the rate applicable to judgments under section 549.09, computed from the date the funds were required to be withheld or transferred;

(ii) liable for reasonable attorney fees of the obligee or public authority incurred in enforcing the liability under this paragraph; and

(iii) subject to contempt of court if it fails to comply with the requirements of this section for 30 days or more.

Sec. 20. Minnesota Statutes 1991 Supplement, section 518.64, subdivision 1, is amended to read:

Subdivision 1. [MODIFICATION; CONTEMPT.] After an order for maintenance or support money, temporary or permanent, or for the appointment of trustees to receive property awarded as maintenance or support money, the court may from time to time, on motion of either of the parties, a copy of which is served on the public authority responsible for child support enforcement if payments are made through it, or on motion of the public authority responsible for support enforcement, modify the order respecting the amount of maintenance or support money, and the payment of it, and also respecting the appropriation and payment of the principal and income of property held in trust, and may make an order respecting these matters which it might have made in the original proceeding, except as herein otherwise provided. The obligee or public authority also may bring a motion for contempt of court if the obligor is in arrears in support or maintenance payments.

Sec. 21. Minnesota Statutes 1991 Supplement, section 518.64, subdivision 2, is amended to read:

Subd. 2. [MODIFICATION.] (a) The terms of an order respecting maintenance or support may be modified upon a showing of one or more of the following: (1) substantially increased or decreased earnings of a party; (2) substantially increased or decreased need of a party or the child or children that are the subject of these proceedings; (3) receipt of assistance under sections 256.72 to 256.87; ~~or~~ (4) a change in the cost of living for either party as measured by the federal bureau of statistics, any of which makes the terms unreasonable and unfair; or (5) extraordinary medical expenses of the child.

The terms of a current support order shall be rebuttably presumed to be unreasonable and unfair if the application of the child support guidelines in section 518.551, subdivision 5, to the current circumstances of the parties results in a calculated court order that is at least 20 percent and at least $50 per month higher or lower than the current support order.

(b) On a motion for modification of maintenance, including a motion for the extension of the duration of a maintenance award, the court shall apply, in addition to all other relevant factors, the factors for an award of maintenance under section 518.552 that exist at the time of the motion. On a motion for modification of support, the court:

(1) shall apply section 518.551, subdivision 5, and shall not consider the financial circumstances of each party's spouse, if any; and

(2) shall not consider compensation received by a party for employment in excess of a 40-hour work week, provided that the party demonstrates, and the court finds, that:

(i) the excess employment began after entry of the existing support order;

(ii) the excess employment is voluntary and not a condition of employment;

(iii) the excess employment is in the nature of additional, part-time employment, or overtime employment compensable by the hour or fractions of an hour;

(iv) the party's compensation structure has not been changed for the purpose of affecting a support or maintenance obligation;

(v) in the case of an obligor, current child support payments are at least equal to the guidelines amount based on income not excluded under this clause; and

(vi) in the case of an obligor who is in arrears in child support payments to the obligee, any net income from excess employment must be used to pay the arrearages until the arrearages are paid in full; and

(3) may consider the financial needs of any child born to, or adopted by, the obligor after entry of the support order, but only if:

(i) the motion is to increase the amount of support; and

(ii) the court also considers the financial circumstances of each party's spouse, if any.

(c) A modification of support or maintenance may be made retroactive only with respect to any period during which the petitioning party has pending a motion for modification but only from the date of service of notice of the motion on the responding party and on the public authority if public assistance is being furnished or the county attorney is the attorney of record. However, modification may be applied to an earlier period if the court makes express findings that the party seeking modification was precluded from serving a motion by reason of a significant physical or mental disability, a material misrepresentation of another party, or fraud upon the court and that the party seeking modification, when no longer precluded, promptly served a motion.

(d) Except for an award of the right of occupancy of the homestead, provided in section 518.63, all divisions of real and personal property provided by section 518.58 shall be final, and may be revoked or modified only where the court finds the existence of conditions that justify reopening a judgment under the laws of this state, including motions under section 518.145, subdivision 2. The court may impose a lien or charge on the divided property at any time while the property, or subsequently acquired property, is owned by the parties or either of them, for the payment of maintenance or support money, or may sequester the property as is provided by section 518.24.

(e) The court need not hold an evidentiary hearing on a motion for modification of maintenance or support.

(f) Section 518.14 shall govern the award of attorney fees for motions brought under this subdivision.

Sec. 22. Minnesota Statutes 1991 Supplement, section 518.64, subdivision 5, is amended to read:

Subd. 5. [FORM.] The department of human services shall prepare and make available to courts, obligors and persons to whom child support is owed a form to be submitted by the obligor or the person to whom child support is owed in support of a motion for a modification of an order for support or maintenance or for contempt of court. The rulemaking provisions of chapter 14 shall not apply to the preparation of the form.

Sec. 23. Minnesota Statutes 1990, section 548.091, subdivision 1a, is amended to read:

Subd. 1a. [CHILD SUPPORT JUDGMENT BY OPERATION OF LAW.] Any payment or installment of support required by a judgment or decree of dissolution or legal separation, determination of

parentage, an order under chapter 518C, an order under section 256.87, or an order under section 260.251, that is not paid or withheld from the obligor's income as required under section 518.611 or 518.613, is a judgment by operation of law on and after the date it is due and is entitled to full faith and credit in this state and any other state. Interest accrues at an annual rate of ten percent from the date the ~~judgment on the payment or installment is entered and docketed under subdivision 3a, at the annual rate provided in section 549.09, subdivision 1~~ unpaid amount due is greater than the current support due. A payment or installment of support that becomes a judgment by operation of law between the date on which a party served notice of a motion for modification under section 518.64, subdivision 2, and the date of the court's order on modification may be modified under that subdivision.

Sec. 24. Minnesota Statutes 1990, section 588.20, is amended to read:

588.20 [CRIMINAL CONTEMPTS.]

Every person who shall commit a contempt of court, of any one of the following kinds, shall be guilty of a misdemeanor:

(1) Disorderly, contemptuous, or insolent behavior, committed during the sitting of the court, in its immediate view and presence, and directly tending to interrupt its proceedings, or to impair the respect due to its authority;

(2) Behavior of like character in the presence of a referee, while actually engaged in a trial or hearing, pursuant to an order of court, or in the presence of a jury while actually sitting for the trial of a cause, or upon an inquest or other proceeding authorized by law;

(3) Breach of the peace, noise, or other disturbance directly tending to interrupt the proceedings of a court, jury, or referee;

(4) Willful disobedience to the lawful process or other mandate of a court;

(5) Resistance willfully offered to its lawful process or other mandate;

(6) Contumacious and unlawful refusal to be sworn as a witness, or, after being sworn, to answer any legal and proper interrogatory;

(7) Publication of a false or grossly inaccurate report of its proceedings; or

(8) Willful failure to pay court-ordered child support when the obligor has the ability to pay.

No person shall be punished as herein provided for publishing a true, full, and fair report of a trial, argument, decision, or other proceeding had in court.

Sec. 25. Minnesota Statutes 1990, section 609.375, subdivision 1, is amended to read:

Subdivision 1. Whoever is legally obligated to provide care and support to a spouse who is in necessitous circumstances, or child, whether or not its custody has been granted to another, and knowingly omits and fails without lawful excuse to do so is guilty of ~~nonsupport of the spouse or child, as the case may be~~ a misdemeanor, and upon conviction ~~thereof~~ may be sentenced to imprisonment for not more than 90 days or to payment of a fine of not more than ~~$300~~ $700, or both. Willful failure to make court-ordered child support or spousal maintenance payments is prima facie evidence of a violation of this subdivision.

Sec. 26. Minnesota Statutes 1990, section 609.375, subdivision 2, is amended to read:

Subd. 2. If the ~~knowing omission and failure without lawful excuse to provide care and support to a spouse, a minor child, or a pregnant wife~~ violation of subdivision 1 continues for a period in excess of 90 days the person is guilty of a felony and may be sentenced to imprisonment for not more than five years or to payment of a fine of not more than $10,000, or both.

Sec. 27. [INCOME WITHHOLDING; SINGLE CHECK SYSTEM.]

Within the limits of available appropriations, the commissioner of human services shall designate one or more counties where the public authority will receive and distribute combined child support payments withheld from income by employers under Minnesota Statutes, section 518.611, subdivision 4, paragraph (b). The commissioner shall specify the information to be provided by employers in order to separately identify each obligor making a payment.

Sec. 28. [REPEALER.]

Minnesota Statutes 1990, section 609.37, is repealed.

Sec. 29. [EFFECTIVE DATE; APPLICATION.]

(a) Section 18 is effective August 1, 1992, for all judgments, decrees, and orders entered on or after that date.

(b) Section 19, paragraph (b), is effective January 1, 1994.

(d) Section 23 is effective August 1, 1992, for all payments and installments of child support due on or after that date.

(d) Sections 24 to 26 and 28 are effective August 1, 1992, and apply to crimes committed on or after that date.

ARTICLE 2

ADMINISTRATION AND FUNDING

Section 1. Minnesota Statutes 1990, section 357.021, subdivision 1a, is amended to read:

Subd. 1a. (a) Every person, including the state of Minnesota and all bodies politic and corporate, who shall transact any business in the district court, shall pay to the court administrator of said court the sundry fees prescribed in subdivision 2. Except as provided in paragraph (d), the court administrator shall transmit the fees monthly to the state treasurer for deposit in the state treasury and credit to the general fund.

(b) In a county which has a screener-collector position, fees paid by a county pursuant to this subdivision shall be transmitted monthly to the county treasurer, who shall apply the fees first to reimburse the county for the amount of the salary paid for the screener-collector position. The balance of the fees collected shall then be forwarded to the state treasurer for deposit in the state treasury and credited to the general fund. A screener-collector position for purposes of this paragraph is an employee whose function is to increase the collection of fines and to review the incomes of potential clients of the public defender, in order to verify eligibility for that service.

(c) No fee is required under this section from the public authority or the party the public authority represents in an action for:

(1) child support enforcement or modification, medical assistance enforcement, or establishment of parentage in the district court, or child or medical support enforcement conducted by an administrative law judge in an administrative hearing under section 518.551, subdivision 10;

(2) civil commitment under chapter 253B;

(3) the appointment of a public conservator or public guardian or any other action under chapters 252A and 525;

(4) wrongfully obtaining public assistance under section 256.98 or 256D.07, or recovery of overpayments of public assistance;

(5) court relief under chapter 260;

(6) forfeiture of property under sections 609.531 to 609.5317;

(7) recovery of amounts issued by political subdivisions or public institutions under sections 246.52, 252.27, 256.045, 256.25, 256.87, 256B.042, 256B.14, 256B.15, 256B.37, and 260.251, or other sections referring to other forms of public assistance; or

(8) restitution under section 611A.04.

(d) The fees collected for child support modifications under subdivision 2, clause (11), must be transmitted to the county treasurer for deposit in the county general fund. The fees must be used by the county to pay for child support enforcement efforts by county attorneys.

Sec. 2. Minnesota Statutes 1991 Supplement, section 357.021, subdivision 2, is amended to read:

Subd. 2. [FEE AMOUNTS.] The fees to be charged and collected by the court administrator shall be as follows:

(1) In every civil action or proceeding in said court, the plaintiff, petitioner, or other moving party shall pay, when the first paper is filed for that party in said action, a fee of $85.

The defendant or other adverse or intervening party, or any one or more of several defendants or other adverse or intervening parties appearing separately from the others, shall pay, when the first paper is filed for that party in said action, a fee of $85.

The party requesting a trial by jury shall pay $30.

The fees above stated shall be the full trial fee chargeable to said parties irrespective of whether trial be to the court alone, to the court and jury, or disposed of without trial, and shall include the entry of judgment in the action, but does not include copies or certified copies of any papers so filed or proceedings under chapter 103E, except the provisions therein as to appeals.

(2) Certified copy of any instrument from a civil or criminal proceeding, $5, plus 25 cents per page after the first page, and $3.50, plus 25 cents per page after the first page for an uncertified copy.

(3) Issuing a subpoena, $3 for each name.

(4) Issuing an execution and filing the return thereof; issuing a writ of attachment, injunction, habeas corpus, mandamus, quo warranto, certiorari, or other writs not specifically mentioned, $10.

(5) Issuing a transcript of judgment, or for filing and docketing a transcript of judgment from another court, $7.50.

(6) Filing and entering a satisfaction of judgment, partial satisfaction, or assignment of judgment, $5.

(7) Certificate as to existence or nonexistence of judgments docketed, $5 for each name certified to.

(8) Filing and indexing trade name; or recording notary commission; or recording basic science certificate; or recording certificate of physicians, osteopaths, chiropractors, veterinarians, or optometrists, $5.

(9) For the filing of each partial, final, or annual account in all trusteeships, $10.

(10) For the deposit of a will, $5.

(11) Filing a motion or response to a motion for modification of child support, a fee fixed by rule or order of the supreme court.

(12) All other services required by law for which no fee is provided, such fee as compares favorably with those herein provided, or such as may be fixed by rule or order of the court.

Sec. 3. Minnesota Statutes 1990, section 518.551, subdivision 7, is amended to read:

Subd. 7. [SERVICE FEE.] When the public agency responsible for child support enforcement provides child support collection services either to a public assistance recipient or to a party who does not receive public assistance, the public agency may upon written notice to the obligor charge a monthly collection fee equivalent to the full monthly cost to the county of providing collection services, in addition to the amount of the child support which was ordered by the court. The fee shall be deposited in the county general fund. The service fee assessed is limited to ten percent of the monthly court ordered child support and shall not be assessed to obligors who are current in payment of the monthly court ordered child support. The public agency may impose a late fee penalty at an annual rate of six percent of the unpaid support due, commending 30 days after the end of the month when the support was due. An application fee not to exceed $5 $25 shall be paid by the person who applies for child support and maintenance collection services, except persons who transfer from public assistance to nonpublic assistance status. Fees assessed by state and federal tax agencies for collection of overdue support owed to or on behalf of a person not receiving public assistance must be imposed on the person for whom these services are provided.

However, the limitations of this subdivision on the assessment of fees shall not apply to the extent inconsistent with the requirements of federal law for receiving funds for the programs under Title IV-A and Title IV-D of the Social Security Act, United States Code, title 42, sections 601 to 613 and United States Code, title 42, sections 651 to 662.

Sec. 4. Minnesota Statutes 1990, section 518.551, subdivision 10, is amended to read:

Subd. 10. [ADMINISTRATIVE PROCESS FOR CHILD AND MEDICAL SUPPORT ORDERS.] (a) An administrative process is established to obtain, modify, and enforce child and medical support orders and maintenance.

The commissioner of human services may designate counties to participate in the administrative process established by this section. All proceedings for obtaining, modifying, or enforcing child and medical support orders and maintenance and adjudicating uncontested parentage proceedings, required to be conducted in counties designated by the commissioner of human services in which the county human services agency is a party or represents a party to the action must be conducted by an administrative law judge from the office of administrative hearings, except for the following proceedings:

(1) adjudication of contested parentage;

(2) motions to set aside a paternity adjudication or declaration of parentage;

(3) evidentiary hearing on contempt motions; and

(4) motions to sentence or to revoke the stay of a jail sentence in contempt proceedings.

(b) An administrative law judge may hear a stipulation reached on a contempt motion, but any stipulation that involves a finding of contempt and a jail sentence, whether stayed or imposed, shall require the review and signature of a district judge.

(c) For the purpose of this process, all powers, duties, and responsibilities conferred on judges of the district court to obtain and enforce child and medical support obligations, subject to the limitation set forth herein, are conferred on the administrative law judge conducting the proceedings, including the power to issue orders to show cause and to issue bench warrants for failure to appear.

(d) Before implementing the process in a county, the chief administrative law judge, the commissioner of human services, the direc-

tor of the county human services agency, the county attorney, and the county court administrator shall jointly establish procedures and the county shall provide hearing facilities for implementing this process in a county.

(e) Nonattorney employees of the public agency responsible for child support in the counties designated by the commissioner, acting at the direction of the county attorney, may prepare, sign, serve, and file complaints and motions for obtaining, modifying, or enforcing child and medical support orders and maintenance and related documents, appear at prehearing conferences, and participate in proceedings before an administrative law judge. This activity shall not be considered to be the unauthorized practice of law.

(f) The hearings shall be conducted under the rules of the office of administrative hearings, Minnesota Rules, parts 1400.7100 to 1400.7500, 1400.7700, and 1400.7800, as adopted by the chief administrative law judge. All other aspects of the case, including, but not limited to, pleadings, discovery, and motions, shall be conducted under the rules of family court, the rules of civil procedure, and chapter 518. The administrative law judge shall make findings of fact, conclusions, and a final decision and issue an order. Orders issued by an administrative law judge are enforceable by the contempt powers of the county and district courts.

(g) The decision and order of the administrative law judge is appealable to the court of appeals in the same manner as a decision of the district court.

(h) Within the limits of available appropriations, the commissioner shall provide grants to counties to cover the costs of the administrative process, including salaries of administrative law judges.

Sec. 5. Minnesota Statutes 1990, section 518.551, is amended by adding a subdivision to read:

Subd. 13. [CONSULTATION WITH LEGAL STAFF AND PRACTITIONERS.] When considering and developing legislative initiatives and when developing rules, procedures, and forms, the state office of child support shall consult judges, attorneys in the department and the attorney general's office, county attorneys and support enforcement staff, and family law practitioners.

Sec. 6. [TASK FORCE.]

The commissioner of human services shall convene a task force consisting of representatives of the office of child support enforcement, local social service agencies, the department of revenue, and legislative staff to make recommendations for a process to collect

child support arrearages. The commissioner of human services and the commissioner of revenue shall report the recommendations of the task force to the chairs of the committees on health and human services and judiciary in the senate and the house of representatives by January 15, 1993.

Sec. 7. [CHILD SUPPORT COMPUTER SYSTEM.]

The commissioner of human services shall take appropriate action to ensure that the statewide computer system for the collection and enforcement of child support is operating effectively and efficiently as soon as possible. The commissioner shall report to the chairs of the committees on health and human services and judiciary in the senate and the house of representatives by January 15, 1993, concerning the status of the computer system and any problems in the functioning of the system.

Sec. 8. [SAVINGS DESIGNATED FOR COUNTY ADMINISTRATION.]

The commissioner of human services and the commissioner of finance shall estimate the savings to the state that will result from reducing the number of instances in which there are downward deviations from the child support guidelines in cases where the children receive AFDC. Before the end of fiscal year 1993, the amount of the estimated savings for fiscal year 1993 must be transferred from the appropriation for AFDC to the appropriation for county child support enforcement incentive grants in Laws 1991, chapter 292, article 1, section 2, subdivision 4, to be allocated to counties in the same manner as the original appropriation for fiscal year 1993. For purposes of the governor's 1994-1995 biennial budget recommendations, the amount transferred during fiscal year 1993 and any additional savings projected for the biennium as a result of prohibiting downward deviations in AFDC cases must be added to the direct legislative appropriations and considered part of the base level funding for county child support enforcement incentives.

Sec. 9. [APPROPRIATION.]

$..... is appropriated from the general fund to the commissioner of human services for fiscal year 1993, to provide grants to counties for the costs of the administrative process for child and medical support orders established under Minnesota Statutes, section 518.551, subdivision 10."

Delete the title and insert:

"A bill for an act relating to family law; modifying provisions dealing with the administration, computation, and enforcement of child support; modifying visitation provisions; imposing penalties;

appropriating money; amending Minnesota Statutes 1990, sections 257.67, subdivision 3; 357.021, subdivision 1a; 518.14; 518.171, subdivisions 1, 3, 4, and 6; 518.175, subdivision 1; 518.54, subdivision 4; 518.551, subdivisions 1, 7, and 10, and by adding subdivisions; 518.57, subdivision 1, and by adding a subdivision; 518.611, subdivision 4; 548.091, subdivision 1a; 588.20; 609.375, subdivisions 1 and 2; Minnesota Statutes 1991 Supplement, sections 214.101, subdivision 1; 357.021, subdivision 2; 518.551, subdivisions 5 and 12; 518.64, subdivisions 1, 2, and 5; proposing coding for new law in Minnesota Statutes, chapters 16B; and 518; repealing Minnesota Statutes 1990, section 609.37."

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Health and Human Services.

The report was adopted.

Begich from the Committee on Labor-Management Relations to which was referred:

H. F. No. 2294, A bill for an act relating to occupations and professions; establishing a board of plumbing; preempting certain local units of government from licensing plumbers; providing administrative remedies; providing penalties; appropriating money; amending Minnesota Statutes 1990, sections 214.01, subdivision 3; 326.01, subdivision 9; 326.37; 326.38; 326.39; 326.40; 326.401, subdivisions 2, 3, and by adding a subdivision; 326.405; 326.41; 326.42; and 326.44; Minnesota Statutes 1991 Supplement, section 214.04, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 326; repealing Minnesota Statutes 1990, sections 325F.75, subdivision 2; and 326.45.

Reported the same back with the following amendments:

Page 4, line 35, delete "1991" and insert "1992"

Page 6, line 2, delete "single-family"

Page 9, delete lines 31 to 34

Page 10, line 35, delete "1992" and insert "1993"

Page 13, line 34, reinstate "~~pay for~~" and delete "cover" and delete "costs of"

Page 13, line 35, delete "The"

Page 13, delete line 36

Page 14, delete lines 1 to 3

Page 14, line 11, delete "or more stringent than"

Page 16, delete section 19

Amend the title as follows:

Page 1, line 12, delete the semicolon and insert a period

Page 1, delete lines 13 and 14

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Governmental Operations.

The report was adopted.

SECOND READING OF HOUSE BILLS

H. F. Nos. 1791, 2099 and 2115 were read for the second time.

INTRODUCTION AND FIRST READING OF HOUSE BILLS

The following House Files were introduced:

Cooper introduced:

H. F. No. 2778, A bill for an act relating to health; changing the membership requirements of the board of nursing; amending Minnesota Statutes 1990, section 148.181, subdivision 1.

The bill was read for the first time and referred to the Committee on Health and Human Services.

Clark, Bishop, Vellenga, McGuire and Solberg introduced:

H. F. No. 2779, A bill for an act relating to taxation; imposing additional sales tax on adult oriented materials; providing for deposit of the revenue in a sexual assault and domestic violence account; amending Minnesota Statutes 1990, sections 297A.01, by adding a subdivision; 297A.02, by adding a subdivision; and 297A.44, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 16A.

The bill was read for the first time and referred to the Committee on Judiciary.

Koppendrayer, Lourey and Erhardt introduced:

H. F. No. 2780, A bill for an act relating to taxation; allowing Kanabec county to levy a property tax for the county historical society.

The bill was read for the first time and referred to the Committee on Taxes.

Jaros introduced:

H. F. No. 2781, A bill for an act relating to controlled substances; requiring the chemical abuse prevention resource council to examine and report on whether a drug legalization strategy should be adopted in Minnesota.

The bill was read for the first time and referred to the Committee on Judiciary.

Johnson, R., and Reding introduced:

H. F. No. 2782, A bill for an act relating to retirement; the public employees retirement association; making changes in eligibility and conditions of eligibility for receipt of disability benefits; amending Minnesota Statutes 1990, sections 353.03, subdivisions 3 and 3a; and 353.33, subdivision 4.

The bill was read for the first time and referred to the Committee on Governmental Operations.

Sparby and Wenzel introduced:

H. F. No. 2783, A bill for an act relating to agriculture; authorizing the commissioner of agriculture to make certain adjustments, agreements, and settlements in family farm security loans; providing for transfer and disposition of certain funds; appropriating money; amending Minnesota Statutes 1990, sections 41.56, subdivision 3; 41.57, by adding subdivisions; and 41.61, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Agriculture.

Sarna introduced:

H. F. No. 2784, A bill for an act relating to retirement; Minneapolis police relief association; recodifying the local laws applicable to the local relief association; amending Laws 1980, chapter 607, article XV, sections 8, 9, as amended, and 10; Laws 1989, chapter 319, article 19, sections 6 and 7, subdivisions 1 and 4, as amended; and Laws 1990, chapter 589, article 1, section 6; repealing Minnesota Statutes 1957, sections 423.71; 423.715; 423.72; 423.725; 423.73; 423.735; 423.74; 423.745; 423.75; 423.755; 423.76; 423.765; 423.77; 423.775; Special Laws 1891, chapter 143; Laws 1943, chapter 280; Laws 1949, chapter 406; Laws 1953, chapter 127; Laws 1957, chapters 721 and 939; Laws 1959, chapters 428 and 662; Laws 1961, chapter 532; Laws 1963, chapter 315; Laws 1965, chapters 493, 520, and 534; Laws 1967, chapters 820 and 825; Laws 1969, chapters 258 and 560; Laws 1973, chapters 272 and 309; Laws 1975, chapter 428; Laws 1980, chapter 607, article XV, section 21; Laws 1983, chapter 88; Laws 1987, chapters 322, sections 2, 3, 4, 5, 6, 7, and 8; and 372, article 2, sections 2, 3, 4, 6, and 15; Laws 1988, chapters 572, sections 3, 5, and 6; and 574, sections 2, 4, and 5; Laws 1990, chapter 589, article 1, section 4; and Laws 1991, chapter 90.

The bill was read for the first time and referred to the Committee on Governmental Operations.

Winter introduced:

H. F. No. 2785, A bill for an act relating to education; creating the Waseca higher education center; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 135A.

The bill was read for the first time and referred to the Committee on Education.

Ozment introduced:

H. F. No. 2786, A bill for an act relating to elections; allowing a school district to designate voting hours; amending Minnesota Statutes 1990, section 205A.09.

The bill was read for the first time and referred to the Committee on General Legislation, Veterans Affairs and Gaming.

Hasskamp and Johnson, R., introduced:

H. F. No. 2787, A bill for an act relating to education; defining comparable courses under post-secondary enrollment options;

amending Minnesota Statutes 1990, section 123.3514, subdivisions 4a, 5, and by adding a subdivision.

The bill was read for the first time and referred to the Committee on Education.

Johnson, R., and Hasskamp introduced:

H. F. No. 2788, A bill for an act relating to education; amending post-secondary enrollment options funding for school districts for fiscal year 1993 and later years; reenacting and amending Minnesota Statutes 1990, section 123.3514, subdivisions 6 and 6b, as amended; and amending Laws 1991, chapter 265, article 9, section 75.

The bill was read for the first time and referred to the Committee on Education.

Olsen, S., and Dempsey introduced:

H. F. No. 2789, A bill for an act proposing an amendment to the Minnesota Constitution, article IV, section 23; amending provisions governing time deadlines for governors' vetoes.

The bill was read for the first time and referred to the Committee on Rules and Legislative Administration.

Segal introduced:

H. F. No. 2790, A bill for an act relating to economic development; proposing an amendment to the Minnesota Constitution; adding a section to article XI establishing a science technology and manufacturing advancement fund; providing implementing legislation for the advancement fund; creating a legislative commission and advisory committee; providing for advancement fund expenditures; appropriating certain tax collections to the advancement fund; allocating certain lottery proceeds to the advancement fund; amending Minnesota Statutes 1990, section 349.212, by adding a subdivision; Minnesota Statutes 1991 Supplement, section 349A.10, subdivision 5; proposing coding for new law as Minnesota Statutes, chapter 116S.

The bill was read for the first time and referred to the Committee on Economic Development.

Reding introduced:

H. F. No. 2791, A bill for an act relating to state government; revising procedures governing state contracts for professional and technical services; amending Minnesota Statutes 1990, sections 15.061; 16B.17; and 16B.19, subdivisions 2 and 10.

The bill was read for the first time and referred to the Committee on Governmental Operations.

Rice introduced:

H. F. No. 2792, A bill for an act relating to retirement; providing level benefits for members of the Minneapolis fire department relief association.

The bill was read for the first time and referred to the Committee on Governmental Operations.

Ogren, Krueger, Bauerly, Bertram and Wenzel introduced:

H. F. No. 2793, A bill for an act relating to agriculture; changing procedures for refunds of commodity promotion checkoff fees; amending Minnesota Statutes 1991 Supplement, section 17.63.

The bill was read for the first time and referred to the Committee on Agriculture.

Solberg introduced:

H. F. No. 2794, A bill for an act relating to traffic regulations; authorizing television screens in police vehicles; amending Minnesota Statutes 1990, section 169.471, subdivision 1.

The bill was read for the first time and referred to the Committee on Transportation.

Krueger, Vanasek, Abrams and Hugoson introduced:

H. F. No. 2795, A bill for an act relating to elections; requiring a study by the secretary of state of mail or telephone balloting in certain primaries.

The bill was read for the first time and referred to the Committee on General Legislation, Veterans Affairs and Gaming.

Clark introduced:

H. F. No. 2796, A bill for an act relating to aging; establishing an advisory task force to study issues of concern to Indian elders; proposing coding for new law in Minnesota Statutes, chapter 256.

The bill was read for the first time and referred to the Committee on Health and Human Services.

Clark, Segal and Greenfield introduced:

H. F. No. 2797, A bill for an act relating to chemical abuse prevention and treatment; requiring coordinated prevention efforts concerning fetal alcohol syndrome and drug-exposed infants; appropriating money for community chemical abuse prevention program grants; providing grants for chemical dependency programs targeted at pregnant women and mothers, high-risk youth, and young children; requiring chemical use assessments for certain juveniles at an earlier stage of the juvenile court process; clarifying the duties of the office of drug policy and the chemical abuse prevention resource council; expanding the council's membership; requiring the development of a chemical health index model; requiring a statewide chemical health media campaign; appropriating money; amending Minnesota Statutes 1990, sections 241.021, by adding a subdivision; 254A.14, by adding a subdivision; 254A.17, subdivision 1, and by adding a subdivision; 260.151, subdivision 1; and 260.172, by adding a subdivision; Minnesota Statutes 1991 Supplement, sections 299A.30, subdivision 2; 299A.31, subdivision 1; and 299A.32, subdivision 2a; proposing coding for new law in Minnesota Statutes, chapters 145; and 299A.

The bill was read for the first time and referred to the Committee on Health and Human Services.

Clark introduced:

H. F. No. 2798, A bill for an act relating to animals; providing for a grant to study the levels of lead in domestic and farm animals; appropriating money.

The bill was read for the first time and referred to the Committee on Environment and Natural Resources.

Hanson, Garcia and Kinkel introduced:

H. F. No. 2799, A bill for an act relating to state government; reorganizing, consolidating, and restructuring state agencies and departments; creating the department of environmental protection

and conservation, the board of environmental review, and the office of assistance and public advocacy; transferring all powers and duties of the pollution control agency, the department of natural resources, the environmental quality board, the board of water and soil resources, the office of waste management, the harmful substances compensation board, the petroleum tank release compensation board, and the agricultural chemical response compensation board; transferring certain powers and duties of the departments of agriculture, health, public safety, trade and economic development, and transportation; authorizing rulemaking; amending Minnesota Statutes 1991 Supplement, section 15A.081, subdivision 1; proposing coding for new law as Minnesota Statutes, chapters 100A; and 100B.

The bill was read for the first time and referred to the Committee on Governmental Operations.

Ogren; Anderson, R.; Vanasek; Lourey and Long introduced:

H. F. No. 2800, A bill for an act relating to health care; providing health coverage for low-income uninsured persons; establishing statewide and regional cost containment programs; reforming requirements for health insurance companies; establishing rural health system initiatives; creating quality of care and data collection programs; revising malpractice laws; creating a health care access account; imposing taxes; appropriating money; amending Minnesota Statutes 1990, sections 43A.316, by adding a subdivision; 62A.02, subdivisions 1, 2, 3, and by adding subdivisions; 62E.11, by adding a subdivision; 62H.01; 136A.1355, subdivisions 2 and 3; 145.682, subdivision 4; 256.936, subdivisions 1, 2, 3, 4, and by adding subdivisions; and 290.01, subdivision 19b; Minnesota Statutes 1991 Supplement, sections 62A.31, subdivision 1; 145.61, subdivision 5; 145.64, subdivision 2; 256.936, subdivision 5; and 297.02, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 16A; 62A; 62E; 62J; 136A; 137; 144; 144A; 256; 256B; 295; and 604; proposing coding for new law as Minnesota Statutes, chapter 62L; repealing Minnesota Statutes 1990, sections 62A.02, subdivisions 4 and 5.

The bill was read for the first time and referred to the Committee on Judiciary.

Greenfield, Rodosovich, Segal, Jefferson and Welle introduced:

H. F. No. 2801, A bill for an act relating to health care; providing health coverage for low-income uninsured persons; establishing statewide and regional cost containment programs; reforming requirements for health insurance companies; establishing rural health system initiatives; creating quality of care and data collection programs; revising malpractice laws; creating a health care

access account; imposing taxes; appropriating money; amending Minnesota Statutes 1990, sections 43A.316, by adding a subdivision; 62A.02, subdivisions 1, 2, 3, and by adding subdivisions; 62E.11, by adding a subdivision; 62H.01; 136A.1355, subdivisions 2 and 3; 145.682, subdivision 4; 256.936, subdivisions 1, 2, 3, 4, and by adding subdivisions; and 290.01, subdivision 19b; Minnesota Statutes 1991 Supplement, sections 62A.31, subdivision 1; 145.61, subdivision 5; 145.64, subdivision 2; 256.936, subdivision 5; and 297.02, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 16A; 62A; 62E; 62J; 136A; 137; 144; 144A; 256; 256B; 295; and 604; proposing coding for new law as Minnesota Statutes, chapter 62L; repealing Minnesota Statutes 1990, sections 62A.02, subdivisions 4 and 5.

The bill was read for the first time and referred to the Committee on Health and Human Services.

Gruenes, Stanius, Dauner, Dempsey and Leppik introduced:

H. F. No. 2802, A bill for an act relating to health care; providing health coverage for low-income uninsured persons; establishing statewide and regional cost containment programs; reforming requirements for health insurance companies; establishing rural health system initiatives; creating quality of care and data collection programs; revising malpractice laws; creating a health care access account; imposing taxes; appropriating money; amending Minnesota Statutes 1990, sections 43A.316, by adding a subdivision; 62A.02, subdivisions 1, 2, 3, and by adding subdivisions; 62E.11, by adding a subdivision; 62H.01; 136A.1355, subdivisions 2 and 3; 145.682, subdivision 4; 256.936, subdivisions 1, 2, 3, 4, and by adding subdivisions; and 290.01, subdivision 19b; Minnesota Statutes 1991 Supplement, sections 62A.31, subdivision 1; 145.61, subdivision 5; 145.64, subdivision 2; 256.936, subdivision 5; and 297.02, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 16A; 62A; 62E; 62J; 136A; 137; 144; 144A; 256; 256B; 295; and 604; proposing coding for new law as Minnesota Statutes, chapter 62L; repealing Minnesota Statutes 1990, sections 62A.02, subdivisions 4 and 5.

The bill was read for the first time and referred to the Committee on Financial Institutions and Insurance.

Orfield, Kahn, Sarna, Greenfield and Knickerbocker introduced:

H. F. No. 2803, A bill for an act relating to retirement; the Minneapolis teachers retirement fund association; providing for purchase of allowable service credit for public employment outside the state of Minnesota; proposing coding for new law in Minnesota Statutes, chapter 354A.

The bill was read for the first time and referred to the Committee on Governmental Operations.

Olson, E., introduced:

H. F. No. 2804, A bill for an act relating to agriculture; requiring labels for packaged wild rice offered for wholesale or retail sale in Minnesota to customers or consumers in Minnesota to include the place of origin and the method of harvesting; eliminating annual reporting requirements and modifying record keeping requirements; amending Minnesota Statutes 1990, section 30.49, subdivisions 1, 2, 3, and by adding subdivisions.

The bill was read for the first time and referred to the Committee on Agriculture.

Sviggum introduced:

H. F. No. 2805, A bill for an act relating to human services; regarding transfering and restructuring of work readiness; amending Minnesota Statutes 1990, sections 237.701, subdivision 1; 256D.01, subdivision 1; 256D.02, subdivision 12a; 256D.05, by adding a subdivision; 256D.051, subdivisions 3b, 13, and by adding a subdivision; 256D.09, subdivisions 2a and 3; 261.001, subdivision 1; 261.003; 261.063; and 383A.06, subdivision 1; Minnesota Statutes 1991 Supplement, sections 256D.03, subdivisions 2 and 2a; 256D.05, subdivisions 1 and 6; 256D.051, subdivisions 3 and 8; 256D.065; 256D.10; and 256D.101, subdivision 1; repealing Minnesota Statutes 1990, sections 256D.051, subdivisions 6b, 7, 9, 10, and 15; 256D.052; 256D.111; and 256D.113; Minnesota Statutes 1991 Supplement, sections 256D.051, subdivisions 1, 1a, 2, 3a, and 6; 256D.101, subdivision 3; and 261.062.

The bill was read for the first time and referred to the Committee on Health and Human Services.

Sviggum introduced:

H. F. No. 2806, A bill for an act relating to taxation; sales tax; exempting municipal art organizations from sales tax on tickets and admissions; amending Minnesota Statutes 1990, section 297A.25, subdivision 24.

The bill was read for the first time and referred to the Committee on Taxes.

Jaros introduced:

H. F. No. 2807, A bill for an act relating to utilities; consumer protection; establishing the Minnesota utility consumers' nonprofit corporation; appropriating money; proposing coding for new law as Minnesota Statutes, chapter 216E.

The bill was read for the first time and referred to the Committee on Commerce.

MESSAGES FROM THE SENATE

The following message was received from the Senate:

Madam Speaker:

I hereby announce the passage by the Senate of the following Senate Files, herewith transmitted:

S. F. Nos. 797, 1608 and 1716.

PATRICK E. FLAHAVEN, Secretary of the Senate

FIRST READING OF SENATE BILLS

S. F. No. 797, A bill for an act relating to traffic regulations; authorizing the use of studded tires by mail carriers; amending Minnesota Statutes 1990, section 169.72, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Transportation.

S. F. No. 1608, A bill for an act relating to occupational health and safety; requiring a study of video display terminal operators health risks.

The bill was read for the first time and referred to the Committee on Appropriations.

S. F. No. 1716, A bill for an act relating to Olmsted county; permitting the appointment of the recorder; authorizing the abolishment and reorganization of the office.

The bill was read for the first time.

Bishop moved that S. F. No. 1716 and H. F. No. 1853, now on General Orders, be referred to the Chief Clerk for comparison. The motion prevailed.

CONSENT CALENDAR

Welle moved that the bills on the Consent Calendar for today be continued. The motion prevailed.

GENERAL ORDERS

Welle moved that the bills on General Orders for today be continued. The motion prevailed.

MOTIONS AND RESOLUTIONS

Solberg moved that the names of Kinkel and Anderson, R., be added as authors on H. F. No. 1416. The motion prevailed.

Dawkins moved that the names of Jennings, Jacobs, Schreiber and Morrison be added as authors on H. F. No. 1488. The motion prevailed.

Wejcman moved that the name of Skoglund be added as an author on H. F. No. 1833. The motion prevailed.

Pugh moved that his name be stricken as an author on H. F. No. 1853. The motion prevailed.

Clark moved that the name of O'Connor be added as an author on H. F. No. 1934. The motion prevailed.

Johnson, A., moved that the name of Heir be added as an author on H. F. No. 2187. The motion prevailed.

Wejcman moved that the names of Jefferson, Blatz and Wagenius be added as authors on H. F. No. 2193. The motion prevailed.

Orenstein moved that his name be stricken as an author on H. F. No. 2226. The motion prevailed.

Winter moved that the name of Skoglund be added as an author on H. F. No. 2261. The motion prevailed.

Garcia moved that the names of Bettermann and Jaros be added as authors on H. F. No. 2443. The motion prevailed.

Nelson, K., moved that the name of Olsen, S., be added as an author on H. F. No. 2460. The motion prevailed.

Dauner moved that his name be stricken as an author on H. F. No. 2517. The motion prevailed.

Uphus moved that the name of Bertram be added as an author on H. F. No. 2535. The motion prevailed.

Bishop moved that the name of Vellenga be added as an author on H. F. No. 2538. The motion prevailed.

Bauerly moved that the name of Bertram be added as an author on H. F. No. 2549. The motion prevailed.

Anderson, R. H., moved that the names of Kalis; Olson, K., and Haukoos be added as authors on H. F. No. 2606. The motion prevailed.

Janezich moved that the name of Solberg be added as an author on H. F. No. 2622. The motion prevailed.

Hausman moved that the names of Lasley and Leppik be added as authors on H. F. No. 2631. The motion prevailed.

Seaberg moved that the name of Welker be added as an author on H. F. No. 2670. The motion prevailed.

Gutknecht moved that the names of McPherson and Haukoos be added as authors on H. F. No. 2681. The motion prevailed.

Bishop moved that the name of Kalis be added as an author on H. F. No. 2684. The motion prevailed.

Clark moved that the name of Koppendrayer be added as an author on H. F. No. 2704. The motion prevailed.

Hanson moved that the name of Janezich be added as chief author on H. F. No. 2711. The motion prevailed.

Sparby moved that the name of Jennings be added as an author on H. F. No. 2720. The motion prevailed.

Runbeck moved that the name of Hanson be added as an author on H. F. No. 2731. The motion prevailed.

Morrison moved that the names of Carlson and Krambeer be added as authors on H. F. No. 2736. The motion prevailed.

Sviggum moved that the name of Welker be added as an author on H. F. No. 2737. The motion prevailed.

Macklin moved that the names of Jennings and Henry be added as authors on H. F. No. 2745. The motion prevailed.

Bishop moved that the name of Orenstein be added as an author on H. F. No. 2750. The motion prevailed.

Leppik moved that the name of Krambeer be added as an author on H. F. No. 2763. The motion prevailed.

Olson, K., moved that the names of Lieder and Girard be added as authors on H. F. No. 2776. The motion prevailed.

McGuire moved that H. F. No. 2757 be recalled from the Committee on Judiciary and be re-referred to the Committee on Local Government and Metropolitan Affairs. The motion prevailed.

Morrison moved that H. F. No. 2736 be recalled from the Committee on Education and be re-referred to the Committee on Appropriations. The motion prevailed.

Welle moved that H. F. No. 2202 be recalled from the Committee on Education and be re-referred to the Committee on Appropriations. The motion prevailed.

Uphus moved that H. F. No. 2640 be recalled from the Committee on Regulated Industries and be re-referred to the Committee on Labor-Management Relations. The motion prevailed.

Newinski moved that H. F. No. 1725 be returned to its author. The motion prevailed.

ADJOURNMENT

Welle moved that when the House adjourns today it adjourn until 2:30 p.m., Thursday, March 12, 1992. The motion prevailed.

Welle moved that the House adjourn. The motion prevailed, and

the Speaker declared the House stands adjourned until 2:30 p.m., Thursday, March 12, 1992.

EDWARD A. BURDICK, Chief Clerk, House of Representatives