STATE OF MINNESOTA

SEVENTY-SEVENTH SESSION—1992

NINETY-THIRD DAY

SAINT PAUL, MINNESOTA, TUESDAY, APRIL 7, 1992

The House of Representatives convened at 1:00 p.m. and was called to order by Dee Long, Speaker of the House.

Prayer was offered by the Reverend Vivian Jones, Plymouth Congregational Church, Minneapolis, Minnesota.

The roll was called and the following members were present:

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

A quorum was present.

Olsen, S., was excused until 1:30 p.m.

The Chief Clerk proceeded to read the Journal of the preceding day. Peterson moved that further reading of the Journal be dis-

pensed with and that the Journal be approved as corrected by the Chief Clerk. The motion prevailed.

REPORTS OF CHIEF CLERK

S. F. No. 304 and H. F. No. 487, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Thompson moved that the rules be so far suspended that S. F. No. 304 be substituted for H. F. No. 487 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 522 and H. F. No. 905, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Reding moved that the rules be so far suspended that S. F. No. 522 be substituted for H. F. No. 905 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 651 and H. F. No. 802, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Orenstein moved that the rules be so far suspended that S. F. No. 651 be substituted for H. F. No. 802 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 1230 and H. F. No. 1334, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Reding moved that the rules be so far suspended that S. F. No.

1230 be substituted for H. F. No. 1334 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 1590 and H. F. No. 2360, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Tunheim moved that the rules be so far suspended that S. F. No. 1590 be substituted for H. F. No. 2360 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 1856 and H. F. No. 1938, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Pugh moved that the rules be so far suspended that S. F. No. 1856 be substituted for H. F. No. 1938 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 1993 and H. F. No. 2219, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Johnson, A., moved that the rules be so far suspended that S. F. No. 1993 be substituted for H. F. No. 2219 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2017 and H. F. No. 1943, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

O'Connor moved that the rules be so far suspended that S. F. No. 2017 be substituted for H. F. No. 1943 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2137 and H. F. No. 2696, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Greenfield moved that the rules be so far suspended that S. F. No. 2137 be substituted for H. F. No. 2696 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2194 and H. F. No. 2404, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Pugh moved that the rules be so far suspended that S. F. No. 2194 be substituted for H. F. No. 2404 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2236 and H. F. No. 2343, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Rest moved that the rules be so far suspended that S. F. No. 2236 be substituted for H. F. No. 2343 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2510 and H. F. No. 2510, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Simoneau moved that the rules be so far suspended that S. F. No. 2510 be substituted for H. F. No. 2510 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2556 and H. F. No. 2318, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Lynch moved that the rules be so far suspended that S. F. No. 2556 be substituted for H. F. No. 2318 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2599 and H. F. No. 2754, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Simoneau moved that the rules be so far suspended that S. F. No. 2599 be substituted for H. F. No. 2754 and that the House File be indefinitely postponed. The motion prevailed.

PETITIONS AND COMMUNICATIONS

The following communications were received:

STATE OF MINNESOTA
OFFICE OF THE GOVERNOR
SAINT PAUL 55155

March 31, 1992

The Honorable Dee Long
Speaker of the House of Representatives
The State of Minnesota

Dear Speaker Long:

It is my honor to inform you that I have received, approved, signed and deposited in the Office of the Secretary of State the following House File:

H. F. No. 1763, relating to state lands; authorizing the conveyance or release of a state easement in Faribault.

Warmest regards,

ARNE H. CARLSON
Governor

STATE OF MINNESOTA
OFFICE OF THE SECRETARY OF STATE
ST. PAUL 55155

The Honorable Dee Long
Speaker of the House of Representatives

The Honorable Jerome M. Hughes
President of the Senate

I have the honor to inform you that the following enrolled Acts of the 1992 Session of the State Legislature have been received from the Office of the Governor and are deposited in the Office of the Secretary of State for preservation, pursuant to the State Constitution, Article IV, Section 23:

S.F. No.	*H.F. No.*	*Session Laws Chapter No.*	*Time and Date Approved 1992*	*Date Filed 1992*
2385		378	6:00 p.m. March 31	April 1
1666		380	6:02 p.m. March 31	April 1
764		382	6:05 p.m. March 31	April 1
1633		384	6:07 p.m. March 31	April 1
	1763	387	6:10 p.m. March 31	April 1
2307		388	6:12 p.m. March 31	April 1
2337		391	5:58 p.m. March 31	April 1

Sincerely,

JOAN ANDERSON GROWE
Secretary of State

STATE OF MINNESOTA
OFFICE OF THE GOVERNOR
SAINT PAUL 55155

April 1, 1992

The Honorable Dee Long
Speaker of the House of Representatives
The State of Minnesota

Dear Speaker Long:

It is my honor to inform you that I have received, approved, signed and deposited in the Office of the Secretary of State the following House Files:

H. F. No. 1567, relating to retirement; Falcon Heights volunteer

firefighters relief associations; authorizing full vesting with five years of service.

H. F. No. 1744, relating to retirement; public employees retirement association; providing entitlement for optional annuities to certain surviving spouses of certain deceased disabilitants; mandating a study of coordinated program survivorship benefit gaps.

H. F. No. 1013, repealing certain pipeline approval authority of the commissioner of natural resources.

H. F. No. 2744, relating to the department of employee relations; modifying expense account terms and uses.

H. F. No. 2397, relating to pipelines; regulating liquefied natural gas facilities.

Warmest regards,

ARNE H. CARLSON
Governor

STATE OF MINNESOTA
OFFICE OF THE GOVERNOR
SAINT PAUL 55155

April 2, 1992

The Honorable Dee Long
Speaker of the House of Representatives
The State of Minnesota

Dear Speaker Long:

It is my honor to inform you that I have received, approved, signed and deposited in the Office of the Secretary of State the following House Files:

H. F. No. 980, relating to the legislature; authorizing joint legislative commissions to issue subpoenas.

H. F. No. 2254, relating to occupations and professions; clarifying membership requirements for the board of pharmacy.

H. F. No. 2375, relating to metropolitan government; providing a name for the transportation accessibility advisory committee.

Warmest regards,

ARNE H. CARLSON
Governor

STATE OF MINNESOTA
OFFICE OF THE GOVERNOR
SAINT PAUL 55155

April 3, 1992

The Honorable Dee Long
Speaker of the House of Representatives
The State of Minnesota

Dear Speaker Long:

It is my honor to inform you that I have received, approved, signed and deposited in the Office of the Secretary of State the following House Files:

H. F. No. 2769, relating to retirement; providing for the calculation of pension increases for the Virginia police relief association.

H. F. No. 2225, relating to retirement; St. Paul police relief association; authorizing retirees and surviving spouses to participate in relief association board elections and other governance issues.

Warmest regards,

ARNE H. CARLSON
Governor

STATE OF MINNESOTA
OFFICE OF THE GOVERNOR
SAINT PAUL 55155

April 3, 1992

The Honorable Dee Long
Speaker of the House of Representatives
The State of Minnesota

Dear Speaker Long:

It is my honor to inform you that I have received, approved, signed and deposited in the Office of the Secretary of State the following House Files:

H. F. No. 2341, relating to transportation; authorizing nonoperating assistance for public transit service.

H. F. No. 2046, relating to commerce; motor vehicle lienholders; requiring notice to certain secured creditors before the vehicle is sold.

Warmest regards,

ARNE H. CARLSON
Governor

STATE OF MINNESOTA
OFFICE OF THE SECRETARY OF STATE
ST. PAUL 55155

The Honorable Dee Long
Speaker of the House of Representatives

The Honorable Jerome M. Hughes
President of the Senate

I have the honor to inform you that the following enrolled Acts of the 1992 Session of the State Legislature have been received from the Office of the Governor and are deposited in the Office of the Secretary of State for preservation, pursuant to the State Constitution, Article IV, Section 23:

S.F. No.	*H.F. No.*	*Session Laws Chapter No.*	*Time and Date Approved 1992*	*Date Filed 1992*
	1567	372	5:12 p.m. April 1	April 2
	1744	373	5:10 p.m. April 1	April 2
	1013	374	5:08 p.m. April 1	April 2
	2744	375	5:02 p.m. April 1	April 2
720		376	4:58 p.m. April 1	April 2
1919		377	4:52 p.m. April 1	April 2
1689		379	4:50 p.m. April 1	April 2
1300		381	4:49 p.m. April 1	April 2
2210		383	4:42 p.m. April 1	April 2
	980	385	11:54 a.m. April 2	April 2
	2397	386	4:07 p.m. April 1	April 2

Sincerely,

JOAN ANDERSON GROWE
Secretary of State

STATE OF MINNESOTA
OFFICE OF THE SECRETARY OF STATE
ST. PAUL 55155

The Honorable Dee Long
Speaker of the House of Representatives

The Honorable Jerome M. Hughes
President of the Senate

I have the honor to inform you that the following enrolled Acts of the 1992 Session of the State Legislature have been received from the Office of the Governor and are deposited in the Office of the Secretary of State for preservation, pursuant to the State Constitution, Article IV, Section 23:

S.F. No.	*H.F. No.*	*Session Laws Chapter No.*	*Time and Date Approved 1992*	*Date Filed 1992*
	2254	389	2:12 p.m. April 2	April 2
	2375	390	2:17 p.m. April 2	April 2
	2769	392	3:52 p.m. April 3	April 6
	2225	393	4:02 p.m. April 3	April 6
	2341	394	2:44 p.m. April 3	April 6
	2046	395	3:00 p.m. April 3	April 6
1767		396	2:58 p.m. April 3	April 6
2069		397	2:56 p.m. April 3	April 6
1991		398	3:56 p.m. April 3	April 6
2310		399	2:54 p.m. April 3	April 6
1900		400	2:50 p.m. April 3	April 6
1298		401	2:47 p.m. April 3	April 6
2208		402	2:45 p.m. April 3	April 6
2182		403	4:06 p.m. April 3	April 6
2308		404	2:42 p.m. April 3	April 6

Sincerely,

JOAN ANDERSON GROWE
Secretary of State

SECOND READING OF SENATE BILLS

S. F. Nos. 304, 522, 651, 1230, 1590, 1856, 1993, 2017, 2137, 2194, 2236, 2510, 2556 and 2599 were read for the second time.

NTRODUCTION AND FIRST READING OF HOUSE BILLS

The following House File was introduced:

Runbeck, Tompkins and Bettermann introduced:

H. F. No. 3036, A bill for an act relating to taxation; property tax relief; changing the funding and payment of certain aids to local governments; appropriating money; amending Minnesota Statutes 1991 Supplement, sections 16A.711, subdivisions 1, 3, and 4; and 477A.014, subdivision 1a; proposing coding for new law in Minnesota Statutes, chapter 16A; repealing Laws 1991, chapter 291, article 2, section 3.

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

MESSAGES FROM THE SENATE

The following messages were received from the Senate:

Madam Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 1350, A bill for an act relating to retirement; major and statewide retirement plans; crediting service and salary when back pay is awarded in the event of a wrongful discharge; proposing coding for new law in Minnesota Statutes, chapter 356; repealing Minnesota Statutes 1991 Supplement, section 353.27, subdivision 5a.

PATRICK E. FLAHAVEN, Secretary of the Senate

CONCURRENCE AND REPASSAGE

Jaros moved that the House concur in the Senate amendments to H. F. No. 1350 and that the bill be repassed as amended by the Senate. The motion prevailed.

H. F. No. 1350, A bill for an act relating to retirement; major and statewide retirement plans; crediting service and salary when back pay is awarded in the event of a wrongful discharge; proposing coding for new law in Minnesota Statutes, chapter 356; repealing

Minnesota Statutes 1991 Supplement, section 353.27, subdivision 5a.

The bill was read for the third time, as amended by the Senate, and placed upon its repassage.

The question was taken on the repassage of the bill and the roll was called. There were 128 yeas and 0 nays as follows:

Those who voted in the affirmative were:

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

The bill was repassed, as amended by the Senate, and its title agreed to.

Madam Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 1978, A bill for an act relating to health; regulating ionizing radiation; delaying the effective date of certain rules; requiring their review by the commissioner of health.

PATRICK E. FLAHAVEN, Secretary of the Senate

CONCURRENCE AND REPASSAGE

Cooper moved that the House concur in the Senate amendments to

H. F. No. 1978 and that the bill be repassed as amended by the Senate. The motion prevailed.

H. F. No. 1978, A bill for an act relating to health; delaying the effective date of rules regulating ionizing radiation; requiring a study.

The bill was read for the third time, as amended by the Senate, and placed upon its repassage.

The question was taken on the repassage of the bill and the roll was called. There were 126 yeas and 4 nays as follows:

Those who voted in the affirmative were:

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

Those who voted in the negative were:

Heir	Hufnagle	Krambeer	Marsh

The bill was repassed, as amended by the Senate, and its title agreed to.

Madam Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 1889, A bill for an act relating to employment; modifying provisions related to access to employee personnel records; amend-

ing Minnesota Statutes 1990, sections 181.961, subdivision 2; and 181.962, subdivision 1.

PATRICK E. FLAHAVEN, Secretary of the Senate

CONCURRENCE AND REPASSAGE

Rukavina moved that the House concur in the Senate amendments to H. F. No. 1889 and that the bill be repassed as amended by the Senate. The motion prevailed.

H. F. No. 1889, A bill for an act relating to employment; modifying provisions related to access to employee personnel records; amending Minnesota Statutes 1990, sections 181.961, subdivision 2; and 181.962, subdivision 1.

The bill was read for the third time, as amended by the Senate, and placed upon its repassage.

The question was taken on the repassage of the bill and the roll was called. There were 131 yeas and 0 nays as follows:

Those who voted in the affirmative were:

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

The bill was repassed, as amended by the Senate, and its title agreed to.

Madam Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 2438, A bill for an act relating to retirement; individual retirement account plan; expanding plan coverage to include certain higher education employees; amending Minnesota Statutes 1990, sections 136.88, subdivision 1; 352C.033; 352D.02, subdivisions 1 and 1a; 352D.03; 354B.01, subdivision 2, and by adding subdivisions; 354B.015; 354B.02, subdivisions 1, 4, and by adding subdivisions; 354B.03, by adding a subdivision; 354B.04, subdivision 1; and 354B.05, subdivision 1; Minnesota Statutes 1991 Supplement, section 354B.04, subdivision 2; repealing Laws 1986, chapter 458, section 36.

PATRICK E. FLAHAVEN, Secretary of the Senate

CONCURRENCE AND REPASSAGE

Reding moved that the House concur in the Senate amendments to H. F. No. 2438 and that the bill be repassed as amended by the Senate. The motion prevailed.

H. F. No. 2438, A bill for an act relating to retirement; individual retirement account plan; expanding plan coverage to include certain higher education employees; changing the formula for compounding interest on deferred annuities of constitutional officers or commissioners; amending Minnesota Statutes 1990, sections 136.88, subdivision 1; 352C.033; 352D.02, subdivisions 1 and 1a; 352D.03; 354B.01, subdivision 2, and by adding subdivisions; 354B.015; 354B.02, subdivisions 1, 4, and by adding subdivisions; 354B.03, by adding a subdivision; 354B.04, subdivision 1; and 354B.05, subdivision 1; Minnesota Statutes 1991 Supplement, section 354B.04, subdivision 2; repealing Laws 1986, chapter 458, section 36.

The bill was read for the third time, as amended by the Senate, and placed upon its repassage.

The question was taken on the repassage of the bill and the roll was called. There were 133 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abrams	Begich	Carlson	Dempsey	Garcia
Anderson, I.	Bertram	Carruthers	Dille	Girard
Anderson, R.	Bettermann	Clark	Dorn	Goodno
Anderson, R. H.	Blatz	Cooper	Erhardt	Greenfield
Battaglia	Bodahl	Dauner	Farrell	Gruenes
Bauerly	Boo	Davids	Frederick	Gutknecht
Beard	Brown	Dawkins	Frerichs	Hanson

Hartle	Knickerbocker	Murphy	Pugh	Swenson
Hasskamp	Koppendrayer	Nelson, K.	Reding	Thompson
Haukoos	Krambeer	Nelson, S.	Rest	Tompkins
Hausman	Krinkie	Newinski	Rice	Trimble
Heir	Krueger	O'Connor	Rodosovich	Tunheim
Henry	Lasley	Ogren	Rukavina	Uphus
Hufnagle	Leppik	Olsen, S.	Runbeck	Valento
Hugoson	Lieder	Olson, E.	Sarna	Vanasek
Jacobs	Limmer	Olson, K.	Schafer	Vellenga
Janezich	Lourey	Omann	Schreiber	Wagenius
Jaros	Lynch	Onnen	Seaberg	Waltman
Jefferson	Macklin	Orenstein	Segal	Weaver
Jennings	Mariani	Orfield	Simoneau	Wejcman
Johnson, A.	Marsh	Osthoff	Skoglund	Welker
Johnson, R.	McEachern	Ostrom	Smith	Welle
Johnson, V.	McGuire	Ozment	Solberg	Wenzel
Kahn	McPherson	Pauly	Sparby	Winter
Kalis	Milbert	Pellow	Stanius	Spk. Long
Kelso	Morrison	Pelowski	Steensma	
Kinkel	Munger	Peterson	Sviggum	

The bill was repassed, as amended by the Senate, and its title agreed to.

Madam Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 2031, A bill for an act relating to taxation; property; providing for the valuation and assessment of vacant platted property; excluding certain unimproved land sales from sales ratio studies; amending Minnesota Statutes 1990, section 124.2131, subdivision 1; Minnesota Statutes 1991 Supplement, section 273.11, subdivision 1.

PATRICK E. FLAHAVEN, Secretary of the Senate

Olson, E., moved that the House refuse to concur in the Senate amendments to H. F. No. 2031, that the Speaker appoint a Conference Committee of 3 members of the House, and that the House requests that a like committee be appointed by the Senate to confer on the disagreeing votes of the two houses. The motion prevailed.

Madam Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 2608, A bill for an act relating to consumer protection; requiring certain creditors to file credit card disclosure reports with

the state treasurer; providing rulemaking authority; proposing coding for new law in Minnesota Statutes, chapter 325G.

PATRICK E. FLAHAVEN, Secretary of the Senate

O'Connor moved that the House refuse to concur in the Senate amendments to H. F. No. 2608, that the Speaker appoint a Conference Committee of 3 members of the House, and that the House requests that a like committee be appointed by the Senate to confer on the disagreeing votes of the two houses. The motion prevailed.

Welle moved that the House recess subject to the call of the Chair. The motion prevailed.

RECESS

RECONVENED

The House reconvened and was called to order by the Speaker.

There being no objection, the order of business reverted to Reports of Standing Committees.

REPORTS OF STANDING COMMITTEES

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2042, A bill for an act relating to education; abolishing the higher education board; amending Minnesota Statutes 1991 Supplement, sections 15A.081, subdivision 7b; and 179A.10, subdivision 2; repealing Minnesota Statutes 1991 Supplement, sections 136E.01; 136E.02; 136E.03; 136E.04; and 136E.05; and Laws 1991, chapter 356, article 9, sections 8, 9, 10, 11, 12, 13, and 14.

Reported the same back with the recommendation that the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2768, A bill for an act relating to education; transferring functions of the higher education coordinating board; changing the membership, terms, and functions of the higher education board; allowing the merger of certain technical colleges by agreement; amending Minnesota Statutes 1991 Supplement, sections 15A.081, subdivision 7b; 136E.01; 136E.02; 179A.10, subdivision 2; Laws 1991, chapter 356, article 9, section 8, subdivisions 1 and 2; proposing coding for new law in Minnesota Statutes, chapter 136E; repealing Minnesota Statutes 1990, sections 136A.01; 136A.02; 136A.03; Minnesota Statutes 1991 Supplement, sections 135A.061; 135A.50; 136A.04; 136E.03; 136E.04; 136E.05; Laws 1991, chapter 356, article 9, section 8, subdivisions 3 to 9; and sections 9 to 16.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 1991 Supplement, section 15A.081, subdivision 7b, is amended to read:

Subd. 7b. [HIGHER EDUCATION OFFICERS.] The higher education board, state university board, the state board for community colleges, and the state board of technical colleges~~, and the higher education coordinating board~~ shall set the salary rates for, respectively, the ~~chancellor~~ director of the higher education ~~system~~ board, the chancellor of the state universities, the chancellor of the community colleges, and the chancellor of ~~vocational~~ the technical ~~education, and the executive director of the higher education coordinating board~~ colleges. The respective board shall submit the proposed salary increase to the legislative commission on employee relations for approval, modification, or rejection in the manner provided in section 43A.18, subdivision 2. Salary rates for the positions specified in this subdivision may not exceed 95 percent of the salary of the governor under section 15A.082, subdivision 3. In deciding whether to recommend a salary increase, the governing board shall consider the performance of the chancellor or director, including the chancellor's or director's progress toward attaining affirmative action goals.

Sec. 2. Minnesota Statutes 1991 Supplement, section 136E.01, is amended to read:

136E.01 [HIGHER EDUCATION BOARD.]

Subdivision 1. [ESTABLISHMENT.] The permanent higher education board is established. The board must be in operation by July 1, 1994.

Subd. 2. [MEMBERSHIP.] The higher education board~~, referred to in sections 136E.01 to 136E.05 as "the board,"~~ consists of ~~13~~ 12 members as follows: the president of the University of Minnesota; the chancellors of the state university, community college, and technical college systems; the president of the private college council; and seven citizen members appointed by the governor with the advice and consent of the senate~~. At least one member of the board must be a resident of each congressional district.~~, including one member who must be a student or have graduated from an institution governed by the board within one year of the date of appointment. ~~The remaining members must be appointed to represent the state at large.~~

Subd. ~~2.~~ 3. [TERM; COMPENSATION; REMOVAL; VACANCIES.] The compensation, removal of members, and filling of vacancies for the citizen members on the board are as provided in section 15.0575. Members are appointed for a term of six years, except that the term of the student member is two years. Terms end on June 30.

Subd. ~~3.~~ 4. [BOARD ADMINISTRATION.] The board shall elect a chair and other officers as it may desire. It shall determine its meeting dates and places.

Subd. 5. [ADVISORY GROUPS.] The board may appoint advisory task forces to assist it in the study of higher education within the state or in the administration of federal programs. The task forces expire and the terms, compensation, and removal of members are as provided in section 15.059. The board must, if requested by the student advisory council, have at least one student from an affected educational system on a council, committee, commission, study group, or task force it creates. The student member or members shall be appointed by the student advisory council.

Subd. 6. [REGIONAL ADVISORY COUNCILS.] To improve cooperation, coordination, and educational delivery throughout the state, the board shall determine a regional structure for the state, consisting of seven to ten regions. The board may use an existing regional configuration or design its own, but each region must include at least one public baccalaureate campus. The board shall appoint a regional advisory council for each designated region. The councils shall include citizen and student members and at least one campus president or chancellor for each system that has a campus in the region. The advisory councils shall make recommendations to the board and the system governing boards to coordinate and improve the efficiency of the delivery of post-secondary education within their respective regions.

Subd. 7. [STUDENT ADVISORY COUNCIL.] (a) A student advisory council to the board is established. The members of the council shall include the chair of the University of Minnesota university student senate, the state chair of the Minnesota state university

student association, the president of the Minnesota community college student association, the president of the Minnesota technical college student association, the president of the Minnesota association of private college students, and a student who is enrolled in a private vocational school registered under sections 136A.61 to 136A.71, to be appointed by the Minnesota association of private post-secondary schools. A member may be represented by a designee.

(b) The advisory council shall:

(1) bring to the attention of the board any matter that the council believes needs the attention of the board;

(2) make recommendations to the board that the council considers appropriate;

(3) review and comment on proposals and other matters before the board;

(4) appoint student members to board advisory groups as provided in subdivision 5;

(5) provide any reasonable assistance to the board; and

(6) select one of its members to serve as chair.

(c) The board shall inform the council of all matters under consideration by the board and shall refer all proposals to the council before the board acts or sends the proposals to the governor or the legislature. The board shall provide time for a report from the advisory council at each meeting of the board.

(d) The student advisory council shall report to the board quarterly and at other times that the council considers desirable.

(e) The council shall determine its meeting time, but the council shall also meet with the director of the board within 30 days after the director's request for a council meeting.

(f) The council expires June 30, 1993.

Sec. 3. Minnesota Statutes 1991 Supplement, section 136E.02, is amended to read:

136E.02 [HIGHER EDUCATION BOARD CANDIDATE ADVISORY COUNCIL.]

Subdivision 1. [PURPOSE.] A higher education board candidate advisory council shall assist the governor in determining criteria for,

and identifying and recruiting qualified candidates for, ~~membership~~ the citizens members on the higher education board.

Subd. 2. [MEMBERSHIP.] The advisory council consists of ~~24~~ 12 members. ~~Twelve~~ Six members are appointed by the subcommittee on committees of the committee on rules and administration of the senate. ~~Twelve~~ Six members are appointed by the speaker of the house of representatives. No more than one-third of the members appointed by each appointing authority may be current or former legislators. No more than two-thirds of the members appointed by each appointing authority may belong to the same political party; however, political activity or affiliation is not required for the appointment of a member. Geographical representation must be taken into consideration when making appointments. Section 15.0575 governs the advisory council, except that the members must be appointed to six-year terms.

Subd. 3. [DUTIES.] The advisory council shall:

(1) develop a statement of the selection criteria to be applied and a description of the responsibilities and duties of a citizen member of the higher education board and shall distribute this to potential candidates; and

(2) for each citizen position on the board, identify and recruit qualified candidates for the board, based on the background and experience of the candidates, and their potential for discharging the responsibilities of a member of the board.

Subd. 4. [RECOMMENDATIONS.] The advisory council shall recommend at least two and not more than four candidates for each seat. By ~~January 2~~ June 1 of each even-numbered year, the advisory council shall submit its recommendations to the governor. The governor is not bound by these recommendations.

Subd. 5. [SUPPORT SERVICES.] The legislative coordinating commission shall provide administrative and support services for the advisory council.

Sec. 4. [136E.06] [EXECUTIVE OFFICERS; EMPLOYEES.]

The higher education board may appoint a director as its principal executive officer, and other officers and employees as necessary to carry out its duties. The director shall possess powers and perform duties as delegated by the board and shall serve in the unclassified service of the state civil service. The salary of the director shall be established by the board. The director shall be a person qualified by training or experience in the field of higher education. The board may also appoint other officers and professional employees who shall serve in the unclassified service of the state civil service and fix

salaries which shall be commensurate with salaries in the classified service. All other employees shall be in the classified civil service.

An officer or professional employee in the unclassified service as provided in this section is a person who has studied higher education or a related field at the graduate level or has similar experience and who is qualified for a career in some aspect of higher education and for activities in keeping with the planning and administrative responsibilities of the board and who is appointed to assume responsibility for administration of educational programs or research in matters of higher education.

Sec. 5. [136E.07] [POWERS AND DUTIES OF THE BOARD.]

Subdivision 1. [GENERAL.] The board shall possess the powers and duties necessary to provide policy leadership and coordination for post-secondary systems and institutions in the state. The board shall prescribe policies, procedures, and rules necessary to administer the programs under its supervision.

Subd. 2. [PLANNING; MISSIONS.] (a) The board shall develop and submit to the governor and the legislature a master plan for Minnesota post-secondary education. After consultation with the governing boards and as a part of the master planning process, the board shall have the authority to:

(1) establish a policy-based and continuing systemwide planning, programming, and coordination process to make the best use of available resources and to sustain statewide goals of high quality, access, diversity, efficiency, and accountability;

(2) determine the role and mission of each public system of higher education, within statutory guidelines;

(3) determine the role and mission of each public institution of higher education;

(4) establish enrollment policies, consistent with roles and missions, at public institutions of higher education; and

(5) consider and propose changes to the legislature not less than every six years on the need for and advisability of changes in the master plan.

(b) The board shall develop criteria for determining if a campus, center, or site should be consolidated, or if its status should be redesignated. After consultation with the appropriate governing board, the board shall make recommendations to the legislature for consolidation or redesignation of campuses, centers, and sites which meet the criteria.

(c) The board shall develop, after consultation with the governing boards, cooperative programs among public post-secondary institutions.

(d) The board shall report annually to the governor and the legislature on institutional and governing board performance and responsiveness to statewide objectives set by the board in its master plan.

Subd. 3. [PROGRAM APPROVAL, DISAPPROVAL, AND REVIEW.] (a) The board shall review and approve or disapprove, consistent with the institutional role and mission and statewide educational needs, the proposal for any new program before its establishment in any public or private post-secondary institution. No institution shall establish a new program, change an existing program, or offer a program at a site other than that for which it was approved originally without first receiving the approval of the board.

(b) The board shall establish, after consultation with the governing boards, policies and criteria for the discontinuance of academic or vocational programs.

(c) The board may direct the governing boards of the state universities, community colleges, and technical colleges, and request the board of regents or the governing board of a private post-secondary institution to discontinue an academic or vocational degree program offering.

(d) The governing board of a public institution of higher education directed to discontinue an academic or vocational degree program under this subdivision shall have not more than four years to discontinue graduate and baccalaureate programs and not more than two years to discontinue associate programs following the board's directive.

(e) If the board directs the governing board of an institution to discontinue an academic or vocational degree program, and the governing board refuses to do so, the board may recommend to the legislature that the governing board remit to the general fund any money appropriated for the program.

(f) The board shall create the procedures and a schedule for periodic program reviews and evaluation of each academic program at each institution consistent with the role and mission of each institution. The plan shall include, but shall not be limited to, the procedures for using internal and external evaluators, the sequence of the reviews, and the anticipated use of the evaluations.

(g) Before the discontinuance of a program, the governing boards of public institutions are directed to develop appropriate early

retirement, professional retraining, and other programs to assist faculty members who may be displaced as a result of discontinued programs.

(h) The board shall ensure that each system has a process for the phaseout of programs.

Subd. 4. [SERVICE AREAS AND OFF-CAMPUS SITES.] After consultation with the governing boards, the board shall define the geographic and programmatic service areas for each public institution of higher education. No institution shall provide instruction off campus in geographic areas or at large-scale sites or centers not approved by the board, unless otherwise provided by law. The board shall establish policies and procedures for reviewing, approving, and disapproving proposals for off-campus sites and centers.

Subd. 5. [CREDIT TRANSFER.] After consultation with the governing boards, the board shall establish and enforce student transfer agreements between public two-year and four-year institutions and among public four-year institutions. The governing boards shall conform to the agreements. The transfer agreements shall include provisions under which institutions shall accept all credit hours of acceptable course work for automatic transfer to another institution of higher education in Minnesota. The board shall have final authority in resolving transfer disputes.

Subd. 6. [BUDGETS.] (a) The board shall review and comment on all budgetary requests of the post-secondary systems and shall transmit its recommendations to the legislature.

(b) After consultation with the governing boards, the board shall make biennial statewide funding recommendations to the legislature and the governor.

Subd. 7. [CAPITAL BUDGETS.] Biennially, the board shall request from each governing board a five-year projection of capital development projects. The projections shall include the estimated cost, the method of funding, a schedule for project completion, and the governing board-approved priority for each project. The board shall review whether a proposed project is consistent with the role and mission and master plan of the institution and report its comments on each project to the legislature. The board may exempt from its review, any project which will require less than $250,000 of state money.

Subd. 8. [FINANCIAL AID PLANNING.] The board shall continuously engage in long-range planning for financial aid needs of Minnesota students and if necessary, cooperatively engage in planning with neighboring states and agencies of the federal government.

Sec. 6. Minnesota Statutes 1991 Supplement, section 179A.10, subdivision 2, is amended to read:

Subd. 2. [STATE EMPLOYEES.] Unclassified employees, unless otherwise excluded, are included within the units which include the classifications to which they are assigned for purposes of compensation. Supervisory employees shall only be assigned to units 12 and 16. The following are the appropriate units of executive branch state employees:

(1) law enforcement unit;

(2) craft, maintenance, and labor unit;

(3) service unit;

(4) health care nonprofessional unit;

(5) health care professional unit;

(6) clerical and office unit;

(7) technical unit;

(8) correctional guards unit;

(9) state university instructional unit;

(10) community college instructional unit;

(11) ~~technical college instructional unit;~~

~~(12)~~ state university administrative unit;

~~(13)~~ (12) professional engineering unit;

~~(14)~~ (13) health treatment unit;

~~(15)~~ (14) general professional unit;

~~(16)~~ (15) professional state residential instructional unit; and

~~(17)~~ (16) supervisory employees unit.

Each unit consists of the classifications or positions assigned to it in the schedule of state employee job classification and positions maintained by the commissioner. The commissioner may only make changes in the schedule in existence on the day prior to August 1, 1984, as required by law or as provided in subdivision 4.

Sec. 7. Laws 1991, chapter 356, article 9, section 8, subdivision 1, is amended to read:

Subdivision 1. [APPOINTMENTS TO BOARD.] Appointments to the higher education board must be made by July 1, 1991. Notwithstanding section 2, the initial higher education board consists of two members each from the state board of technical colleges, state board for community colleges, ~~and~~ the state university board, and the board of regents of the University of Minnesota, appointed by their respective boards and ~~six~~ seven members appointed by the governor including the student member. The governor's appointees may also be members of the current governing boards. Except for members appointed by the board of regents, the members appointed by boards must have been confirmed by the senate to the board from which they are appointed and served for at least one year on the board from which they were appointed. Initial higher education board members appointed by boards are not subject to further senate confirmation. Initial appointees of the governor are not subject to section 3. The governor shall appoint the student member July 1, ~~1995~~ 1992. Notwithstanding section 2, subdivision 2, the initial members of the higher education board must be appointed so that an equal number will have terms expiring in three, five, and seven years. To the extent possible, the initial board must have the geographic balance required by section 2.

Sec. 8. Laws 1991, chapter 356, article 9, section 8, is amended by adding a subdivision to read:

Subd. 1a. [FILLING OF VACANCIES.] To provide for the transition between the interim and permanent higher education boards, vacancies on the interim board shall be filled as follows:

(a) If a vacancy occurs in a position representing a public post-secondary system, that vacancy shall be filled by the president or chancellor of that same system.

(b) The first vacancy to occur in the second position representing a public post-secondary system shall be filled by the president of the private college council. Later vacancies in the second positions representing public post-secondary systems shall not be filled.

(c) The terms of any remaining original members representing public post-secondary systems shall expire June 30, 1994.

Sec. 9. Laws 1991, chapter 356, article 9, section 8, subdivision 2, is amended to read:

Subd. 2. [INTERIM CHANCELLOR.] By November 1, 1991, the board shall hire a chancellor on an interim basis for the period

ending June 30, ~~1995~~ 1992. Thereafter, the board shall conduct a search and hire a ~~chancellor~~ director to serve on a continuing basis.

Sec. 10. [TRANSFER PROVISIONS.]

On July 1, 1992, the duties and responsibilities of the higher education coordinating board are transferred to the higher education board as provided in Minnesota Statutes, section 15.039.

Sec. 11. [REPEALER.]

Minnesota Statutes 1990, sections 136A.01; 136A.02; 136A.03; and 136A.04, subdivision 2; Minnesota Statutes 1991 Supplement, sections 135A.061; 135A.50; 136A.04, subdivision 1; 136E.03; 136E.04; and 136E.05; and Laws 1991, chapter 356, article 9, section 8, subdivisions 3, 4, 5, 6, 7, 8, and 9; and sections 9; 10; 11; 12; 13; 14; 15; and 16, are repealed.

Sec. 12. [INSTRUCTION TO REVISOR.]

Subdivision 1. [RECODIFY.] In the next edition of Minnesota Statutes, the revisor of statutes shall recodify chapters 136A and 136E into a new chapter. The revisor shall make necessary cross-reference changes consistent with the recodification.

Subd. 2. [NAME CHANGE.] The revisor of statutes is directed to change the term "higher education coordinating board," and similar terms, to "higher education board," or similar terms in the sections enumerated in subdivision 1. The change must be made in the next edition of Minnesota Statutes.

Sec. 13. [EFFECTIVE DATE.]

Sections 1 to 11 are effective July 1, 1992."

Delete the title and insert:

"A bill for an act relating to education; transferring functions of the higher education coordinating board; changing the membership, terms, and functions of the higher education board; allowing the merger of certain technical colleges by agreement; amending Minnesota Statutes 1991 Supplement, sections 15A.081, subdivision 7b; 136E.01; 136E.02; 179A.10, subdivision 2; Laws 1991, chapter 356, article 9, section 8, subdivisions 1 and 2, and by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 136E; repealing Minnesota Statutes 1990, sections 136A.01; 136A.02; 136A.03; and 136A.04, subdivision 2; Minnesota Statutes 1991 Supplement, sections 135A.061; 135A.50; 136A.04, subdivision

1; 136E.03; 136E.04; and 136E.05; Laws 1991, chapter 356, article 9, section 8, subdivisions 3 to 9; and sections 9 to 16."

With the recommendation that when so amended the bill pass.

The report was adopted.

Welle from the Committee on Rules and Legislative Administration to which was referred:

H. F. No. 3003, A resolution making application to the Congress of the United States to adopt an amendment to the Constitution of the United States, for submission to the States, to require, with certain exceptions, that the Federal budget be balanced.

Reported the same back with the recommendation that the bill pass.

The report was adopted.

SECOND READING OF HOUSE BILLS

H. F. Nos. 2042, 2768 and 3003 were read for the second time.

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 House File, herewith returned, as amended by the Senate, in which amendment the concurrence of the House is respectfully requested:

H. F. No. 2121, A bill for an act relating to education; providing for general education and related revenue, transportation, special programs, other aids, levies, and programs; appropriating money; amending Minnesota Statutes 1990, sections 120.101, subdivision 5; 120.102, subdivision 1; 120.17, subdivisions 3a, 8a, 12, 14, 16, and by adding subdivisions; 121.148, subdivision 3; 121.11, by adding a subdivision; 121.16, subdivision 1; 121.935, by adding subdivisions; 122.22, by adding a subdivision; 122.23, subdivisions 13, 16, and by adding a subdivision; 122.247, subdivision 1; 122.531, subdivisions 1a, 2, 2a, 2b, and 2c; 122.532, subdivision 2; 123.35, by adding a

subdivision; 123.3514, subdivisions 6, as amended, as reenacted, 6b, as amended, as reenacted, and by adding a subdivision; 123.39, subdivision 8d; 123.58, by adding a subdivision; 123.744, as amended, as reenacted; 124.243, subdivision 2, and by adding a subdivision; 124.2725, subdivision 13; 124.331, subdivisions 1 and 3; 124.431, by adding a subdivision; 124.493, subdivision 1; 124.494, subdivisions 2, 4, and 5; 124.73, subdivision 1; 124.83, subdivisions 2, 6, and by adding subdivisions; 124.85, subdivision 4; 124A.22, subdivision 2a, and by adding subdivisions; 124A.23, subdivision 3; 124A.26, subdivision 2, and by adding a subdivision; 124C.07; 124C.08, subdivision 2; 124C.09; 124C.61; 125.05, subdivisions 1, 7, and by adding subdivisions; 125.12, by adding a subdivision; 125.17, by adding a subdivision; 126.12, subdivision 2; 126.22, by adding a subdivision; 127.46; 128A.09, subdivision 2, and by adding a subdivision; 128C.01, subdivision 4; 128C.02, by adding a subdivision; 134.34, subdivision 1, and by adding a subdivision; 136C.69, subdivision 3; 136D.75; 182.666, subdivision 6; 275.125, subdivision 10, and by adding subdivisions; Minnesota Statutes 1991 Supplement, sections 120.062, subdivision 8a; 120.064, subdivision 4; 120.17, subdivisions 3b, 7a, and 11a; 120.181; 121.585, subdivision 3; 121.831; 121.904, subdivisions 4a and 4e; 121.912, subdivision 6; 121.932, subdivisions 2 and 5; 121.935, subdivisions 1 and 6; 122.22, subdivision 9; 122.23, subdivision 2; 122.242, subdivision 9; 122.243, subdivision 2; 122.531, subdivision 4a; 123.3514, subdivisions 4 and 11; 123.702, subdivisions 1, 1a, and 1b; 124.155, subdivision 2; 124.19, subdivisions 1, 1b, and 7; 124.195, subdivision 2; 124.214, subdivisions 2 and 3; 124.2601, subdivision 6; 124.2721, subdivision 3b; 124.2727, subdivision 6, and by adding subdivisions; 124.479; 124.493, subdivision 3; 124.646, subdivision 4; 124.83, subdivision 1; 124.95, subdivisions 1, 2, 3, 4, 5, and by adding a subdivision; 124A.03, subdivisions 1c, 2, 2a, and by adding a subdivision; 124A.23, subdivisions 1 and 4; 124A.24; 124A.26, subdivision 1; 124A.29, subdivision 1; 125.185, subdivisions 4 and 4a; 125.62, subdivision 6; 126.70; 135A.03, subdivision 3a; 136D.22, subdivision 3; 136D.71, subdivision 2; 136D.76, subdivision 2; 136D.82, subdivision 3; 245A.03, subdivision 2; 275.065, subdivision 1; 275.125, subdivisions 6j and 11g; 364.09; and 373.42, subdivision 2; Laws 1990, chapter 366, section 1, subdivision 2; Laws 1991, chapter 265, articles 3, section 39, subdivision 16; 4, section 30, subdivision 11; 5, sections 18, 23, and 24, subdivision 4; 6, sections 64, subdivision 6, 67, subdivision 3, and 68; 7, sections 37, subdivision 6, 41, subdivision 4, and 44; 8, sections 14 and 19, subdivision 6; and 9, sections 75 and 76; proposing coding for new law in Minnesota Statutes, chapters 123; 124; 124C; and 135A; repealing Minnesota Statutes 1990, sections 121.25; 121.26; 121.27; 121.28; 122.23, subdivisions 16a and 16b; 124.274; 125.03, subdivision 5; 128A.022, subdivision 5; 134.34, subdivision 2; 136D.74, subdivision 3; 136D.76, and subdivision 3; Minnesota Statutes 1991 Supplement, sections 121.935, subdivisions 7 and 8; 123.35, subdivision 19; 124.2721, subdivisions 5a and 5b; 124.2727, subdivisions 1, 2, 3, 4, and 5; and 136D.90, subdivision 2; Laws 1990, chapters 562, article 12; 604, article 8, section 12; and 610, article 1, section 7, subdivision 4; and

Laws 1991, chapter 265, article 9, section 73.

PATRICK E. FLAHAVEN, Secretary of the Senate

Nelson, K., moved that the House refuse to concur in the Senate amendments to H. F. No. 2121, that the Speaker appoint a Conference Committee of 5 members of the House, and that the House requests that a like committee be appointed by the Senate to confer on the disagreeing votes of the two houses. The motion prevailed.

CONSIDERATION UNDER RULE 1.10

Pursuant to rule 1.10, Simoneau requested immediate consideration of H. F. No. 1849.

H. F. No. 1849 was reported to the House.

The Speaker called Krueger to the Chair.

Jefferson moved to amend H. F. No. 1849, the second engrossment, as follows:

Page 56, after line 3, insert:

"Sec. 7. Minnesota Statutes 1990, section 611A.52, subdivision 8, is amended to read:

Subd. 8. [ECONOMIC LOSS.] "Economic loss" means actual economic detriment incurred as a direct result of injury or death.

(a) In the case of injury the term is limited to:

(1) reasonable expenses incurred for necessary medical, chiropractic, hospital, rehabilitative, and dental products, services, or accommodations, including ambulance services, drugs, appliances, and prosthetic devices;

(2) reasonable expenses associated with recreational therapy where a claimant has suffered amputation of a limb;

(3) reasonable expenses incurred for psychological or psychiatric products, services, or accommodations where the nature of the injury or the circumstances of the crime are such that the treatment is necessary to the rehabilitation of the victim, subject to the following limitations:

(i) if treatment is likely to continue longer than six months after the date the claim is filed and the cost of the additional treatment will exceed $1,500, or if the total cost of treatment in any case will exceed $4,000, the provider shall first submit to the board a plan which includes the measurable treatment goals, the estimated cost of the treatment, and the estimated date of completion of the treatment. Claims submitted for treatment that was provided more than 30 days after the estimated date of completion may be paid only after advance approval by the board of an extension of treatment; and

(ii) the board may, in its discretion, elect to pay claims under this clause on a quarterly basis;

(4) loss of income that the victim would have earned had the victim not been injured;

(5) loss of income that the parent or guardian of a minor victim would have earned had the parent or guardian not been needed to care for the victim;

(6) reasonable expenses incurred for substitute child care or household services to replace those the victim would have performed had the victim not been injured. As used in this clause, "child care services" means services provided by facilities licensed under and in compliance with either Minnesota Rules, parts 9502.0315 to 9502.0445, or 9545.0510 to 9545.0670, or exempted from licensing requirements pursuant to section 245A.03. Licensed facilities must be paid at a rate not to exceed their standard rate of payment. Facilities exempted from licensing requirements must be paid at a rate not to exceed $3 an hour per child for daytime child care or $4 an hour per child for evening child care; and

~~(6)~~ (7) reasonable expenses actually incurred to return a child who was a victim of a crime under section 609.25 or 609.26 to the child's parents or lawful custodian. These expenses are limited to transportation costs, meals, and lodging from the time the child was located until the child was returned home.

(b) In the case of death the term is limited to:

(1) reasonable expenses actually incurred for funeral, burial, or cremation, not to exceed an amount to be determined by the board on the first day of each fiscal year;

(2) reasonable expenses for medical, chiropractic, hospital, rehabilitative, psychological and psychiatric services, products or accommodations which were incurred prior to the victim's death and for which the victim's survivors or estate are liable;

(3) loss of support, including contributions of money, products or goods, but excluding services which the victim would have supplied to dependents if the victim had lived; and

(4) reasonable expenses incurred for substitute child care and household services to replace those which the victim would have performed for the benefit of dependents if the victim had lived.

Claims for loss of support for minor children made under clause (3) must be paid for three years or until the child reaches 18 years old, whichever is the shorter period. After three years, if the child is less than 18 years old a claim for loss of support may be resubmitted to the board, and the board shall evaluate the claim giving consideration to the child's financial need and to the availability of funds to the board.

Claims for substitute child care services made under clause (4) must be limited to the actual care that the deceased victim would have provided to enable surviving family members to pursue economic, educational, and other activities other than recreational activities."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

The Speaker resumed the Chair.

Olsen, S., moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Page 4, line 19, after the headnote, insert "(a)"

Page 4, after line 32, insert:

"(b) A person shall comply with this section if:

(1) the person was convicted and sentenced to imprisonment in another state for a crime which, if committed in this state, would be a violation of a law described in paragraph (a);

(2) the person enters and remains in this state for 30 days or longer; and

(3) ten years have not elapsed since the person was released from imprisonment."

Page 4, line 35, after the headnote, insert "(a)"

Page 4, line 36, strike "this section" and insert "subdivision 1, paragraph (a),"

Page 5, after line 12, insert:

"(b) The commissioner of public safety shall give a written notice of the registration requirement in subdivision 1, paragraph (b), to any person who enters this state from another jurisdiction and applies for a Minnesota driver's license or identification card. The commissioner shall require the person to read and sign a form stating that the registration requirement has been explained. Upon request, the commissioner shall assist the person in complying with the registration requirements in subdivision 3."

Page 5, line 15, strike "The" and insert "A" and after "person" insert "who is required to register under subdivision 1, paragraph (a),"

Page 5, line 19, strike "(b)"

Page 5, after line 23, insert:

"(b) A person who is required to register under subdivision 1, paragraph (b), shall, within ten days after receiving notice of the registration requirement from the commissioner of public safety, register with the commissioner of public safety. If the person changes residence address, the person shall give the new address to the commissioner of public safety within ten days. The commissioner of public safety shall, within three days after receipt of this information, forward it to the bureau of criminal apprehension."

Page 28, line 12, after "prison" insert "or entering this state"

A roll call was requested and properly seconded.

The question was taken on the Olsen, S., amendment and the roll was called. There were 130 yeas and 1 nay as follows:

Those who voted in the affirmative were:

Abrams	Beard	Boo	Dauner	Erhardt
Anderson, I.	Begich	Brown	Davids	Farrell
Anderson, R.	Bertram	Carlson	Dawkins	Frederick
Anderson, R. H.	Bettermann	Carruthers	Dempsey	Frerichs
Battaglia	Blatz	Clark	Dille	Garcia
Bauerly	Bodahl	Cooper	Dorn	Girard

Goodno	Johnson, V.	McGuire	Pauly	Stanius
Greenfield	Kahn	McPherson	Pellow	Steensma
Gruenes	Kalis	Milbert	Pelowski	Sviggum
Gutknecht	Kelso	Morrison	Peterson	Swenson
Hanson	Kinkel	Murphy	Pugh	Thompson
Hartle	Knickerbocker	Nelson, K.	Reding	Tompkins
Hasskamp	Koppendrayer	Nelson, S.	Rest	Trimble
Haukoos	Krambeer	Newinski	Rodosovich	Tunheim
Hausman	Krinkie	O'Connor	Rukavina	Uphus
Heir	Krueger	Ogren	Runbeck	Valento
Henry	Lasley	Olsen, S.	Sarna	Vellenga
Hufnagle	Leppik	Olson, E.	Schafer	Wagenius
Hugoson	Lieder	Olson, K.	Schreiber	Waltman
Jacobs	Limmer	Omann	Seaberg	Weaver
Janezich	Lourey	Onnen	Segal	Wejcman
Jaros	Lynch	Orenstein	Simoneau	Welker
Jefferson	Macklin	Orfield	Skoglund	Welle
Jennings	Mariani	Osthoff	Smith	Wenzel
Johnson, A.	Marsh	Ostrom	Solberg	Winter
Johnson, R.	McEachern	Ozment	Sparby	Spk. Long

Those who voted in the negative were:

Vanasek

The motion prevailed and the amendment was adopted.

Krambeer, Swenson, Leppik, Lynch and Blatz moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Page 48, after line 22, insert:

"(3) driving, operating, or being in actual physical control of a motor vehicle, snowmobile, all terrain vehicle, or motorboat while under the influence of alcohol or of a controlled substance in violation of section 84.91, 86B.331, 169.121, or a local ordinance in conformity with any of them and has a passenger who is a minor child. A conviction for an offense under section 84.91, 86B.331, 169.121, or a local ordinance in conformity with any of them arising from the same incident is prima facie evidence that the parent, legal guardian, or caretaker was under the influence of alcohol or a controlled substance for purposes of this section.

Sec. 6. Minnesota Statutes 1990, section 609.378, is amended by adding a subdivision to read:

Subd. 3. [DEFINITIONS.] The definitions in this subdivision apply to this section.

(a) "Controlled substance" has the meaning given the term in section 152.01, subdivision 4.

(b) "Motorboat" has the meaning given the term in section 86B.005, subdivision 9.

(c) "Motor vehicle" has the meaning given the term in section 169.01, subdivision 3.

(d) "Snowmobile" has the meaning given the term in section 84.81, subdivision 3.

(e) "Under the influence of alcohol or of a controlled substance" has the meaning given the term in sections 84.91 or 86B.331 or 169.121 or a local ordinance in conformity with any of them."

Page 50, line 29, delete "6" and insert "7"

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Krambeer et al amendment and the roll was called. There were 127 yeas and 6 nays as follows:

Those who voted in the affirmative were:

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

Those who voted in the negative were:

Janezich	Kahn	Rukavina
Jaros	Rice	Vanasek

The motion prevailed and the amendment was adopted.

Newinski moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Page 48, lines 10 to 16, delete the new language

Page 48, after line 22, insert:

"(c) [ENDANGERMENT; PRESENCE OF CONTROLLED SUBSTANCES.] A parent, legal guardian, or caretaker who knowingly causes or permits a child to be present where any person is selling or possessing a controlled substance, as defined in section 152.01, subdivision 4, in violation of sections 152.021, 152.022, 152.023, or 152.024, is guilty of a crime and may be sentenced to imprisonment for not more than three years or to payment of a fine of not more than $5,000, or both. A person convicted of a second or subsequent offense under this paragraph 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."

A roll call was requested and properly seconded.

The question was taken on the Newinski amendment and the roll was called. There were 53 yeas and 74 nays as follows:

Those who voted in the affirmative were:

Abrams	Goodno	Johnson, V.	Olsen, S.	Steensma
Anderson, R.	Gruenes	Knickerbocker	Omann	Sviggum
Anderson, R. H.	Gutknecht	Koppendrayer	Onnen	Swenson
Bettermann	Hanson	Krambeer	Ozment	Tompkins
Boo	Hartle	Leppik	Pellow	Uphus
Davids	Haukoos	Limmer	Pelowski	Valento
Dempsey	Heir	Lynch	Runbeck	Waltman
Erhardt	Henry	Marsh	Sarna	Weaver
Frederick	Hufnagle	Morrison	Schafer	Welker
Frerichs	Hugoson	Newinski	Smith	
Girard	Johnson, R.	O'Connor	Stanius	

Those who voted in the negative were:

Anderson, I.	Brown	Farrell	Jefferson	Lasley
Battaglia	Carlson	Garcia	Jennings	Lieder
Bauerly	Carruthers	Greenfield	Johnson, A.	Lourey
Beard	Clark	Hasskamp	Kahn	Mariani
Begich	Cooper	Hausman	Kalis	McEachern
Bertram	Dauner	Jacobs	Kelso	McGuire
Bishop	Dawkins	Janezich	Kinkel	Munger
Bodahl	Dorn	Jaros	Krueger	Murphy

Nelson, K.	Osthoff	Rodosovich	Solberg	Wagenius
Nelson, S.	Ostrom	Rukavina	Sparby	Wejcman
Ogren	Peterson	Schreiber	Thompson	Welle
Olson, E.	Pugh	Seaberg	Trimble	Wenzel
Olson, K.	Reding	Segal	Tunheim	Winter
Orenstein	Rest	Simoneau	Vanasek	Spk. Long
Orfield	Rice	Skoglund	Vellenga	

The motion did not prevail and the amendment was not adopted.

Tompkins moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Page 83, after line 26, insert:

"Sec. 3. Minnesota Statutes 1991 Supplement, section 541.073, is amended by adding a subdivision to read:

Subd. 4. [PREREQUISITE TO FILING CERTAIN CLAIMS.] Notwithstanding any law to the contrary, an action for damages under this section may not be commenced unless the plaintiff reports the sexual abuse to a law enforcement agency before commencing the action. This prohibition does not apply if the statute of limitations governing the criminal sexual conduct has expired."

Page 85, line 14, delete "4" and insert "5"

Renumber the sections in sequence

Amend the title accordingly

The motion did not prevail and the amendment was not adopted.

Dille moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Page 44, lines 22 to 32, delete Sec. 2.

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Dille amendment and the roll was called. There were 53 yeas and 79 nays as follows:

Those who voted in the affirmative were:

Abrams	Erhardt	Kelso	Ostrom	Sviggum
Anderson, R. H.	Frerichs	Knickerbocker	Pauly	Tompkins
Beard	Girard	Koppendrayer	Pellow	Uphus
Bettermann	Goodno	Krinkie	Pelowski	Valento
Bishop	Gutknecht	Krueger	Reding	Vanasek
Blatz	Haukoos	Lynch	Runbeck	Waltman
Boo	Heir	McPherson	Schafer	Weaver
Dauner	Henry	Morrison	Schreiber	Welker
Davids	Hufnagle	Newinski	Seaberg	Wenzel
Dille	Jacobs	Olson, K.	Smith	
Dorn	Johnson, V.	Onnen	Stanius	

Those who voted in the negative were:

Anderson, I.	Greenfield	Krambeer	O'Connor	Simoneau
Anderson, R.	Gruenes	Lasley	Ogren	Skoglund
Battaglia	Hanson	Leppik	Olsen, S.	Solberg
Bauerly	Hartle	Lieder	Olson, E.	Sparby
Begich	Hasskamp	Limmer	Omann	Steensma
Bertram	Hausman	Lourey	Orenstein	Swenson
Bodahl	Hugoson	Macklin	Orfield	Thompson
Brown	Janezich	Mariani	Osthoff	Trimble
Carlson	Jaros	Marsh	Ozment	Tunheim
Carruthers	Jefferson	McEachern	Peterson	Vellenga
Clark	Jennings	McGuire	Pugh	Wagenius
Cooper	Johnson, A.	Milbert	Rest	Wejcman
Dempsey	Johnson, R.	Munger	Rodosovich	Welle
Farrell	Kahn	Murphy	Rukavina	Winter
Frederick	Kalis	Nelson, K.	Sarna	Spk. Long
Garcia	Kinkel	Nelson, S.	Segal	

The motion did not prevail and the amendment was not adopted.

The Speaker called Krueger to the Chair.

Ozment moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Page 131, after line 35, insert:

"Of this appropriation, $300,000 is for battered women shelters."

The motion prevailed and the amendment was adopted.

The Speaker resumed the Chair.

Farrell moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Page 82, delete section 1

Page 82, line 36, delete "Sec. 2" and insert "Section 1"

Page 83, delete lines 5 to 7

Amend the title as follows:

Page 1, line 22, delete everything after the semicolon

Page 1, line 23, delete everything before "creating"

Page 2, line 16, delete "631.035;"

A roll call was requested and properly seconded.

The question was taken on the Farrell amendment and the roll was called. There were 72 yeas and 61 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Farrell	Lieder	Orfield	Steensma
Anderson, R. H.	Garcia	Lourey	Osthoff	Thompson
Battaglia	Greenfield	Mariani	Ostrom	Trimble
Bauerly	Hanson	McEachern	Ozment	Tunheim
Beard	Hasskamp	McGuire	Pugh	Vanasek
Begich	Hausman	Milbert	Reding	Vellenga
Bodahl	Jacobs	Munger	Rest	Wagenius
Brown	Janezich	Murphy	Rice	Wejcman
Carlson	Jaros	Nelson, K.	Rodosovich	Welle
Carruthers	Jefferson	Nelson, S.	Rukavina	Wenzel
Clark	Jennings	O'Connor	Sarna	Winter
Cooper	Johnson, A.	Ogren	Segal	Spk. Long
Dauner	Kahn	Olson, E.	Skoglund	
Dawkins	Kelso	Olson, K.	Sparby	
Dorn	Lasley	Orenstein	Stanius	

Those who voted in the negative were:

Abrams	Goodno	Knickerbocker	Olsen, S.	Solberg
Bertram	Gruenes	Koppendrayer	Omann	Sviggum
Bettermann	Gutknecht	Krambeer	Onnen	Swenson
Bishop	Hartle	Krinkie	Pauly	Tompkins
Blatz	Haukoos	Krueger	Pellow	Uphus
Boo	Heir	Leppik	Pelowski	Valento
Davids	Henry	Limmer	Peterson	Waltman
Dempsey	Hufnagle	Lynch	Runbeck	Weaver
Dille	Hugoson	Macklin	Schafer	Welker
Erhardt	Johnson, R.	Marsh	Schreiber	
Frederick	Johnson, V.	McPherson	Seaberg	
Frerichs	Kalis	Morrison	Simoneau	
Girard	Kinkel	Newinski	Smith	

The motion prevailed and the amendment was adopted.

Bertram, McEachern and Pellow moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Pages 51 and 52, delete section 2

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Bertram et al amendment and the roll was called. There were 39 yeas and 92 nays as follows:

Those who voted in the affirmative were:

Bauerly	Garcia	Lasley	Nelson, S.	Rice
Bertram	Hasskamp	Lieder	Orenstein	Rukavina
Bodahl	Hausman	Mariani	Orfield	Segal
Boo	Janezich	McEachern	Osthoff	Steensma
Brown	Jaros	McGuire	Ostrom	Thompson
Dawkins	Kalis	Milbert	Pellow	Vanasek
Dempsey	Kelso	Munger	Pugh	Vellenga
Dorn	Kinkel	Nelson, K.	Reding	

Those who voted in the negative were:

Abrams	Frerichs	Knickerbocker	Omann	Sviggum
Anderson, I.	Girard	Koppendrayer	Onnen	Swenson
Anderson, R.	Goodno	Krambeer	Ozment	Tompkins
Anderson, R. H.	Gruenes	Krinkie	Pauly	Trimble
Battaglia	Gutknecht	Krueger	Pelowski	Tunheim
Beard	Hanson	Leppik	Peterson	Uphus
Begich	Hartle	Limmer	Rest	Valento
Bettermann	Haukoos	Lourey	Rodosovich	Wagenius
Blatz	Heir	Lynch	Runbeck	Waltman
Carlson	Henry	Macklin	Sarna	Weaver
Carruthers	Hufnagle	Marsh	Schafer	Wejcman
Clark	Hugoson	McPherson	Schreiber	Welker
Cooper	Jacobs	Morrison	Seaberg	Welle
Dauner	Jefferson	Murphy	Simoneau	Wenzel
Davids	Jennings	Newinski	Skoglund	Winter
Dille	Johnson, A.	O'Connor	Smith	Spk. Long
Erhardt	Johnson, R.	Olsen, S.	Solberg	
Farrell	Johnson, V.	Olson, E.	Sparby	
Frederick	Kahn	Olson, K.	Stanius	

The motion did not prevail and the amendment was not adopted.

McPherson moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Page 129, after line 4, insert:

"Section 1. Minnesota Statutes 1990, section 3.739, subdivision 1, is amended to read:

Subdivision 1. [PERMISSIBLE CLAIMS.] Claims and demands arising out of the circumstances described in this subdivision shall be presented to, heard, and determined as provided in subdivision 2:

(1) an injury to or death of an inmate of a state, regional, or local correctional facility or county jail who has been conditionally released and ordered to perform uncompensated work for a state agency, a political subdivision or public corporation of this state, a nonprofit educational, medical, or social service agency, or a private business or individual, as a condition of the release, while performing the work;

(2) an injury to or death of a person sentenced by a court, granted a suspended sentence by a court, or subject to a court disposition order, and who, under court order, is performing work (a) in restitution, (b) in lieu of or to work off fines or court ordered costs, (c) in lieu of incarceration, or (d) as a term or condition of a sentence, suspended sentence, or disposition order, while performing the work;

(3) an injury to or death of a person, who has been diverted from the court system and who is performing work as described in paragraph (1) or (2) under a written agreement signed by the person, and if a juvenile, by a parent or guardian; ~~or~~

(4) an injury to or death of an inmate of a state correctional facility who has been conditionally released through a community work program and ordered to perform work for a non-profit organization as a condition of the release, while performing the work; or

(5) an injury to or death of any person caused by an individual who was performing work as described in paragraph (1), (2), ~~or~~ (3), or (4)."

Page 131, line 15, delete "1" and insert "2"

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The motion did not prevail and the amendment was not adopted.

Dempsey, Ostrom, Dorn, Schafer and Frederick moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Page 131, line 26, delete "$3,673,000" and insert "$3,697,000"

Page 132, after line 3, insert:

"Of this appropriation, $24,000 is for the counties of Brown, Nicollet, and Blue Earth for the acquisition and construction of a juvenile detention center."

Adjust totals accordingly

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The question was taken on the Dempsey et al amendment and the roll was called. There were 66 yeas and 61 nays as follows:

Those who voted in the affirmative were:

Abrams	Dorn	Hugoson	Olsen, S.	Stanius
Anderson, I.	Erhardt	Jennings	Olson, E.	Sviggum
Anderson, R. H.	Frederick	Johnson, V.	Omann	Swenson
Battaglia	Frerichs	Knickerbocker	Ostrom	Tompkins
Begich	Girard	Koppendrayer	Ozment	Uphus
Bettermann	Goodno	Krambeer	Pauly	Valento
Bishop	Gruenes	Krinkie	Pellow	Waltman
Blatz	Gutknecht	Limmer	Pelowski	Weaver
Boo	Hartle	Lynch	Peterson	Welker
Brown	Hasskamp	Macklin	Runbeck	Wenzel
Cooper	Haukoos	Marsh	Schafer	
Davids	Heir	McPherson	Seaberg	
Dempsey	Henry	Morrison	Smith	
Dille	Hufnagle	Newinski	Sparby	

Those who voted in the negative were:

Anderson, R.	Dauner	Jaros	Lasley	Munger
Bauerly	Dawkins	Jefferson	Leppik	Murphy
Beard	Farrell	Johnson, A.	Lieder	Nelson, S.
Bertram	Garcia	Johnson, R.	Lourey	O'Connor
Bodahl	Hanson	Kahn	Mariani	Olson, K.
Carlson	Hausman	Kelso	McEachern	Onnen
Carruthers	Jacobs	Kinkel	McGuire	Orenstein
Clark	Janezich	Krueger	Milbert	Orfield

Osthoff	Rukavina	Solberg	Vellenga	Spk. Long
Pugh	Sarna	Steensma	Wagenius	
Rest	Segal	Thompson	Wejcman	
Rice	Simoneau	Trimble	Welle	
Rodosovich	Skoglund	Tunheim	Winter	

The motion did not prevail and the amendment was not adopted.

Welker moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Pages 51 to 52, delete section 2 and insert:

"Sec. 2. Minnesota Statutes 1990, section 135A.15, is amended to read:

135A.15 [SEXUAL HARASSMENT AND VIOLENCE POLICY.]

Subdivision 1. [POLICY REQUIRED.] The governing board of each public post-secondary system and each public post-secondary institution shall adopt a clear, understandable written policy on sexual harassment and sexual violence. The policy must apply to students and employees and must provide information about their rights and duties. It must include procedures for reporting incidents of sexual harassment or sexual violence and for disciplinary actions against violators. During student registration, each public post-secondary institution shall provide each student with information regarding its policy. A copy of the policy also shall be posted at appropriate locations on campus at all times. Each private post-secondary institution that enrolls students who receive state financial aid must adopt a policy that meets the requirements of this section. The higher education coordinating board shall coordinate the policy development of the systems and institutions and periodically provide for review and necessary changes in the policies.

Subd. 2. [VICTIMS RIGHTS.] The policy required under subdivision 1 shall, at a minimum, inform victims of the following rights:

(1) the right to the prompt assistance of campus authorities in notifying the appropriate prosecutorial and disciplinary authorities of a sexual assault incident;

(2) the right to an investigation and resolution of a sexual assault complaint by the appropriate criminal prosecutor and campus disciplinary authorities;

(3) the right to participate in and have the assistance of the victim's attorney or other support person at any campus disciplinary proceeding concerning the sexual assault complaint;

(4) the right to be notified of the outcome of any campus disciplinary proceeding concerning the sexual assault complaint;

(5) the right to the complete and prompt assistance of campus authorities, in cooperation with the appropriate legal authorities, in obtaining, securing, and maintaining evidence relevant to the campus disciplinary proceeding or other legal proceeding concerning the sexual assault complaint; and

(6) the right to have campus personnel, in cooperation with the appropriate legal authorities, take reasonable steps at the victim's request to shield the victim from unwanted contact with the alleged assailant, including but not limited to transfer of the victim to alternative classes or to alternative college-owned housing, if alternative classes or housing are available."

The motion did not prevail and the amendment was not adopted.

Welker, Clark and Swenson moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Page 65, line 31, delete "legislature" and insert "commissioner of corrections"

Page 68, line 6, delete "recommend" and insert "adopt"

Page 69, line 24, delete "legislature" and insert "commissioner of corrections"

The motion prevailed and the amendment was adopted.

Frederick, Henry, Krambeer, Newinski, Heir and Marsh offered an amendment to H. F. No. 1849, the second engrossment, as amended.

Osthoff requested a division of the Frederick et al amendment to H. F. No. 1849, the second engrossment, as amended.

The first portion of the Frederick et al amendment to H. F. No. 1849, the second engrossment, as amended, reads as follows:

Page 48, after line 22, insert:

"Sec. 7. Minnesota Statutes 1990, section 609.40, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] In this section "flag" means anything which is or purports to be the Stars and Stripes, the United States shield, the United States coat of arms, the Minnesota state flag, the MIA/POW flag, as described in Laws 1986, chapter 393, section 1, or a copy, picture, or representation of any of them."

Page 50, line 29, delete "6" and insert "7"

Renumber the sections in sequence

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the first portion of the Frederick et al amendment and the roll was called. There were 119 yeas and 12 nays as follows:

Those who voted in the affirmative were:

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

Those who voted in the negative were:

Clark	Hausman	Orenstein	Skoglund
Dawkins	Kahn	Orfield	Vanasek
Greenfield	Mariani	Rice	Wejcman

The motion prevailed and the first portion of the Frederick et al amendment was adopted.

Frederick withdrew the second portion of the Frederick et al amendment to H. F. No. 1849, the second engrossment, as amended.

Lasley moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Pages 48 and 49, delete section 6

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Lasley amendment and the roll was called. There were 11 yeas and 121 nays as follows:

Those who voted in the affirmative were:

Dawkins	Jaros	Reding	Trimble
Greenfield	Lasley	Rodosovich	Vanasek
Janezich	Mariani	Rukavina	

Those who voted in the negative were:

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

The motion did not prevail and the amendment was not adopted.

Uphus, Valento, Omann, Waltman and Jennings moved to amend H. F. No. 1849, the second engrossment, as amended, as follows:

Page 129, after line 2, insert:

"ARTICLE 13

DEATH PENALTY

Section 1. [609A.01] [REQUIRING NOTICE BY STATE IN DEATH PENALTY CASES.]

If the state intends to seek the death penalty for an offense punishable by death, the prosecuting attorney shall sign and file with the court, and serve upon the defendant, a notice that the state will seek the sentence of death in the event of conviction. The notice must be filed and served within a reasonable time before trial or acceptance by the court of a plea of guilty. If the prosecuting attorney does not comply with the notice requirements of this section, the court may not impose the death penalty under section 4.

Sec. 2. [609A.02] [APPOINTMENT OF ATTORNEYS IN CAPITAL CASES.]

Upon notification under section 1 that the prosecuting attorney intends to seek the death penalty, the court shall order the appointment of two attorneys to counsel the defendant, at least one of whom has had significant criminal defense experience, unless the court is satisfied that the defendant has retained a competent attorney. If the defendant is not represented by an attorney and is not able to afford one, the court shall order the appropriate district public defender to assign two public defenders. If the defendant is convicted and sentenced to death, the state public defender shall represent the defendant during the appeal process.

Sec. 3. [609A.03] [SENTENCE OF DEATH FOR MURDER IN CERTAIN CASES; SENTENCING PROCEEDINGS.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the following terms have the meanings given.

(b) "First degree murder" means murder in the first degree as defined in section 609.185.

(c) "Heinous crime" means a violation of section 609.185, 609.19, 609.195, or a violation of section 609.342 or 609.343 if the offense was committed with force or violence.

Subd. 2. [EXCLUDING DEATH SENTENCE.] When a defendant is found guilty of first degree murder, and the defendant has one or

more previous convictions for a heinous crime, the court shall impose a sentence other than that of death if it is satisfied that:

(1) none of the aggravating circumstances listed in subdivision 4 was established by the evidence at the trial or will be established at a sentencing proceeding under subdivision 3;

(2) substantial mitigating circumstances, established by the evidence at the trial, call for leniency;

(3) the defendant, with the consent of the prosecuting attorney and the approval of the court, pleaded guilty to murder with life imprisonment or a lesser sentence as the maximum term;

(4) the defendant was under 18 years of age at the time of the commission of the crime;

(5) the defendant's physical or mental condition calls for leniency; or

(6) although the evidence is sufficient to sustain the verdict, it does not foreclose all doubt about the defendant's guilt.

Subd. 3. [SEPARATE SENTENCING PROCEEDING TO DETERMINE IF DEATH PENALTY WARRANTED.] (a) When a defendant is convicted of first degree murder, and the defendant has one or more previous convictions for a heinous crime, the court shall conduct a separate proceeding to determine whether the defendant should be sentenced to death or to a sentence other than death as required by law, unless the court imposes a sentence under subdivision 2. The proceeding must be conducted before the court alone if the defendant was convicted by a court sitting without a jury, if the defendant pleaded guilty, or if the prosecuting attorney and the defendant waive a jury with respect to sentence. In other cases it must be conducted before the court sitting with the jury that determined the defendant's guilt or, if the court for good cause shown discharges that jury, with a new jury impaneled for the purpose.

(b) In the proceeding, evidence may be presented about any matter that the court considers relevant to sentence, including the nature and circumstances of the crime, the defendant's character, background, history, mental and physical condition, and any of the aggravating or mitigating circumstances listed in subdivisions 4 and 5. Any evidence relevant to the sentence, not legally privileged, that the court considers to have probative force, may be received, regardless of its admissibility under the exclusionary rules of evidence. The defendant's counsel must be given a fair opportunity to rebut the evidence. The prosecuting attorney and the defendant or defendant's counsel must be permitted to present argument for or against a sentence of death.

Subd. 4. [AGGRAVATING CIRCUMSTANCES.] (a) In this subdivision, "involved in" means engaged in committing a crime or attempting to commit a crime, acting as an accomplice in a crime or an attempt at a crime, or fleeing after committing or attempting to commit a crime.

(b) "Aggravating circumstances" are limited to the following:

(1) the victim of the murder was a public safety officer, as defined in section 299A.41, subdivision 4;

(2) the victim was under the age of 12 years and had a past history of physical or sexual abuse by the defendant, as defined in section 626.556, subdivision 2;

(3) the defendant was being held in lawful custody at the time of the murder;

(4) the murder was committed while the defendant was involved in criminal sexual conduct in the first degree by force or threat of force;

(5) the defendant intentionally killed the victim while the defendant was involved in a major controlled substance offense. "Major controlled substance offense" means an offense or series of offenses constituting a felony violation or violations under chapter 152, related to trafficking in controlled substances under circumstances more onerous than the usual offense and including at least one of the following circumstances:

(i) the offense involved an attempted or actual sale or transfer of controlled substances in quantities substantially larger than for personal use;

(ii) the defendant knowingly possessed a firearm during the commission of the offense;

(iii) the circumstances of the offense reveal that the defendant occupied a high position in the drug distribution hierarchy; or

(iv) the offense involved a high degree of sophistication or planning; or

(6) at the time of the murder the defendant had previously been convicted of two or more state or federal offenses punishable by a term of imprisonment of more than one year, committed on different occasions, involving the distribution of a controlled substance in violation of chapter 152.

Subd. 5. [MITIGATING CIRCUMSTANCES.] "Mitigating circumstances" include:

(1) the defendant has no significant history of prior criminal activity;

(2) the murder was committed while the defendant was under extreme mental or emotional disturbance, although not sufficiently impaired as to constitute a defense to prosecution;

(3) the victim was a participant in the defendant's homicidal conduct or consented to the homicidal act;

(4) the defendant acted on a threat of imminent infliction of death or great bodily harm;

(5) at the time of the offense, the capacity of the offender to appreciate the criminality of the conduct or to conform that conduct to law was impaired as a result of mental disease or defect or intoxication; or

(6) any other relevant mitigating circumstance.

Sec. 4. [609A.04] [IMPOSITION OF DEATH SENTENCE; MODE OF EXECUTION.]

Subdivision 1. [DECISION.] (a) The court has discretion to determine whether a sentence of death will be imposed, except that when the proceeding is conducted before the court sitting with a jury, the court may not impose a sentence of death unless (1) it submits to the jury the issue whether the defendant should be sentenced to death or to imprisonment, and (2) the jury returns a verdict that the sentence should be death. If the jury is unable to reach a unanimous verdict, the court shall dismiss the jury and impose a sentence other than death as required by law.

(b) The court, in exercising its discretion as to sentence, and the jury, in determining its verdict, shall take into account the aggravating and mitigating circumstances listed in section 3, subdivisions 4 and 5, and any other facts that the court or jury considers relevant, but the court or jury may not impose or recommend a sentence of death unless the court or jury unanimously finds one of the aggravating circumstances listed in subdivision 4 and further unanimously finds that there are no mitigating circumstances sufficiently substantial to call for leniency.

(c) The burden of establishing the existence of an aggravating circumstance is on the state and is not satisfied unless established beyond a reasonable doubt. The burden of establishing the existence of a mitigating circumstance is on the defendant and is not satisfied unless established by a preponderance of the evidence.

(d) When the issue is submitted to the jury, the court shall instruct

the jury on the requirements of this subdivision. At that time, the court shall also inform the jury of the nature of the sentence of imprisonment that may be imposed if the jury verdict is against a sentence of death, including the implications of the sentence for possible supervised release. The court shall instruct the jury about the aggravating and mitigating circumstances listed in section 3. The court may provide the jury with a list of the aggravating and mitigating circumstances about which the jury is instructed.

Subd. 2. [IMPOSITION.] (a) When the proceeding is conducted without a jury, the court shall sentence the defendant to death when it:

(1) finds beyond a reasonable doubt that at least one statutory aggravating circumstance exists; and

(2) finds that there are no mitigating circumstances sufficiently substantial to call for leniency.

(b) When the proceeding is conducted before a jury, the court shall sentence the defendant to death when the jury unanimously:

(1) finds beyond a reasonable doubt that at least one statutory aggravating circumstance exists;

(2) finds that there are no mitigating circumstances sufficiently substantial to call for leniency; and

(3) recommends that the sentence of death be imposed.

(c) When the jury does not recommend a sentence of death, the court shall sentence the defendant to imprisonment as provided by law.

Subd. 3. [SENTENCE OF DEATH PRECLUDED.] A sentence of death may not be carried out upon a person who is under 18 years of age at the time the crime was committed. A sentence of death may not be carried out upon a person who, by reason of a mental disease or defect, is unable to understand the impending death or the reasons for it. A sentence of death may not be carried out upon a person who is pregnant.

Subd. 4. [EXECUTION BY LETHAL INJECTION.] When the court sentences a defendant to death under subdivision 2, the order of execution must be carried out by administration of a continuous, intravenous injection of a lethal quantity of an ultra-fast-acting barbiturate in combination with a chemical paralytic agent until a licensed physician pronounces that the defendant is dead according to accepted standards of medical practice. The execution by lethal injection must be performed by a person selected by the chief

executive officer of the maximum security facility at which the execution will take place and trained to administer the injection. The person administering the injection need not be a physician, registered nurse, or licensed practical nurse licensed or registered under the laws of this or another state.

Sec. 5. [609A.05] [SENTENCING COURT; ADMINISTRATIVE REQUIREMENTS.]

Subdivision 1. [DATE OF EXECUTION.] In pronouncing a sentence of death, the court shall set the date of execution not less than 60 days nor more than 90 days from the date the sentence is pronounced. If execution has been stayed by a court and the date set for execution has passed before dissolution of the stay, the court in which the defendant was previously sentenced shall, upon dissolution of the stay, set a new date of execution not less than five nor more than 90 days from the day the date is set. The defendant is entitled to be present in court on the day the new date of execution is set.

Subd. 2. [COPIES OF ORDER OF EXECUTION.] When a person is sentenced to death, the court administrator shall prepare certified copies of the judgment and order of execution and send these documents to the governor, defendant, defendant's counsel, attorney general, chief justice of the supreme court, state court administrator, and the state public defender's office within five business days following entrance of the order of execution.

Subd. 3. [DELIVERY OF DEFENDANT TO MAXIMUM SECURITY FACILITY.] Pending execution of a sentence of death, the sheriff or other chief law enforcement officer who has custody of the defendant may deliver the defendant to the maximum security facility designated by the commissioner of corrections to be the place where the execution is to be held. The state shall bear the costs of imprisoning the defendant from the date of delivery.

Sec. 6. [609A.06] [REVIEW OF DEATH SENTENCES BY SUPREME COURT.]

Subdivision 1. [AUTOMATIC REVIEW.] The judgment of conviction and a sentence of death are subject to automatic review by the supreme court within 60 days after certification by the sentencing court of the entire record, unless the supreme court extends the time, for good cause shown, for an additional period not to exceed 30 days. The review by the supreme court has priority over all other cases and must be heard in accordance with rules adopted by the supreme court.

Subd. 2. [TRANSCRIPT.] The court administrator, within ten days after receiving the transcript, shall transmit the entire record and transcript to the supreme court together with a notice prepared by

the administrator and a report prepared by the trial judge. The notice shall set forth the title and docket number of the case, the name of the defendant, the name and address of the defendant's attorney, a narrative statement of the judgment, the offense, and the punishment prescribed. The report shall be in the form of a standard questionnaire prepared and supplied by the supreme court.

Subd. 3. [REVIEW GUIDELINES.] Each sentence of death must be reviewed by the supreme court to determine if it is excessive. In determining whether the sentence is excessive, the supreme court shall determine whether the:

(1) sentence was imposed under the influence of passion, prejudice, or other arbitrary factors;

(2) evidence supports the finding of a statutory aggravating circumstance; and

(3) sentence is disproportionate to the penalty imposed in similar cases, considering both the crime and the defendant.

Subd. 4. [BRIEFS.] Both the defendant and the state have the right to submit briefs within the time provided by the court and to present oral argument to the court.

Subd. 5. [DECISION.] The supreme court shall:

(1) affirm the sentence of death; or

(2) set the sentence aside and remand the case for resentencing by the trial judge based on the record and argument of counsel.

Subd. 6. [NOTICE TO GOVERNOR.] Within five business days after reaching a decision under subdivision 5, the supreme court shall notify the governor whether the death sentence has been affirmed or set aside.

Sec. 7. [609A.07] [UNIFIED REVIEW PROCEDURE.]

Subdivision 1. [PROCEDURE.] The supreme court shall establish by rule a unified review procedure to provide for the presentation to the sentencing court and to the supreme court of all possible challenges to the trial, conviction, sentence, and detention of defendants upon whom the sentence of death has been or may be imposed. The unified review procedure governs both pretrial and posttrial appellate review of death penalty cases.

Subd. 2. [CHECKLISTS.] The supreme court shall establish by rule a series of checklists to be used by the trial court, the prosecuting attorney, and defense counsel before, during, and after

the trial of cases in which the death penalty is sought to make certain that all possible matters that could be raised in defense have been considered by the defendant and defense counsel and either asserted in a timely and correct manner or waived in accordance with applicable legal requirements, so that, for purposes of any pretrial review and the trial and posttrial review, the record and transcript of proceedings will be complete for a review by the sentencing court and the supreme court of all possible challenges to the trial, conviction, sentence, and detention of the defendant.

Subd. 3. [WRIT OF HABEAS CORPUS.] Nothing in this section or in the rules of the supreme court limits or restricts the grounds of review or suspends the rights or remedies available through the procedures governing the writ of habeas corpus.

Sec. 8. [609A.08] [STAY OF EXECUTION OF DEATH.]

Subdivision 1. [GOVERNOR OR APPEAL.] The execution of a death sentence may be stayed only by the governor or incident to an appeal.

Subd. 2. [PROCEEDINGS WHEN INMATE UNDER SENTENCE OF DEATH APPEARS TO BE MENTALLY ILL OR PREGNANT.] When the governor is informed that an inmate under sentence of death may be mentally ill or pregnant, the governor shall stay execution of the sentence and require the sentencing court to order a mental or physical examination of the inmate, as appropriate.

Subd. 3. [EXAMINATION AND HEARING.] (a) If the court orders a mental examination of the inmate, it shall appoint at least one qualified psychiatrist, clinical psychologist, or physician experienced in the field of mental illness to examine the defendant and report on the defendant's mental condition. If the inmate or prosecution has retained a qualified psychiatrist, clinical psychologist, or physician experienced in the field of mental illness, the court on request of the inmate or prosecuting attorney shall direct that the psychiatrist, clinical psychologist, or physician be permitted to observe the mental examination and to conduct a mental examination of the inmate.

(b) At the conclusion of the examination, the examiner shall submit a written report to the court and send copies to the prosecuting attorney and defense attorney. The report must contain a diagnosis of the inmate's mental condition and whether the inmate has the mental capacity to understand the nature of the death penalty and the reasons why it was imposed.

(c) If the court orders a physical examination, it shall appoint a qualified physician to examine the inmate and report on whether the inmate is pregnant.

(d) The hearing shall be scheduled so that the parties have adequate time to prepare and present arguments regarding the issue of mental illness or pregnancy. The parties may submit written arguments to the court before the date of the hearing and may make oral arguments before the court at the sentencing hearing. Before the hearing, the court shall send to the defendant or the defendant's attorney and the prosecuting attorney copies of the mental or physical examination.

Subd. 4. [MENTAL ILLNESS.] (a) If mental illness is the issue and the court decides that the inmate has the mental capacity to understand the nature of the death penalty and why it was imposed, the court shall so inform the governor. The governor shall issue a warrant to the chief executive officer of the maximum security facility where the execution is to be held directing the officer to execute the sentence at a time designated in the warrant.

(b) If the court decides that the inmate does not have the mental capacity to understand the nature of the death penalty and why it was imposed, the court shall so inform the governor. The governor shall have the inmate committed to the St. Peter Regional Treatment Center.

(c) When a person under sentence of death has been committed to the St. Peter Regional Treatment Center, that person shall be kept there until the proper official of the hospital determines that the person has been restored to mental health. The hospital official shall then notify the governor of the official's determination, and the governor shall request the sentencing court to proceed as provided in this section.

Subd. 5. [PREGNANCY.] (a) If the court determines that the inmate is not pregnant, the court shall so tell the governor. The governor shall issue a warrant to the chief executive officer of the maximum security facility where the execution is to be held directing the chief executive officer to execute the sentence at a time designated in the warrant.

(b) If the court determines that the inmate is pregnant, the court shall so tell the governor. The governor shall stay execution of sentence during the pregnancy.

(c) If the court determines that an inmate whose execution has been stayed because of pregnancy is no longer pregnant, the court shall so tell the governor. The governor shall issue a warrant to the chief executive officer directing the chief executive officer to execute the sentence at a time designated in the warrant.

Subd. 6. [FEE.] The court shall allow a reasonable fee to the physician appointed under this section that shall be paid by the state.

Sec. 9. [609A.09] [GOVERNOR'S DUTIES; ISSUANCE OF DEATH WARRANT.]

When notified by the supreme court under section 6 that a death sentence has been upheld, the governor shall issue a death warrant, attach it to a copy of the record, including the trial court's order of execution and the supreme court's affirming opinion, and send it to the chief executive officer of the maximum security facility where the inmate under sentence of death is being held. The warrant must direct that officer to execute the sentence at a time designated in the warrant. When notified by the supreme court under section 6 that a death sentence has been set aside, the governor shall order the commissioner of corrections to remove the inmate under sentence of death from the unit where inmates under sentence of death are confined and reassign the inmate consistent with the supreme court's opinion.

Sec. 10. [609A.10] [COMMISSIONER OF CORRECTIONS; DUTIES; DESIGNATION OF PLACE OF EXECUTION.]

Subdivision 1. [MAXIMUM SECURITY FACILITIES.] The commissioner of corrections shall designate one or more maximum security facilities at which executions of inmates under death sentence will take place. In each maximum security facility designated as a place where executions will take place, the commissioner shall establish and maintain a unit for the segregated confinement of inmates under sentence of death.

Subd. 2. [PLACE OF EXECUTION.] The chief executive officer of a maximum security facility where executions will take place shall provide a suitable and efficient room or place in which executions will be carried out, enclosed from public view, and all implements necessary to executions. The chief executive officer shall select the person to perform executions and the chief executive officer or the officer's designee shall supervise the execution.

Subd. 3. [EXECUTIONER'S IDENTITY; PRIVATE DATA.] Information relating to the identity and compensation of the executioner is private data as defined in section 13.02, subdivision 12. The chief executive officer of the maximum security facility is not required to record the name of an individual acting as an executioner or any information that could identify that individual.

Subd. 4. [REGULATION OF EXECUTION.] The chief executive officer of the maximum security facility holding an execution or a deputy designated by that officer must be present at the execution. The chief executive officer shall set the day for execution within the week designated by the governor in the warrant.

Subd. 5. [WITNESS TO EXECUTION.] Twelve citizens selected by the chief executive officer must witness the execution. The chief

executive officer shall select six representatives of the news media to witness the execution. Counsel for the inmate under sentence of death and members of the clergy requested by the inmate may be present at the execution. All other persons, except correctional facility officers and the executioner, must be excluded during the execution.

Subd. 6. [READING DEATH WARRANT.] The warrant authorizing the execution must be read to the convicted person immediately before death.

Subd. 7. [RETURN OF WARRANT OF EXECUTION ISSUED BY GOVERNOR.] After the death sentence has been executed, the chief executive officer of the maximum security facility where the execution took place shall return to the governor the warrant and a signed statement of the execution. The chief executive officer shall file an attested copy of the warrant and statement with the court administrator that imposed the sentence.

Subd. 8. [SENTENCE OF DEATH UNEXECUTED FOR UNJUSTIFIABLE REASONS.] If a death sentence is not executed because of unjustified failure of the governor to issue a warrant or for any other unjustifiable reason, on application of the attorney general, the supreme court shall issue a warrant directing the sentence to be executed during a week designated in the warrant.

Subd. 9. [RETURN OF WARRANT OF EXECUTION ISSUED BY SUPREME COURT.] After the sentence has been executed under a warrant issued by the supreme court, the chief executive officer shall return to the supreme court the warrant and a signed statement of the execution. The chief executive officer shall file an attested copy of the warrant and statement with the court administrator that imposed the sentence. The chief executive officer shall send to the governor an attested copy of the warrant and statement.

Sec. 11. [609A.11] [COSTS OF EXECUTION; REIMBURSEMENT; ATTORNEY GENERAL ASSISTANCE.]

Subdivision 1. [COSTS.] The state shall reimburse a county for all costs incurred for prosecution of a case involving the death penalty if the crimes for which the defendant is on trial occurred in that county. In a case involving the death penalty, if crimes for which the defendant is on trial occurred in more than one county, the state shall reimburse the county prosecuting the case for one-half of all costs incurred for prosecution.

Subd. 2. [ATTORNEY GENERAL ASSISTANCE.] The attorney general shall assist in the prosecution of cases involving the death penalty when requested to do so by the county prosecuting attorney.

Sec. 12. [EFFECTIVE DATE.]

Sections 1 to 11 are effective August 1, 1992, and apply to crimes committed on or after that date. The court shall consider convictions for heinous crimes occurring before, on, or after August 1, 1992, as previous convictions for purposes of sentencing under sections 3 and 4.

ARTICLE 14

TECHNICAL AMENDMENTS

Section 1. Minnesota Statutes 1990, section 243.05, subdivision 1, is amended to read:

Subdivision 1. [CONDITIONAL RELEASE.] Except for a person sentenced to death under article 1, section 4, the commissioner of corrections may parole any person sentenced to confinement in any state correctional facility for adults under the control of the commissioner of corrections, provided that:

(a) no inmate serving a life sentence for committing murder before May 1, 1980, other than murder committed in violation of clause (1) of section 609.185 who has not been previously convicted of a felony shall be paroled without having served 20 years, less the diminution that would have been allowed for good conduct had the sentence been for 20 years;

(b) no inmate serving a life sentence for committing murder before May 1, 1980, who has been previously convicted of a felony or though not previously convicted of a felony is serving a life sentence for murder in the first degree committed in violation of clause (1) of section 609.185 shall be paroled without having served 25 years, less the diminution which would have been allowed for good conduct had the sentence been for 25 years;

(c) any inmate sentenced prior to September 1, 1963, who would be eligible for parole had the inmate been sentenced after September 1, 1963, shall be eligible for parole; and

(d) any new rule or policy or change of rule or policy adopted by the commissioner of corrections which has the effect of postponing eligibility for parole has prospective effect only and applies only with respect to persons committing offenses after the effective date of the new rule or policy or change. Upon being paroled and released, an inmate is and remains in the legal custody and under the control of the commissioner, subject at any time to be returned to a facility of the department of corrections established by law for the confinement or treatment of convicted persons and the parole rescinded by the commissioner. The written order of the commissioner of correc-

tions, is sufficient authority for any peace officer or state parole and probation agent to retake and place in actual custody any person on parole or supervised release, but any state parole and probation agent may, without order of warrant, when it appears necessary in order to prevent escape or enforce discipline, take and detain a parolee or person on supervised release or work release to the commissioner for action. The written order of the commissioner of corrections is sufficient authority for any peace officer or state parole and probation agent to retake and place in actual custody any person on probation under the supervision of the commissioner pursuant to section 609.135, but any state parole and probation agent may, without an order, when it appears necessary in order to prevent escape or enforce discipline, retake and detain a probationer and bring the probationer before the court for further proceedings under section 609.14. Persons conditionally released, and those on probation under the supervision of the commissioner of corrections pursuant to section 609.135 may be placed within or outside the boundaries of the state at the discretion of the commissioner of corrections or the court, and the limits fixed for these persons may be enlarged or reduced according to their conduct.

In considering applications for conditional release or discharge, the commissioner is not required to hear oral argument from any attorney or other person not connected with an adult correctional facility of the department of corrections in favor of or against the parole or release of any inmates, but the commissioner may institute inquiries by correspondence, taking testimony or otherwise, as to the previous history, physical or mental condition, and character of the inmate, and to that end shall have authority to require the attendance of the chief executive officer of any state adult correctional facility and the production of the records of these facilities, and to compel the attendance of witnesses. The commissioner is authorized to administer oaths to witnesses for these purposes.

Sec. 2. Minnesota Statutes 1990, section 609.10, is amended to read:

609.10 [SENTENCES AVAILABLE.]

Upon conviction of a felony and compliance with the other provisions of this chapter and chapter 609A the court, if it imposes sentence, may sentence the defendant to the extent authorized by law as follows:

(1) to death; or

(2) to life imprisonment; or

~~(2)~~ (3) to imprisonment for a fixed term of years set by the court; or

~~(3)~~ (4) to both imprisonment for a fixed term of years and payment of a fine; or

~~(4)~~ (5) to payment of a fine without imprisonment or to imprisonment for a fixed term of years if the fine is not paid; or

~~(5)~~ (6) to payment of court-ordered restitution in addition to either imprisonment or payment of a fine, or both.

Sec. 3. Minnesota Statutes 1990, section 609.12, subdivision 1, is amended to read:

Subdivision 1. A person sentenced to the commissioner of corrections for imprisonment for a period less than life may be paroled or discharged at any time without regard to length of the term of imprisonment which the sentence imposes when in the judgment of the commissioner of corrections, and under the conditions the commissioner imposes, the granting of parole or discharge would be most conducive to rehabilitation and would be in the public interest. A person sentenced to death is not eligible for supervised release or discharge at any time.

Sec. 4. Minnesota Statutes 1990, section 609.135, subdivision 1, is amended to read:

Subdivision 1. [TERMS AND CONDITIONS.] Except when a sentence of death has been imposed under chapter 609A, a life ~~imprisonment~~ sentence is required ~~by law~~ under section 609.185 or 609.19, or ~~when~~ a mandatory minimum term of imprisonment is required by section 609.11, any court may stay imposition or execution of sentence and (a) may order intermediate sanctions without placing the defendant on probation, or (b) may place the defendant on probation with or without supervision and on the terms the court prescribes, including intermediate sanctions when practicable. The court may order the supervision to be under the probation officer of the court, or, if there is none and the conviction is for a felony or gross misdemeanor, by the commissioner of corrections, or in any case by some other suitable and consenting person. No intermediate sanction may be ordered performed at a location that fails to observe applicable requirements or standards of chapter 181A or 182, or any rule promulgated under them. For purposes of this subdivision, subdivision 6, and section 609.14, the term "intermediate sanctions" includes but is not limited to incarceration in a local jail or workhouse, home detention, electronic monitoring, intensive probation, sentencing to service, reporting to a day reporting center, chemical dependency or mental health treatment or counseling, restitution, fines, day-fines, community work service, and work in lieu of or to work off fines.

A court may not stay the revocation of the driver's license of a person convicted of violating the provisions of section 169.121.

Sec. 5. Minnesota Statutes 1990, section 609.185, is amended to read:

609.185 [MURDER IN THE FIRST DEGREE.]

Whoever does any of the following is guilty of murder in the first degree and, unless sentenced to death under article 1, section 4, shall be sentenced to imprisonment for life:

(1) causes the death of a human being with premeditation and with intent to effect the death of the person or of another;

(2) causes the death of a human being while committing or attempting to commit criminal sexual conduct in the first or second degree with force or violence, either upon or affecting the person or another;

(3) causes the death of a human being with intent to effect the death of the person or another, while committing or attempting to commit burglary, aggravated robbery, kidnapping, arson in the first or second degree, tampering with a witness in the first degree, escape from custody, or any felony violation of chapter 152 involving the unlawful sale of a controlled substance;

(4) causes the death of a peace officer or a guard employed at a Minnesota state correctional facility, with intent to effect the death of that person or another, while the peace officer or guard is engaged in the performance of official duties;

(5) causes the death of a minor under circumstances other than those described in clause (1) or (2) while committing child abuse, when the perpetrator has engaged in a past pattern of child abuse upon the child and the death occurs under circumstances manifesting an extreme indifference to human life; or

(6) causes the death of a human being under circumstances other than those described in clause (1), (2), or (5) while committing domestic abuse, when the perpetrator has engaged in a past pattern of domestic abuse upon the victim and the death occurs under circumstances manifesting an extreme indifference to human life.

For purposes of clause (5), "child abuse" means an act committed against a minor victim that constitutes a violation of section 609.221, 609.222, 609.223, 609.224, 609.342, 609.343, 609.344, 609.345, 609.377, or 609.378.

For purposes of clause (6), "domestic abuse" means an act that:

(1) constitutes a violation of section 609.221, 609.222, or 609.223; and

(2) is committed against the victim who is a family or household member as defined in section 518B.01, subdivision 2, paragraph (b).

Sec. 6. Minnesota Statutes 1991 Supplement, section 611.25, is amended by adding a subdivision to read:

Subd. 4. [CAPITAL CASE REPRESENTATION.] The state public defender shall establish a division within the office to handle capital cases. The state public defender shall represent all defendants sentenced to death under article 1, section 4, who cannot retain competent counsel.

Sec. 7. [EFFECTIVE DATE.]

Sections 1 to 6 are effective August 1, 1992, and apply to crimes committed on or after that date."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

PREVIOUS QUESTION

Boo moved the previous question and the motion was properly seconded. The motion prevailed and the previous question was so ordered on the Uphus et al amendment.

The question recurred on the Uphus et al amendment and the roll was called. There were 25 yeas and 108 nays as follows:

Those who voted in the affirmative were:

Anderson, R.	Henry	Krambeer	Omann	Stanius
Bertram	Hufnagle	Limmer	Pellow	Steensma
Bettermann	Hugoson	Marsh	Schafer	Uphus
Goodno	Jennings	Nelson, S.	Schreiber	Valento
Heir	Koppendrayer	Newinski	Sparby	Waltman

Those who voted in the negative were:

Abrams	Beard	Boo	Cooper	Dille
Anderson, I.	Begich	Brown	Dauner	Dorn
Anderson, R. H.	Bishop	Carlson	Davids	Erhardt
Battaglia	Blatz	Carruthers	Dawkins	Farrell
Bauerly	Bodahl	Clark	Dempsey	Frederick

Frerichs	Johnson, V.	McPherson	Pauly	Sviggum
Garcia	Kahn	Milbert	Pelowski	Swenson
Girard	Kalis	Morrison	Peterson	Tompkins
Greenfield	Kelso	Munger	Pugh	Trimble
Gruenes	Kinkel	Murphy	Reding	Tunheim
Gutknecht	Knickerbocker	Nelson, K.	Rest	Vanasek
Hanson	Krinkie	O'Connor	Rice	Vellenga
Hartle	Krueger	Ogren	Rodosovich	Wagenius
Hasskamp	Lasley	Olsen, S.	Rukavina	Weaver
Haukoos	Leppik	Olson, E.	Runbeck	Wejcman
Hausman	Lieder	Olson, K.	Sarna	Welker
Jacobs	Lourey	Onnen	Seaberg	Welle
Janezich	Lynch	Orenstein	Segal	Wenzel
Jaros	Macklin	Orfield	Simoneau	Winter
Jefferson	Mariani	Osthoff	Skoglund	Spk. Long
Johnson, A.	McEachern	Ostrom	Smith	
Johnson, R.	McGuire	Ozment	Solberg	

The motion did not prevail and the amendment was not adopted.

H. F. No. 1849, A bill for an act relating to crime; anti-violence education, prevention and treatment; increasing penalties for repeat sex offenders; providing for life imprisonment for certain repeat sex offenders; providing for life imprisonment without parole for certain persons convicted of first degree murder; increasing penalties for other violent crimes and crimes committed against children; increasing supervision of sex offenders; providing a fund for sex offender treatment; eliminating the "good time" reduction in prison sentences; allowing the extension of prison terms for disciplinary violations in prison; authorizing the commissioner of corrections to establish a "boot camp" program; authorizing the imposition of fees for local correctional services on offenders; requiring the imposition of minimum fines on convicted offenders; providing for HIV testing of certain sex offenders; expanding certain crime victim rights; providing programs for victim-offender mediation; enhancing protection of domestic abuse victims; authorizing secure confinement of dangerous juvenile offenders; creating a civil cause of action for minors used in a sexual performance; providing for a variety of anti-violence education, prevention, and treatment programs; authorizing the issuance of state bonds for a variety of projects; appropriating money; amending Minnesota Statutes 1990, sections 13.87, subdivision 2; 72A.20, by adding a subdivision; 121.882, by adding a subdivision; 127.46; 135A.15; 241.021, by adding a subdivision; 241.67, subdivisions 1, 2, 3, 6, and by adding a subdivision; 242.19, subdivision 2; 242.195, subdivision 1; 243.53; 244.01, subdivision 8; 244.03; 244.04, subdivisions 1 and 3; 244.05, subdivisions 1, 3, 4, 5, and by adding subdivisions; 245.4871, by adding a subdivision; 254A.14, by adding a subdivision; 254A.17, subdivision 1, and by adding a subdivision; 259.11; 260.151, subdivision 1; 260.155, subdivision 1, and by adding a subdivision; 260.172, by adding a subdivision; 260.181, by adding a subdivision; 260.185, subdivisions 1 and 4; 260.311, by adding a subdivision; 270A.03, subdivision 5; 299A.37; 299A.40, subdivision 3; 332.51, subdivisions 1 and 5; 401.02, subdivision 4; 485.018, subdivision 5; 518B.01, subdivisions

7 and 13; 546.27, subdivision 1; 595.02, subdivision 4; 609.02, by adding a subdivision; 609.10; 609.101, by adding a subdivision; 609.115, subdivision 1a; 609.125; 609.135, subdivision 5, and by adding subdivisions; 609.1352, subdivisions 1 and 5; 609.152, subdivisions 2 and 3; 609.184, subdivision 2; 609.19; 609.2231, by adding a subdivision; 609.224, subdivision 2; 609.322; 609.323; 609.342; 609.343; 609.344, subdivisions 1 and 3; 609.345, subdivisions 1 and 3; 609.346, subdivisions 2, 2a, and by adding subdivisions; 609.3471; 609.378, subdivision 1, and by adding a subdivision; 609.40, subdivision 1; 609.605, by adding a subdivision; 609.747, subdivision 2; 611A.03, subdivision 1; 611A.52, subdivision 8; 626.843, subdivision 1; 626.8451; 626.8465, subdivision 1; 629.72, by adding a subdivision; 630.36, subdivision 1, and by adding a subdivision; Minnesota Statutes 1991 Supplement, sections 3.873, subdivisions 1, 5, 7, and by adding a subdivision; 8.15; 121.882, subdivision 2; 124A.29, subdivision 1; 126.70, subdivisions 1 and 2a; 243.166, subdivisions 1, 2, and 3; 244.05, subdivision 6; 244.12, subdivision 3; 245.484; 245.4884, subdivision 1; 299A.30; 299A.31, subdivision 1; 299A.32, subdivisions 2 and 2a; 299A.36; 518B.01, subdivisions 3a, 6, and 14; 609.135, subdivision 2; Laws 1991, chapter 232, section 5; proposing coding for new law in Minnesota Statutes, chapters 126; 145; 145A; 169; 241; 244; 256; 256F; 260; 299A; 609; 611A; 617; and 629.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 125 yeas and 9 nays as follows:

Those who voted in the affirmative were:

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

Those who voted in the negative were:

Dawkins	Janezich	Kahn	Rice	Vanasek
Hausman	Jaros	Ogren	Rukavina	

The bill was passed, as amended, and its title agreed to.

There being no objection, the order of business reverted to Reports of Standing Committees.

REPORTS OF STANDING COMMITTEES

Simoneau from the Committee on Appropriations to which was referred:

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.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"ARTICLE 1

COST CONTAINMENT

Section 1. [62J.03] [DEFINITIONS.]

Subdivision 1. [SCOPE OF DEFINITIONS.] For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. [COMMISSION.] "Commission" or "state commission" means the Minnesota health care commission established in section 62J.05.

Subd. 3. [COMMISSIONER.] "Commissioner" means the commissioner of health.

Subd. 4. [GROUP PURCHASER.] "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, health insurance companies, health maintenance organizations and other health plan companies; employee health plans offered by self-insured employers; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Subd. 5. [PROVIDER.] "Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee, as further defined in rules adopted by the commissioner.

Sec. 2. [62J.04] [CONTROLLING THE RATE OF GROWTH OF HEALTH CARE SPENDING.]

Subdivision 1. [COMPREHENSIVE BUDGET.] The commissioner of health shall set an annual limit on the rate of growth of public and private spending on health care services for Minnesota residents. The limit on growth must be set at a level that will slow the current rate of growth by at least ten percent per year using the spending growth rate for 1991 as a base year. This limit must be achievable through good faith, cooperative efforts of health care consumers, purchasers, and providers.

Subd. 2. [DATA COLLECTION.] For purposes of setting limits under this section, the commissioner shall collect from all Minnesota health care providers data on gross patient revenues received during a time period specified by the commissioner. The commissioner shall also collect data on health care spending from all group purchasers of health care. All health care providers and group purchasers doing business in the state shall provide the data requested by the commissioner at the times and in the form specified by the commissioner. All data received is nonpublic, trade secret information under section 13.37. The commissioner shall establish procedures and safeguards to ensure that data provided to the Minnesota health care commission is in a form that does not identify individual patients, providers, employers, purchasers, or other indi-

viduals and organizations, except with the permission of the affected individual or organization.

Subd. 3. [COST CONTAINMENT DUTIES.] After obtaining the advice and recommendations of the Minnesota health care commission, the commissioner shall:

(1) establish statewide and regional limits on growth in total health care spending under this section, monitor regional and statewide compliance with the spending limits, and take action to achieve compliance to the extent authorized by the legislature;

(2) divide the state into no fewer than four regions for purposes of setting regional spending limits and coordinating regional health care systems;

(3) provide technical assistance to regional coordinating boards;

(4) monitor the quality of health care throughout the state, conduct consumer satisfaction surveys, and take action as necessary to ensure an appropriate level of quality;

(5) develop uniform billing forms, uniform electronic billing procedures, and other uniform claims procedures for health care providers by January 1, 1993;

(6) undertake health planning responsibilities as provided in section 62J.15;

(7) monitor and promote the development and implementation of practice standards;

(8) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(9) designate centers of excellence for specialized and high-cost procedures and treatment and establish minimum standards and requirements for particular procedures or treatment;

(10) administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services;

(11) administer the health care analysis unit under article 7; and

(12) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans.

Subd. 4. [CONSULTATION WITH THE COMMISSION.] Before undertaking any of the duties required under this chapter, the commissioner of health shall consult with the Minnesota health care commission and obtain the commission's advice and recommendations. If the commissioner intends to depart from the commission's recommendations, the commissioner shall inform the commission of the intended departure, provide a written explanation of the reasons for the departure, and give the commission an opportunity to comment on the intended departure. If, after receiving the commission's comment, the commissioner still intends to depart from the commission's recommendations, the commissioner shall notify each member of the legislative oversight commission of the commissioner's intent to depart from the recommendations of the Minnesota health care commission. The notice to the legislative oversight commission must be provided at least ten days before the commissioner takes final action. If emergency action is necessary that does not allow the commissioner to obtain the advice and recommendations of the Minnesota health care commission or to provide advance notice and an opportunity for comment as required in this subdivision, the commissioner shall provide a written notice and explanation to the Minnesota health care commission and the legislative oversight commission at the earliest possible time.

Subd. 5. [APPEALS.] A person or organization may appeal a decision of the commissioner through a contested case proceeding under chapter 14.

Subd. 6. [RULEMAKING.] The commissioner shall adopt rules under chapter 14 to implement this chapter.

Subd. 7. [PLAN FOR CONTROLLING GROWTH IN SPENDING.] (a) By January 15, 1993, the Minnesota health care commission shall submit to the legislature and the governor for approval a detailed plan for slowing the growth in health care spending to the growth rate identified by the commission, beginning July 1, 1993. The goal of the plan shall be to reduce the growth rate of health care spending, adjusted for population changes, so that it declines by at least ten percent per year for each of the next five years. The commission shall use the rate of spending growth in 1991 as the base year for developing its plan. The plan may include tentative targets for reducing the growth in spending for consideration by the legislature.

(b) In developing the plan, the commission shall consider the advisability and feasibility of the following options, but is not obligated to incorporate them into the plan:

(1) data and methods that could be used to calculate regional and statewide spending limits and the various options for expressing spending limits, such as maximum percentage growth rates or

actuarially adjusted average per capita rates that reflect the demographics of the state or a region of the state;

(2) methods of adjusting spending limits to account for patients who are not Minnesota residents, to reflect care provided to a person outside the person's region, and to adjust for demographic changes over time;

(3) methods that could be used to monitor compliance with the limits;

(4) criteria for exempting spending on research and experimentation on new technologies and medical practices when setting or enforcing spending limits;

(5) methods that could be used to help providers, purchasers, consumers, and communities control spending growth;

(6) methods of identifying activities of consumers, providers, or purchasers that contribute to excessive growth in spending;

(7) methods of encouraging voluntary activities that will help keep spending within the limits;

(8) methods of consulting providers and obtaining their assistance and cooperation and safeguards that are necessary to protect providers from abrupt changes in revenues or practice requirements;

(9) methods of avoiding, preventing, or recovering spending in excess of the rate of growth identified by the commission;

(10) methods of depriving those who benefit financially from overspending of the benefit of overspending, including the option of recovering the amount of the excess spending from the greater provider community or from individual providers or groups of providers through targeted assessments;

(11) methods of reallocating health care resources among provider groups to correct existing inequities, reward desirable provider activities, discourage undesirable activities, or improve the quality, affordability, and accessibility of health care services;

(12) methods of imposing mandatory requirements relating to the delivery of health care, such as practice standards, hospital admission protocols, 24-hour emergency care screening systems, or designated specialty providers;

(13) methods of preventing unfair health care practices that give a provider or group purchaser an unfair advantage or financial benefit

or that significantly circumvent, subvert, or obstruct the goals of this chapter;

(14) methods of providing incentives through special spending allowances or other means to encourage and reward special projects to improve outcomes or quality of care;

(15) the advisability or feasibility of a system of permanent, regional coordinating boards to ensure community involvement in activities to improve affordability, accessibility, and quality of health care in each region; and

(16) a report to the legislature on the advisability or feasibility of conditioning the adoption of new technologies or procedures or major capital expenditures on the approval of the state health care commission or some other review body.

Sec. 3. [62J.05] [MINNESOTA HEALTH CARE COMMISSION.]

Subdivision 1. [PURPOSE OF THE COMMISSION.] The Minnesota health care commission consists of health care providers, purchasers, consumers, employers, and employees. The two major functions of the commission are:

(1) to make recommendations to the commissioner of health and the legislature regarding statewide and regional limits on the rate of growth of health care spending and activities to prevent or address spending in excess of the limits; and

(2) to help Minnesota communities, providers, group purchasers, employers, employees, and consumers improve the affordability, quality, and accessibility of health care.

Subd. 2. [MEMBERSHIP.] (a) [NUMBER.] The Minnesota health care commission consists of 26 members, as specified in this subdivision. A member may designate a representative to act as a member of the commission in the member's absence.

(b) [HEALTH PLAN COMPANIES.] The commission includes four members representing health plan companies, including one member appointed by the Minnesota Council of Health Maintenance Organizations, one member appointed by the Insurance Federation of Minnesota, one member appointed by Blue Cross and Blue Shield of Minnesota, and one member appointed by the governor.

(c) [HEALTH CARE PROVIDERS.] The commission includes six members representing health care providers, including two members appointed by the Minnesota Hospital Association, one of whom represents rural hospital administrators and one of whom represents urban hospital administrators, two members appointed by the

Minnesota Medical Association, one of whom practices in a rural area of the state and one of whom practices in an urban area, one member appointed by the Minnesota Nurses' Association, and two members appointed by the governor to represent providers other than hospitals, physicians, and nurses.

(d) [EMPLOYERS.] The commission includes four members representing employers, including two members appointed by the Minnesota Chamber of Commerce, including one self-insured employer and one small employer, and two members appointed by the governor.

(e) [CONSUMERS.] The commission includes five consumer members with no financial interest in the health care system, including three members appointed by the governor, one of whom must be a senior; one appointed under the rules of the senate; and one appointed under the rules of the house of representatives.

(f) [EMPLOYEE UNIONS.] The commission includes three representatives of labor unions, including two appointed by the AFL-CIO Minnesota and one appointed by the governor to represent other unions.

(g) [STATE AGENCIES.] The commission includes the commissioners of commerce, employee relations, and human services.

(h) [CHAIR.] The governor shall designate the chair of the commission from among the governor's appointees.

Subd. 3. [CONFLICTS OF INTEREST.] No member of the commission may participate or vote in commission proceedings involving an individual provider, purchaser, or patient, or a specific activity or transaction, if the commission member has a direct financial interest in the outcome of the commission's proceedings.

Subd. 4. [IMMUNITY FROM LIABILITY.] Members of the commission and persons employed by the commissioner are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter, provided the members or persons are acting in good faith.

Subd. 5. [TERMS; COMPENSATION; REMOVAL; AND VACANCIES.] The commission is governed by section 15.0575.

Subd. 6. [ADMINISTRATION.] The commissioner of health shall provide office space, equipment and supplies, and technical support to the commission.

Subd. 7. [STAFF.] The commission may hire an executive director

who serves in the unclassified service. The executive director may hire employees and consultants as authorized by the commission and may prescribe their duties. The attorney general shall provide legal services to the commission.

Sec. 4. [62J.07] [LEGISLATIVE OVERSIGHT COMMISSION.]

The legislative commission on health care access reviews the activities of the commissioner of health, the state health care commission, and all other state agencies involved in the implementation and administration of this chapter, including efforts to obtain federal approval through waivers and other means. The legislative commission on health care access consists of five members of the senate appointed under the rules of the senate and five members of the house of representatives appointed under the rules of the house of representatives. The legislative commission on health care access must include three members of the majority party and two members of the minority party in each house. The commissioner of health and the Minnesota health care commission shall report on their activities and the activities of the regional boards annually and at other times at the request of the legislative commission on health care access.

Sec. 5. [62J.09] [REGIONAL COORDINATING BOARDS.]

Subdivision 1. [GENERAL DUTIES.] The regional coordinating boards are locally controlled boards consisting of providers, health plan companies, employers, consumers, and elected officials. Regional boards may:

(1) recommend that the commissioner sanction agreements between providers in the region that will improve quality, access, or affordability of health care but might constitute a violation of antitrust laws if undertaken without government direction;

(2) make recommendations to the commissioner regarding major capital expenditures or the introduction of expensive new technologies and medical practices that are being proposed or considered by providers;

(3) undertake voluntary activities to educate consumers, providers, and purchasers or to promote voluntary, cooperative community cost containment, access, or quality of care projects;

(4) make recommendations to the commissioner regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state.

Subd. 2. [MEMBERSHIP.] (a) Each regional health care management board consists of 16 members as provided in this subdivision.

A member may designate a representative to act as a member of the commission in the member's absence.

(b) [PROVIDER REPRESENTATIVES.] Each regional board must include four members representing health care providers who practice in the region. One member is appointed by the Minnesota Medical Association. One member is appointed by the Minnesota Hospital Association. One member is appointed by the Minnesota Nurses' Association. The remaining member is appointed by the governor to represent providers other than physicians, hospitals, and nurses.

(c) [HEALTH PLAN COMPANY REPRESENTATIVES.] Each regional board includes three members representing health plan companies who provide coverage for residents of the region, including one member representing health insurers who is elected by a vote of all health insurers providing coverage in the region, one member elected by a vote of all health maintenance organizations providing coverage in the region, and one member appointed by Blue Cross and Blue Shield of Minnesota. The fourth member is appointed by the governor.

(d) [EMPLOYER REPRESENTATIVES.] Regional boards include three members representing employers in the region. Employer representatives are elected by a vote of the employers who are members of chambers of commerce in the region. At least one member must represent self-insured employers.

(e) [EMPLOYEE UNIONS.] Regional boards include one member appointed by the AFL-CIO Minnesota who is a union member residing or working in the region or who is a representative of a union that is active in the region.

(f) [PUBLIC MEMBERS.] Regional boards include three consumer members with no financial interest in the health care system. One consumer member is elected by the community health boards in the region, with each community health board having one vote. One consumer member is elected by the state legislators with districts in the region. One consumer member is appointed by the governor.

(g) [COUNTY COMMISSIONER.] Regional boards include one member who is a county board member. The county board member is elected by a vote of all of the county board members in the region, with each county board having one vote.

(h) [STATE AGENCY.] Regional boards include one state agency commissioner appointed by the governor to represent state health coverage programs.

Subd. 3. [TECHNICAL ASSISTANCE.] The state health care commission shall provide technical assistance to regional boards.

Subd. 4. [TERMS; COMPENSATION; REMOVAL; AND VACANCIES.] Regional coordinating boards are governed by section 15.0575, except that members do not receive per diem payments.

Subd. 5. [REPEALER.] This section is repealed effective July 1, 1993.

Sec. 6. [62J.15] [HEALTH PLANNING.]

Subdivision 1. [HEALTH PLANNING ADVISORY COMMITTEE.] (a) The state health care commission shall convene an advisory committee to make recommendations regarding the use and distribution of new and existing health care technologies and procedures and major capital expenditures by providers. The advisory committee may include members of the state commission and other persons appointed by the commission. The advisory committee must include at least one person representing physicians, at least one person representing hospitals, and at least one person representing the health care technology industry. Health care technologies and procedures include high-cost pharmaceuticals, organ and other transplants, health care procedures and devices, and expensive, large-scale technologies such as scanners and imagers.

Subd. 2. [HEALTH PLANNING.] In consultation with the health planning advisory committee, the Minnesota health care commission shall:

(1) develop criteria for evaluating new health care technology and procedures and major capital expenditures that take into consideration the effectiveness and value of the new technology, procedure, or capital expenditure in relation to the cost impact on consumers and payors;

(2) recommend to the commissioner of health and the regional boards statewide and regional goals and targets for the distribution and use of new and existing health care technologies and procedures and major capital expenditures;

(3) make recommendations to the commissioner regarding the designation of centers of excellence for transplants and other specialized medical procedures; and

(4) make recommendations to the commissioner regarding minimum volume requirements for the performance of certain procedures by hospitals and other health care facilities or providers.

Sec. 7. [62J.17] [TEMPORARY MORATORIUM ON MAJOR CAP-

ITAL EXPENDITURES AND THE INTRODUCTION OF NEW SPECIALIZED SERVICES; EXCEPTIONS.]

Subdivision 1. [HOSPITAL AND NURSING HOME MORATORIA PRESERVED.] Nothing in this section supersedes or limits the applicability of section 144.551 or 144A.071.

Subd. 2. [SEVERABILITY IF REVIEW PROCESS CHALLENGED.] The legislature intends that, if the exception review process in subdivisions 4 and 5 is enjoined or invalidated by a court, the moratorium in subdivision 3 is severable from the exception review process and must be construed to stand alone without a process for approving exceptions.

Subd. 3. [REPORT AND RECOMMENDATIONS.] The Minnesota health care commission, in consultation with the health planning advisory committee and regional coordinating boards, shall submit recommendations to the legislature by January 15, 1993, for a permanent strategy to ensure that major spending commitments are appropriate in terms of the accessibility, affordability, and quality of health care in Minnesota.

Sec. 8. [62J.19] [PARTICIPATION OF FEDERAL PROGRAMS.]

The commissioner of health shall seek the full participation of federal health care programs under this chapter, including Medicare, medical assistance, veterans administration programs, and other federal programs. The commissioner of human services shall under the direction of the health care commission submit waiver requests and take other action necessary to obtain federal approval to allow participation of the medical assistance program. Other state agencies shall provide assistance at the request of the commission. If federal approval is not given for one or more federal programs, data on the amount of health care spending that is collected under section 62J.04 shall be adjusted so that state and regional spending limits take into account the failure of the federal program to participate.

Sec. 9. [62J.23] [PROVIDER CONFLICTS OF INTEREST.]

Subdivision 1. [RULES PROHIBITING CONFLICTS OF INTEREST.] The commissioner of health shall adopt rules restricting financial relationships or payment arrangements involving health care providers under which a provider benefits financially by referring a patient to another provider, recommending another provider, or furnishing or recommending an item or service. The rules must be compatible with, and no less restrictive than, the federal Medicare antikickback statute, in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and regulations adopted under it. However, the commissioner's rules may be more restrictive than the federal law and regulations and may apply to additional provider groups and business and professional arrange-

ments except that the commissioner shall provide exemptions for group practices and salaried physicians in the same manner as under the federal Medicare antikickback statute and the regulations adopted under it. When the state rules restrict an arrangement or relationship that is permissible under federal laws and regulations, including an arrangement or relationship expressly permitted under the federal safe harbor regulations, the fact that the state requirement is more restrictive than federal requirements must be clearly stated in the rule.

Subd. 2. [PROHIBITED RELATIONSHIPS AND PRACTICES.] At a minimum, rules adopted under this subdivision must prohibit:

(1) referrals to another provider in which the referring provider has a significant financial interest;

(2) furnishing or arranging for the furnishing of an item or service in which the provider has a significant financial interest; and

(3) offering or paying, or soliciting or receiving, any remuneration, directly or indirectly, in return for referring a person to a provider or for providing or recommending an item or service.

Subd. 3. [PRINCIPAL CRITERIA FOR RESTRICTIONS.] In adopting and enforcing rules under this subdivision, the commissioner must consider whether the relationship or arrangement creates a risk that the financial interests of a provider will influence the provider's health care decisions about a particular patient or that the relationship or arrangement is likely to be perceived by the provider's patients or by the community as likely to influence a provider's health care decision making.

Subd. 4. [INTERIM RESTRICTIONS.] From July 1, 1992, until rules are adopted by the commissioner under this subdivision, the restrictions in the federal Medicare antikickback statutes in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and rules adopted under the federal statutes, apply to all health care providers in the state, regardless of whether the provider participates in any state or federal health care program. The commissioner may approve a transition plan submitted by a provider who is in violation of this paragraph to the commission by January 1, 1992, that provides a reasonable time for the provider to modify prohibited practices or divest financial interests in other providers in order to come into compliance with this subdivision.

Sec. 10. [62J.25] [MANDATORY MEDICARE ASSIGNMENT.]

Effective January 1, 1993, a health care provider authorized to participate in the Medicare program shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any

amount in excess of the Medicare-approved amount for any Medicare-covered service provided. This section does not apply to services provided by providers licensed under section 144.802.

Sec. 11. [62J.27] [MALPRACTICE PROTECTION FOR PROVIDERS.]

(a) The commissioner of health, after receiving the advice and recommendations of the Minnesota health care commission and the health care analysis unit, may approve practice parameters as defined in section 62J.30, subdivision 1, in order to minimize unnecessary, unproven, or ineffective care. The approval of practice parameters is not subject to the requirements of chapter 14.

(b) Adherence by a provider to a practice parameter approved by the commissioner of health is clear and convincing evidence in defense of a claim for medical malpractice.

(c) Paragraph (b) applies to claims arising on or after August 1, 1993, or 90 days after the effective date of approval of the practice parameters by the commissioner.

Sec. 12. [62J.29] [ANTITRUST EXCEPTIONS.]

The commissioner shall establish criteria and procedures for sanctioning contracts, business or financial arrangements, or other activities or practices involving providers or purchasers that might be construed to be violations of state or federal antitrust laws but which are in the best interests of the state of Minnesota and further the policies and goals of this chapter. Notwithstanding the Minnesota antitrust law of 1971, as amended, in Minnesota Statutes, sections 325D.49 to 325D.66, contracts, business or financial arrangements, or other activities or practices that are expressly sanctioned by the commissioner do not constitute an unlawful contract, combination, or conspiracy in unreasonable restraint of trade or commerce under Minnesota Statutes, sections 325D.49 to 325D.66. Approval by the commissioner is a defense against any action under state antitrust laws. The commissioner is exempt from rulemaking until January 1, 1994, for purposes of establishing criteria and procedures under this section.

ARTICLE 2

SMALL EMPLOYER INSURANCE REFORM

Section 1. [62L.01] [CITATION.]

Subdivision 1. [POPULAR NAME.] Sections 62L.01 to 62L.23 may be cited as the Minnesota small employer health benefit act.

Subd. 2. [JURISDICTION.] Sections 62L.01 to 62L.23 apply to any health carrier that offers, issues, delivers, or renews a health benefit plan to a small employer.

Subd. 3. [LEGISLATIVE FINDINGS AND PURPOSE.] The legislature finds that underwriting and rating practices in the individual and small employer markets for health coverage create substantial hardship and unfairness, create unnecessary administrative costs, and adversely affect the health of residents of this state. The legislature finds that the premium restrictions provided by this chapter reduce but do not eliminate these harmful effects. Accordingly, the legislature declares its desire to phase out the remaining rating bands as quickly as possible, with the end result of eliminating all rating practices based on risk by July 1, 1997.

Sec. 2. [62L.02] [DEFINITIONS.]

Subdivision 1. [APPLICATION.] The definitions in this section apply to sections 62L.01 to 62L.23.

Subd. 2. [ACTUARIAL OPINION.] "Actuarial opinion" means a written statement by a member of the American Academy of Actuaries that a health carrier is in compliance with this chapter, based on the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the health carrier in establishing premium rates for health benefit plans.

Subd. 3. [ASSOCIATION.] "Association" means the health coverage reinsurance association.

Subd. 4. [BASE PREMIUM RATE.] "Base premium rate" means as to a rating period, the lowest premium rate charged or which could have been charged under the rating system by the health carrier to small employers for health benefit plans with the same or similar coverage.

Subd. 5. [BOARD OF DIRECTORS.] "Board of directors" means the board of directors of the health coverage reinsurance association.

Subd. 6. [CASE CHARACTERISTICS.] "Case characteristics" means the relevant characteristics of a small employer, as determined by a health carrier in accordance with this chapter, which are considered by the carrier in the determination of premium rates for the small employer.

Subd. 7. [COINSURANCE.] "Coinsurance" means an established dollar amount or percentage of health care expenses that an eligible employee or dependent is required to pay directly to a provider of

medical services or supplies under the terms of a health benefit plan.

Subd. 8. [COMMISSIONER.] "Commissioner" means the commissioner of commerce for health carriers subject to the jurisdiction of the department of commerce or the commissioner of health for health carriers subject to the jurisdiction of the department of health, or the relevant commissioner's designated representative.

Subd. 9. [CONTINUOUS COVERAGE.] "Continuous coverage" means the maintenance of continuous and uninterrupted qualifying prior coverage by an eligible employee or dependent. An eligible employee or dependent is considered to have maintained continuous coverage if the individual requests enrollment in a health benefit plan within 30 days of termination of the qualifying prior coverage.

Subd. 10. [DEDUCTIBLE.] "Deductible" means the amount of health care expenses an eligible employee or dependent is required to incur before benefits are payable under a health benefit plan.

Subd. 11. [DEPENDENT.] "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 19 years, unmarried child who is a full-time student under the age of 25 years as defined in section 62A.301 and financially dependent upon the eligible employee, or dependent child of any age who is handicapped and who meets the eligibility criteria in section 62A.14, subdivision 2. For the purpose of this definition, a child may include a child for whom the employee or the employee's spouse has been appointed legal guardian.

Subd. 12. [ELIGIBLE CHARGES.] "Eligible charges" means the actual charges submitted to a health carrier by or on behalf of a provider, eligible employee, or dependent for health services covered by the health carrier's health benefit plan. Eligible charges do not include charges for health services excluded by the health benefit plan, charges for which an alternate health carrier is liable under the coordination of benefit provisions of the health benefit plan, charges for health services that are not medically necessary, or charges that exceed the usual and customary charges.

Subd. 13. [ELIGIBLE EMPLOYEE.] "Eligible employee" means an individual employed by a small employer for at least 20 hours per week and who has satisfied all employer participation and eligibility requirements, including, but not limited to, the satisfactory completion of a probationary period of not less than 30 days but no more than 90 days. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include employees who work on a temporary, seasonal, or substitute basis.

Subd. 14. [FINANCIALLY IMPAIRED CONDITION.] "Financially impaired condition" means a situation in which a health carrier is not insolvent, but (1) is considered by the commissioner to be potentially unable to fulfill its contractual obligations, or (2) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

Subd. 15. [HEALTH BENEFIT PLAN.] "Health benefit plan" means a policy, contract, or certificate issued by a health carrier to a small employer for the coverage of medical and hospital benefits. Health benefit plan includes a small employer plan. Health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense-incurred basis;

(5) credit accident and health insurance issued under chapter 62B;

(6) designed solely to provide dental or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident-only coverage;

(9) long-term care insurance as defined in section 62A.46;

(10) issued as a supplement to Medicare, as defined in sections 62A.31 to 62A.44, or 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., as amended through December 31, 1991; or

(11) workers' compensation insurance.

For the purpose of this chapter, a health benefit plan issued to employees of a small employer who meets the participation requirements of section 62L.03, subdivision 3, is considered to have been issued to a small employer. A health benefit plan issued on behalf of a health carrier is considered to be issued by the health carrier.

Subd. 16. [HEALTH CARRIER.] "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a

policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; and a multiple employer welfare arrangement, as defined in United States Code, title 29, section 1002(40), as amended through December 31, 1991. For the purpose of this chapter, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that any insurance company or health service plan corporation that is an affiliate of a health maintenance organization located in Minnesota, or any health maintenance organization located in Minnesota that is an affiliate of an insurance company or health service plan corporation, or any health maintenance organization that is an affiliate of another health maintenance organization in Minnesota, may treat the health maintenance organization as a separate carrier.

Subd. 17. [HEALTH PLAN.] "Health plan" means a health benefit plan issued by a health carrier, except that it may be issued:

(1) to a small employer;

(2) to an employer who does not satisfy the definition of a small employer as defined under subdivision 26; or

(3) to an individual purchasing an individual or conversion policy of health care coverage issued by a health carrier.

Subd. 18. [INDEX RATE.] "Index rate" means as to a rating period for small employers the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

Subd. 19. [LATE ENTRANT.] "Late entrant" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period applicable to the employee or dependent under the terms of the health benefit plan, provided that the initial enrollment period must be a period of at least 30 days. However, an eligible employee or dependent must not be considered a late entrant if:

(1) the individual was covered under qualifying existing coverage at the time the individual was eligible to enroll in the health benefit plan, declined enrollment on that basis, and presents to the carrier a certificate of termination of the qualifying prior coverage, provided that the individual maintains continuous coverage;

(2) the individual has lost coverage under another group health plan due to the expiration of benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law

Number 99-272, as amended, and any state continuation laws applicable to the employer or carrier, provided that the individual maintains continuous coverage;

(3) the individual is a new spouse of an eligible employee, provided that enrollment is requested within 30 days of becoming legally married;

(4) the individual is a new dependent child of an eligible employee, provided that enrollment is requested within 30 days of becoming a dependent;

(5) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(6) a court has ordered that coverage be provided for a dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order.

Subd. 20. [MCHA.] "MCHA" means the Minnesota comprehensive health association established under section 62E.10.

Subd. 21. [MEDICALLY NECESSARY.] "Medically necessary" means the medical and hospital services commonly recognized by the medical profession and leading medical authorities as essential treatment for the individual's injury or sickness.

Subd. 22. [MEMBERS.] "Members" means the health carriers operating in the small employer market who may participate in the association.

Subd. 23. [PREEXISTING CONDITION.] "Preexisting condition" means a condition manifesting in a manner that causes an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage, or a pregnancy existing as of the effective date of coverage of a health benefit plan.

Subd. 24. [QUALIFYING PRIOR COVERAGE OR QUALIFYING EXISTING COVERAGE.] "Qualifying prior coverage" or "qualifying existing coverage" means health benefits or health coverage provided under:

(1) a health plan, as defined in this section;

(2) Medicare;

(3) medical assistance under chapter 256B;

(4) general assistance medical care under chapter 256D;

(5) MCHA;

(6) a self-insured health plan;

(7) the health right plan established under section 256.936, subdivision 2, when the plan includes inpatient hospital services as provided in section 256.936, subdivision 2a, paragraph (c);

(8) a plan provided under section 43A.316; or

(9) a plan similar to any of the above plans provided in this state or in another state as determined by the commissioner.

Subd. 25. [RATING PERIOD.] "Rating period" means the 12-month period for which premium rates established by a health carrier are assumed to be in effect, as determined by the health carrier. During the rating period, a health carrier may adjust the rate based on the prorated change in the index rate.

Subd. 26. [SMALL EMPLOYER.] "Small employer" means a person, firm, corporation, partnership, association, or other entity actively engaged in business who, on at least 50 percent of its working days during the preceding calendar year, employed no fewer than two nor more than 29 eligible employees, the majority of whom were employed in this state. If a small employer has only two eligible employees, one employee must not be the spouse, child, sibling, parent, or grandparent of the other, except that a small employer plan may be offered through a domiciled association to self-employed individuals and small employers who are members of the association, even if the self-employed individual or small employer has fewer than two employees or the employees are family members. Entities that are eligible to file a combined tax return for purposes of state tax laws are considered a single employer for purposes of determining the number of eligible employees. Small employer status must be determined on an annual basis as of the renewal date of the health benefit plan. The provisions of this chapter continue to apply to an employer who no longer meets the requirements of this definition until the annual renewal date of the employer's health benefit plan.

Subd. 27. [SMALL EMPLOYER MARKET.] (a) "Small employer market" means the market for health benefit plans for small employers.

(b) A health carrier is considered to be participating in the small employer market if the carrier offers, sells, issues, or renews a health benefit plan to: (1) any small employer; or (2) the eligible employees of a small employer offering a health benefit plan if, with the

knowledge of the health carrier, both of the following conditions are met:

(i) any portion of the premium or benefits is paid for or reimbursed by a small employer; and

(ii) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of the Internal Revenue Code, section 106, 125, or 162.

Subd. 28. [SMALL EMPLOYER PLAN.] "Small employer plan" means a health benefit plan issued by a health carrier to a small employer for coverage of the medical and hospital benefits described in section 62L.05.

Sec. 3. [62L.03] [AVAILABILITY OF COVERAGE.]

Subdivision 1. [GUARANTEED ISSUE AND REISSUE.] Every health carrier shall, as a condition of authority to transact business in this state in the small employer market, affirmatively market, offer, sell, issue, and renew any of its health benefit plans to any small employer as provided in this chapter. Every health carrier participating in the small employer market shall make available both of the plans described in section 62L.05 to small employers and shall fully comply with the underwriting and the rate restrictions specified in this chapter for all health benefit plans issued to small employers. A health carrier may cease to transact business in the small employer market as provided under section 62L.09.

Subd. 2. [EXCEPTIONS.] (a) No health maintenance organization is required to offer coverage or accept applications under subdivision 1 in the case of the following:

(1) with respect to a small employer, where the worksite of the employees of the small employer is not physically located in the health maintenance organization's approved service areas;

(2) with respect to an employee, when the employee does not work or reside within the health maintenance organization's approved service areas; or

(3) within an area where the health maintenance organization demonstrates to the satisfaction of the commissioner that it does not have the capacity within the area in its network of providers to deliver service adequately to the members of these groups.

(b) A health maintenance organization that cannot offer coverage pursuant to paragraph (a), clause (3), may not offer coverage in the applicable area to new business involving employer groups with more than 29 eligible employees until 180 days following the date on

which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups.

(c) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subdivision 1 where the commissioner finds that the acceptance of an application or applications would place the small employer carrier in a financially-impaired condition, provided, however, that a small employer carrier that has not offered coverage or accepted applications pursuant to this paragraph shall not offer coverage or accept applications for any health benefit plan until 180 days following a determination by the commissioner that the small employer carrier has ceased to be financially impaired.

Subd. 3. [MINIMUM PARTICIPATION.] (a) A small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan must be guaranteed coverage from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. A health carrier may not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdivision, waiver of coverage includes only waivers due to coverage under another group health plan.

(b) A health carrier may require that small employers contribute a specified minimum percentage toward the cost of the coverage of eligible employees, so long as the requirement is uniformly applied for all small employers. For the small employer plans, a health carrier must require that small employers contribute at least 50 percent of the cost of the coverage of eligible employees. The health carrier must impose this requirement on a uniform basis for both small employer plans and for all small employers.

(c) Nothing in this section obligates a health carrier to issue coverage to a small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer.

Subd. 4. [UNDERWRITING RESTRICTIONS.] Health carriers may apply underwriting restrictions to coverage for health benefit plans for small employers, including any preexisting condition limitations, only as expressly permitted under this chapter. Health carriers may collect information relating to the case characteristics and demographic composition of small employers, as well as health status and health history information about employees of small employers. Except as otherwise authorized for late entrants, preexisting conditions may be excluded by a health carrier for a period not to exceed 12 months from the effective date of coverage of an eligible

employee or dependent. When calculating a preexisting condition limitation, a health carrier shall credit the time period an eligible employee or dependent was previously covered by qualifying prior coverage, provided that the individual maintains continuous coverage. Late entrants may be subject to a preexisting condition limitation not to exceed 18 months from the effective date of coverage of the late entrant. Late entrants may also be excluded from coverage for a period not to exceed 18 months, provided that if a health carrier imposes an exclusion from coverage and a preexisting condition limitation, the combined time period for both the coverage exclusion and preexisting condition limitation must not exceed 18 months.

Subd. 5. [CANCELLATIONS AND FAILURES TO RENEW.] No health carrier shall cancel, decline to issue, or fail to renew a health benefit plan as a result of the claim experience or health status of the small employer group. A health carrier may cancel or fail to renew a health benefit plan:

(1) for nonpayment of the required premium;

(2) for fraud or misrepresentation by the small employer, or, with respect to coverage of an individual eligible employee or dependent, fraud or misrepresentation by the eligible employee or dependent, with respect to eligibility for coverage or any other material fact;

(3) if eligible employee participation during the preceding calendar year declines to less than 75 percent, subject to the waiver of coverage provision in subdivision 3;

(4) if the employer fails to comply with the minimum contribution percentage legally required by the health carrier;

(5) if the health carrier ceases to do business in the small employer market; or

(6) for any other reasons or grounds expressly permitted by the respective licensing laws and regulations governing a health carrier, including, but not limited to, service area restrictions imposed on health maintenance organizations under section 62D.03, subdivision 4, paragraph (m), to the extent that these grounds are not expressly inconsistent with this chapter.

Subd. 6. [MCHA ENROLLEES.] Health carriers shall offer coverage to any eligible employee or dependent enrolled in MCHA at the time of the health carrier's issuance or renewal of a health benefit plan to a small employer. The health benefit plan must require that the employer permit MCHA enrollees to enroll in the small employer's health benefit plan as of the first date of renewal of a health benefit plan occurring on or after July 1, 1993, or, in the case of a new group, as of the initial effective date of the health benefit plan.

Unless otherwise permitted by this chapter, health carriers must not impose any underwriting restrictions, including any preexisting condition limitations or exclusions, on any eligible employee or dependent previously enrolled in MCHA and transferred to a health benefit plan so long as continuous coverage is maintained, provided that the health carrier may impose any unexpired portion of a preexisting condition limitation under the person's MCHA coverage. An MCHA enrollee is not a late entrant, so long as the enrollee has maintained continuous coverage.

Sec. 4. [62L.04] [COMPLIANCE REQUIREMENTS.]

Subdivision 1. [APPLICABILITY OF CHAPTER REQUIREMENTS.] Beginning July 1, 1993, health carriers participating in the small employer market must offer and make available any health benefit plan that they offer, including both of the small employer plans provided in section 62L.05, to all small employers who satisfy the small employer participation requirements specified in this chapter. Compliance with these requirements is required as of the first renewal date of any small employer group occurring after July 1, 1993. For new small employer business, compliance is required as of the first date of offering occurring after July 1, 1993.

Compliance with these requirements is required as of the first renewal date occurring after July 1, 1993, with respect to employees of a small employer who had been issued individual coverage prior to July 1, 1993, administered by the health carrier on a group basis. Notwithstanding any other law to the contrary, the health carrier shall terminate any individual coverage for employees of small employers who satisfy the small employer participation requirements specified in section 62L.03 and offer to replace it with a health benefit plan. If the employer elects not to purchase a health benefit plan, the health carrier must offer all covered employees and dependents individual coverage. Small employer and individual coverage provided under this subdivision must be without application of underwriting restrictions, provided continuous coverage is maintained.

Subd. 2. [NEW CARRIERS.] A health carrier entering the small employer market after July 1, 1993, shall begin complying with the requirements of this chapter as of the first date of offering of a health benefit plan to a small employer. A health carrier entering the small employer market after July 1, 1993, is considered to be a member of the health coverage reinsurance association as of the date of the health carrier's initial offer of a health benefit plan to a small employer.

Sec. 5. [62L.05] [SMALL EMPLOYER PLAN BENEFITS.]

Subdivision 1. [TWO SMALL EMPLOYER PLANS.] Each health carrier in the small employer market must make available to any

small employer both of the small employer plans described in subdivisions 2 and 3. Under subdivisions 2 and 3, coinsurance and deductibles do not apply to child health supervision services and prenatal services, as defined by section 62A.047. The maximum out-of-pocket costs for covered services must be $3,000 per individual and $6,000 per family per year. The maximum lifetime benefit must be $500,000. The out-of-pocket cost limits and the deductible amounts provided in subdivision 2 must be adjusted on July 1 every two years, based upon changes in the consumer price index, as of the end of the previous calendar year, as determined by the commissioner of commerce. Adjustments must be in increments of $50 and must not be made unless at least that amount of adjustment is required.

Subd. 2. [DEDUCTIBLE-TYPE SMALL EMPLOYER PLAN.] The benefits of the deductible-type small employer plan offered by a health carrier must be equal to 80 percent of the eligible charges for health care services, supplies, or other articles covered under the small employer plan, in excess of an annual deductible which must be $500 per individual and $1,000 per family.

Subd. 3. [COPAYMENT-TYPE SMALL EMPLOYER PLAN.] The benefits of the copayment-type small employer plan offered by a health carrier must be equal to 80 percent of the eligible charges for health care services, supplies, or other articles covered under the small employer plan, in excess of the following copayments:

(1) $15 per outpatient visit, other than to a hospital outpatient department or emergency room, urgent care center, or similar facility;

(2) $15 per day for the services of a home health agency or private duty registered nurse;

(3) $50 per outpatient visit to a hospital outpatient department or emergency room, urgent care center, or similar facility; and

(4) $300 per inpatient admission to a hospital.

Subd. 4. [BENEFITS.] The medical services and supplies listed in this subdivision are the benefits that must be covered by the small employer plans described in subdivisions 2 and 3:

(1) inpatient and outpatient hospital services, excluding services provided for the diagnosis, care, or treatment of chemical dependency or a mental illness or condition, other than those conditions specified in clauses (10), (11), and (12);

(2) physician and nurse practitioner services for the diagnosis or treatment of illnesses, injuries, or conditions;

(3) diagnostic X-rays and laboratory tests;

(4) ground transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, or as otherwise required by the health carrier;

(5) services of a home health agency if the services qualify as reimbursable services under Medicare and are directed by a physician or qualify as reimbursable under the health carrier's most commonly sold health plan for insured group coverage;

(6) services of a private duty registered nurse if medically necessary, as determined by the health carrier;

(7) the rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;

(8) child health supervision services up to age 18, as defined in section 62A.047;

(9) maternity and prenatal care services, as defined in sections 62A.041 and 62A.047;

(10) inpatient hospital and outpatient services for the diagnosis and treatment of certain mental illnesses or conditions, as defined by the International Classification of Diseases-Clinical Modification (ICD-9-CM), seventh edition (1990) and as classified as ICD-9 codes 295 to 299;

(11) ten hours per year of outpatient mental health diagnosis or treatment for illnesses or conditions not described in clause (10);

(12) 60 hours per year of outpatient treatment of chemical dependency; and

(13) 50 percent of eligible charges for prescription drugs, up to a separate annual maximum out-of-pocket expense of $1,000 per individual for prescription drugs, and 100 percent of eligible charges thereafter.

Subd. 5. [PLAN VARIATIONS.] (a) No health carrier shall offer to a small employer a health benefit plan that differs from the two small employer plans described in subdivisions 1 to 4, unless the health benefit plan complies with all provisions of chapters 62A, 62C, 62D, 62E, 62H, and 64B that otherwise apply to the health carrier, except as expressly permitted by paragraph (b).

(b) As an exception to paragraph (a), a health benefit plan is deemed to be a small employer plan and to be in compliance with paragraph (a) if it differs from one of the two small employer plans

described in subdivisions 1 to 4 only by providing benefits in addition to those described in subdivision 4, provided that the health care benefit plan has an actuarial value that exceeds the actuarial value of the benefits described in subdivision 4 by no more than two percent. "Benefits in addition" means additional units of a benefit listed in subdivision 4 or one or more benefits not listed in subdivision 4.

Subd. 6. [CHOICE PRODUCTS EXCEPTION.] Nothing in subdivision 1 prohibits a health carrier from offering a small employer plan which provides for different benefit coverages based on whether the benefit is provided through a primary network of providers or through a secondary network of providers so long as the benefits provided in the primary network equal the benefit requirements of the small employer plan as described in this section. For purposes of products issued under this subdivision, out-of-pocket costs in the secondary network may exceed the out-of-pocket limits described in subdivision 1.

Subd. 7. [BENEFIT EXCLUSIONS.] No medical, hospital, or other health care benefits, services, supplies, or articles not expressly specified in subdivision 4 are required to be included in a small employer plan. Nothing in subdivision 4 restricts the right of a health carrier to restrict coverage to those services, supplies, or articles which are medically necessary. Health carriers may exclude a benefit, service, supply, or article not expressly specified in subdivision 4 from a small employer plan.

Subd. 8. [CONTINUATION COVERAGE.] Small employer plans must include the continuation of coverage provisions required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law Number 99-272, as amended through December 31, 1991, and by state law.

Subd. 9. [DEPENDENT COVERAGE.] Other state law and rules applicable to health plan coverage of newborn infants, dependent children who do not reside with the eligible employee, handicapped children and dependents, and adopted children apply to a small employer plan. Health benefit plans that provide dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02.

Subd. 10. [MEDICAL EXPENSE REIMBURSEMENT.] Health carriers may reimburse or pay for medical services, supplies, or articles provided under a small employer plan in accordance with the health carrier's provider contract requirements including, but not limited to, salaried arrangements, capitation, the payment of usual and customary charges, fee schedules, discounts from fee-for-service, per diems, diagnostic-related groups (DRGs), and other payment arrangements. Nothing in this chapter requires a health carrier to develop, implement, or change its provider contract

requirements for a small employer plan. Coinsurance, deductibles, out-of-pocket maximums, and maximum lifetime benefits must be calculated and determined in accordance with each health carrier's standard business practices.

Subd. 11. [PLAN DESIGN.] Notwithstanding any other law, regulation, or administrative interpretation to the contrary, health carriers may offer small employer plans through any provider arrangement, including, but not limited to, the use of open, closed, or limited provider networks. A health carrier may only use product and network designs currently allowed under existing statutory requirements. The provider networks offered by any health carrier may be specifically designed for the small employer market and may be modified at the carrier's election so long as all otherwise applicable regulatory requirements are met. Health carriers may use professionally recognized provider standards of practice when they are available, and may use utilization management practices otherwise permitted by law, including, but not limited to, second surgical opinions, prior authorization, concurrent and retrospective review, referral authorizations, case management, and discharge planning. A health carrier may contract with groups of providers with respect to health care services or benefits, and may negotiate with providers regarding the level or method of reimbursement provided for services rendered under a small employer plan.

Subd. 12. [DEMONSTRATION PROJECTS.] Nothing in this chapter prohibits a health maintenance organization from offering a demonstration project authorized under section 62D.30. The commissioner of health may approve a demonstration project which offers benefits that do not meet the requirements of a small employer plan if the commissioner finds that the requirements of section 62D.30 are otherwise met.

Sec. 6. [62L.06] [DISCLOSURE OF UNDERWRITING RATING PRACTICES.]

When offering or renewing a health benefit plan, health carriers shall disclose in all solicitation and sales materials:

(1) the case characteristics and other rating factors used to determine initial and renewal rates;

(2) the extent to which premium rates for a small employer are established or adjusted based upon actual or expected variation in claim experience;

(3) provisions concerning the health carrier's right to change premium rates and the factors other than claim experience that affect changes in premium rates;

(4) provisions relating to renewability of coverage;

(5) the use and effect of any preexisting condition provisions, if permitted; and

(6) the application of any provider network limitations and their effect on eligibility for benefits.

Sec. 7. [62L.07] [SMALL EMPLOYER REQUIREMENTS.]

Subdivision 1. [VERIFICATION OF ELIGIBILITY.] Health benefit plans must require that small employers offering a health benefit plan maintain information verifying the continuing eligibility of the employer, its employees, and their dependents, and provide the information to health carriers on a quarterly basis or as reasonably requested by the health carrier.

Subd. 2. [WAIVERS.] Health benefit plans must require that small employers offering a health benefit plan maintain written documentation of a waiver of coverage by an eligible employee or dependent and provide the documentation to the health carrier upon reasonable request.

Sec. 8. [62L.08] [RESTRICTIONS RELATING TO PREMIUM RATES.]

Subdivision 1. [RATE RESTRICTIONS.] Premium rates for all health benefit plans sold or issued to small employers are subject to the restrictions specified in this section.

Subd. 2. [GENERAL PREMIUM VARIATIONS.] Beginning July 1, 1993, each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the index rate charged to small employers for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this subdivision must be based only on health status, claims experience, industry of the employer, and duration of coverage from the date of issue. For purposes of this subdivision, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined to be actuarially valid and approved by the commissioner of commerce.

Subd. 3. [AGE-BASED PREMIUM VARIATIONS.] Beginning July 1, 1993, each health carrier may offer premium rates to small employers that vary based upon the ages of the eligible employees and dependents of the small employer only as provided in this subdivision. In addition to the variation permitted by subdivision 2,

each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

Subd. 4. [GEOGRAPHIC PREMIUM VARIATIONS.] A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between regions by more than five percent. The commissioner may grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) the geographic regions are based on the seven-county metropolitan area, urban regions located outside the seven-county metropolitan area, and rural regions; and

(3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

Subd. 5. [GENDER-BASED RATES PROHIBITED.] Beginning July 1, 1993, no health carrier may determine premium rates through a method that is in any way based upon the gender of eligible employees or dependents.

Subd. 6. [RATE CELLS PERMITTED.] Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based on the number of adults and children covered under the policy and may reflect the availability of Medicare coverage.

Subd. 7. [INDEX AND PREMIUM RATE DEVELOPMENT.] In developing its index rates and premiums, a health carrier may take into account only the following factors:

(1) actuarially valid differences in benefit designs of health benefit plans;

(2) actuarially valid differences in the rating factors permitted in subdivisions 2 and 3;

(3) actuarially valid geographic variations if approved by the commissioner as provided in subdivision 4.

Subd. 8. [FILING REQUIREMENT.] No later than July 1, 1993, and each year thereafter, a health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner of commerce the index rates and must demonstrate

that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates.

Subd. 9. [EFFECT OF ASSESSMENTS.] Premium rates must comply with the rating requirements of this section, notwithstanding the imposition of any assessments or premiums paid by health carriers as provided under sections 62L.13 to 62L.22.

Subd. 10. [RATING REPORT.] Beginning January 1, 1995, and annually thereafter, the commissioners of health and commerce shall provide a joint report to the legislature on the effect of the rating restrictions required by this section and the appropriateness of proceeding with additional rate reform. Each report must include an analysis of the availability of health care coverage due to the rating reform, the equitable and appropriate distribution of risk and associated costs, the effect on the self-insurance market, and any resulting or anticipated change in health plan design and market share and availability of health carriers.

Sec. 9. [62L.09] [CESSATION OF SMALL EMPLOYER BUSINESS.]

Subdivision 1. [NOTICE TO COMMISSIONER.] A health carrier electing to cease doing business in the small employer market shall notify the commissioner 180 days prior to the effective date of the cessation. The cessation of business does not include the following activities:

(1) the failure of a health carrier to offer or issue new business in the small employer market or continue an existing product line, provided that a health carrier does not terminate, cancel, or fail to renew its current small employer business or other product lines; or

(2) the inability of any health carrier to offer or renew a health benefit plan because it has given notice to the commissioner that it will not have the capacity within a specific provider site under contract to or owned by the health carrier to adequately deliver services to the enrollees, insureds, or subscribers of health benefit plans. Any health carrier that ceases to offer a particular provider site to the small employer market must also cease to offer that provider site to new groups other than small employers for any of its products.

Subd. 2. [NOTICE TO EMPLOYERS.] A health carrier electing to cease doing business in the small employer market shall provide 120 days' written notice to each small employer covered by a health benefit plan issued by the health carrier. A health carrier that ceases to write new business in the small employer market shall

continue to be governed by this chapter with respect to continuing small employer business conducted by the carrier.

Subd. 3. [REENTRY PROHIBITION.] A health carrier that ceases to do business in the small employer market after July 1, 1993, is prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the commissioner. This subdivision applies to any health maintenance organization that ceases to do business in the small employer market in one service area with respect to that service area only. Nothing in this subdivision prohibits an affiliated health maintenance organization from continuing to do business in the small employer market in that same service area.

Subd. 4. [CONTINUING ASSESSMENT LIABILITY.] A health carrier that ceases to do business in the small employer market remains liable for assessments levied by the association as provided in section 62L.22.

Sec. 10. [62L.10] [SUPERVISION BY COMMISSIONER.]

Subdivision 1. [REPORTS.] A health carrier doing business in the small employer market shall file by April 1 of each year an annual actuarial opinion with the commissioner of commerce certifying that the health carrier complied with the underwriting and rating requirements of this chapter during the preceding year and that the rating methods used by the health carrier were actuarially sound. A health carrier shall retain a copy of the opinion at its principal place of business.

Subd. 2. [RECORDS.] A health carrier doing business in the small employer market shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

Subd. 3. [SUBMISSIONS TO COMMISSIONER.] Subsequent to the annual filing, the commissioner of commerce may request information and documentation from a health carrier describing its rating practices and renewal underwriting practices, including information and documentation that demonstrates that a health carrier's rating methods and practices are in accordance with sound actuarial principles and the requirements of this chapter. Except in cases of violations of this chapter or of another chapter, information received by the commissioner as provided under this subdivision is nonpublic.

Subd. 4. [REVIEW OF PREMIUM RATES.] The commissioner shall regulate premium rates charged or proposed to be charged by

all health carriers in the small employer market under section 62A.02.

Subd. 5. [TRANSITIONAL PRACTICES.] The commissioner of commerce shall disapprove index rates, premium variations, or other practices of a health carrier if they violate the spirit of this chapter and are the result of practices engaged in by the health carrier between the date of final enactment of this act and July 1, 1993, where the practices engaged in were carried out for the purpose of evading the spirit of this chapter.

Sec. 11. [62L.11] [PENALTIES AND ENFORCEMENT.]

Subdivision 1. [DISCIPLINARY PROCEEDINGS.] The commissioner may, by order, suspend or revoke a health carrier's license or certificate of authority and impose a monetary penalty not to exceed $25,000 for each violation of this chapter, including the failure to pay an assessment required by section 62L.22. The notice, hearing, and appeal procedures specified in section 60A.051 or 62D.16, as appropriate, apply to the order. The order is subject to judicial review as provided under chapter 14.

Subd. 2. [ENFORCEMENT POWERS.] The commissioners of health and commerce each has for purposes of this chapter all of each commissioner's respective powers under other chapters that are applicable to their respective duties under this chapter.

Sec. 12. [62L.12] [PROHIBITED PRACTICES.]

Subdivision 1. [PROHIBITION ON ISSUANCE OF INDIVIDUAL POLICIES.] A health carrier operating in the small employer market shall not knowingly offer, issue, or renew an individual policy, subscriber contract, or certificate to an eligible employee or dependent of a small employer that meets the minimum participation requirements defined in section 62L.03, subdivision 3, except as authorized under subdivision 2.

Subd. 2. [EXCEPTIONS.] (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees and dependents otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees and dependents otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees and dependents.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees and dependents as required.

(e) A health carrier may sell, issue, or renew individual coverage if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group coverage or due to the person's need for health care services not covered under the employer's group policy.

(f) A health carrier may sell, issue, or renew an individual policy, with the prior consent of the commissioner, if the individual has elected to buy the individual coverage not as part of a general plan to substitute individual coverage for group coverage nor as a result of any violation of subdivision 3 or 4.

(g) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

Subd. 3. [AGENT'S LICENSURE.] An agent licensed under chapter 60A or section 62C.17 who knowingly and willfully breaks apart a small group for the purpose of selling individual policies to eligible employees and dependents of a small employer that meets the participation requirements of section 62L.03, subdivision 3, is guilty of an unfair trade practice and subject to the revocation or suspension of license under section 60A.17, subdivision 6c, or 62C.17. The action must be by order and subject to the notice, hearing, and appeal procedures specified in section 60A.17, subdivision 6d. The action of the commissioner is subject to judicial review as provided under chapter 14.

Subd. 4. [EMPLOYER PROHIBITION.] A small employer shall not encourage or direct an employee or applicant to:

(1) refrain from filing an application for health coverage when other similarly situated employees may file an application for health coverage;

(2) file an application for health coverage during initial eligibility for coverage, the acceptance of which is contingent on health status, when other similarly situated employees may apply for health coverage, the acceptance of which is not contingent on health status;

(3) seek coverage from another carrier, including, but not limited to, MCHA; or

(4) cause coverage to be issued on different terms because of the

health status or claims experience of that person or the person's dependents.

Subd. 5. [SALE OF OTHER PRODUCTS.] A health carrier shall not condition the offer, sale, issuance, or renewal of a health benefit plan on the purchase by a small employer of other insurance products offered by the health carrier or a subsidiary or affiliate of the health carrier, including, but not limited to, life, disability, property, and general liability insurance. This prohibition does not apply to insurance products offered as a supplement to a health maintenance organization plan, including, but not limited to, supplemental benefit plans under section 62D.05, subdivision 6. This prohibition does not apply to accidental death or dismembership coverage up to $15,000 included in a health benefit plan other than a small employer plan.

Sec. 13. [62L.13] [REINSURANCE ASSOCIATION.]

Subdivision 1. [CREATION.] The health coverage reinsurance association is established as a nonprofit corporation. All health carriers in the small employer market shall be and remain members of the association as a condition of their authority to transact business.

Subd. 2. [PURPOSE.] The association is established to provide for the fair and equitable transfer of risk associated with participation by a health carrier in the small employer market to a private reinsurance pool established and maintained by the association.

Subd. 3. [EXEMPTIONS.] The association, its transactions, and all property owned by it are exempt from taxation under the laws of this state or any of its subdivisions, including, but not limited to, income tax, sales tax, use tax, and property tax. The association may seek exemption from payment of all fees and taxes levied by the federal government. Except as otherwise provided in this chapter, the association is not subject to the provisions of chapters 13, 14, 60A, 62A to 62H, and section 471.705. The association is not a public employer and is not subject to the provisions of chapters 179A and 353. Health carriers who are members of the association are exempt from the provisions of sections 325D.49 to 325D.66 in the performance of their duties as members of the association.

Subd. 4. [POWERS OF ASSOCIATION.] The association may exercise all of the powers of a corporation formed under chapter 317A, including, but not limited to, the authority to:

(1) establish operating rules, conditions, and procedures relating to the reinsurance of members' risks;

(2) assess members in accordance with the provisions of this

section and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses;

(3) sue and be sued, including taking any legal action necessary to recover any assessments;

(4) enter into contracts necessary to carry out the provisions of this chapter;

(5) establish operating, administrative, and accounting procedures for the operation of the association; and

(6) borrow money against the future receipt of premiums and assessments up to the amount of the previous year's assessment, with the prior approval of the commissioner.

The provisions of this chapter govern if the provisions of chapter 317A conflict with this chapter. The association shall adopt bylaws and shall be governed in accordance with this chapter and chapter 317A.

Subd. 5. [SUPERVISION BY COMMISSIONER.] The commissioner of commerce shall supervise the association in accordance with this chapter. The commissioner of commerce may examine the association. The association's reinsurance policy forms, its contracts, its premium rates, and its assessments are subject to the approval of the commissioner of commerce. The association shall notify the commissioner of all association or board meetings, and the commissioner or the commissioner's designee may attend all association or board meetings. The association shall file an annual report with the commissioner on or before July 1 of each year, beginning July 1, 1994, describing its activities during the preceding calendar year. The report must include a financial report and a summary of claims paid by the association. The annual report must be available for public inspection.

Sec. 14. [62L.14] [BOARD OF DIRECTORS.]

Subdivision 1. [COMPOSITION OF BOARD.] The association shall exercise its powers through a board of 13 directors. Four members must be public members appointed by the commissioner. The public members must not be employees of or otherwise affiliated with any member of the association. The nonpublic members of the board must be representative of the membership of the association and must be officers, employees, or directors of the members during their term of office. No member of the association may have more than three members of the board. Directors are automatically removed if they fail to satisfy this qualification.

Subd. 2. [ELECTION OF BOARD.] On or before July 1, 1992, the commissioner shall appoint an interim board of directors of the association who shall serve through the first annual meeting of the members and for the next two years. Except for the public members, the commissioner's initial appointments must be equally apportioned among the following three categories: accident and health insurance companies, nonprofit health service plan corporations, and health maintenance organizations. Thereafter, members of the association shall elect the board of directors in accordance with this chapter and the bylaws of the association, subject to approval by the commissioner. Members of the association may vote in person or by proxy. The public members shall continue to be appointed by the commissioner.

Subd 3. [TERM OF OFFICE.] The first annual meeting must be held by December 1, 1992. After the initial two-year period, each director shall serve a three-year term, except that the board shall make appropriate arrangements to stagger the terms of the board members so that approximately one-third of the terms expire each year. Each director shall hold office until expiration of the director's term or until the director's successor is duly elected or appointed and qualified, or until the director's death, resignation, or removal.

Subd. 4. [RESIGNATION AND REMOVAL.] A director may resign at any time by giving written notice to the commissioner. The resignation takes effect at the time the resignation is received unless the resignation specifies a later date. A nonpublic director may be removed at any time, with cause, by the members.

Subd. 5. [QUORUM.] A majority of the members of the board of directors constitutes a quorum for the transaction of business. If a vacancy exists by reason of death, resignation, or otherwise, a majority of the remaining directors constitutes a quorum.

Subd. 6. [DUTIES OF DIRECTORS.] The board of directors shall adopt or amend the association's bylaws. The bylaws may contain any provision for the purpose of administering the association that is not inconsistent with this chapter. The board shall manage the association in furtherance of its purposes and as provided in its bylaws. On or before January 1, 1993, the board or the interim board shall develop a plan of operation and reasonable operating rules to assure the fair, reasonable, and equitable administration of the association. The plan of operation must include the development of procedures for selecting an administering carrier, establishment of the powers and duties of the administering carrier, and establishment of procedures for collecting assessments from members, including the imposition of interest penalties for late payments of assessments. The plan of operation must be submitted to the commissioner for review and must be submitted to the members for approval at the first meeting of the members. The board of directors

may subsequently amend, change, or revise the plan of operation without approval by the members.

Subd. 7. [COMPENSATION.] Members of the board may be reimbursed by the association for reasonable and necessary expenses incurred by them in performing their duties as directors, but shall not otherwise be compensated by the association for their services.

Subd. 8. [OFFICERS.] The board may elect officers and establish committees as provided in the bylaws of the association. Officers have the authority and duties in the management of the association as prescribed by the bylaws and determined by the board of directors.

Subd. 9. [MAJORITY VOTE.] Approval by a majority of the board members present is required for any action of the board. The majority vote must include one vote from a board member representing an accident and health insurance company, one vote from a board member representing a health service plan corporation, one vote from a board member representing a health maintenance organization, and one vote from a public member.

Sec. 15. [62L.15] [MEMBERS.]

Subdivision 1. [ANNUAL MEETING.] The association shall conduct an annual meeting of the members of the association for the purpose of electing directors and transacting any other appropriate business of the membership of the association. The board shall determine the date, time, and place of the annual meeting. The association shall conduct its first annual member meeting on or before December 1, 1992.

Subd. 2. [SPECIAL MEETINGS.] Special meetings of the members must be held whenever called by any three of the directors. At least two categories must be represented among the directors calling a special meeting of the members. The categories are accident and health insurance companies, nonprofit health service plan corporations, and health maintenance organizations. Special meetings of the members must be held at a time and place designated in the notice of the meeting.

Subd. 3. [MEMBER VOTING.] Each member has an equal vote.

Subd. 4. [INITIAL MEMBER MEETING.] At least 60 days before the first annual meeting of the members, the commissioner shall give written notice to all members of the time and place of the member meeting. The members shall elect directors representing the members, approve the initial plan of operation of the association, and transact any other appropriate business of the membership of the association.

Subd. 5. [MEMBER COMPLIANCE.] All members shall comply with the provisions of this chapter, the association's bylaws, the plan of operation developed by the board of directors, and any other operating, administrative, or other procedures established by the board of directors for the operation of the association. The board may request the commissioner to secure compliance with this chapter through the use of any enforcement action otherwise available to the commissioner.

Sec. 16. [62L.16] [ADMINISTRATION OF ASSOCIATION.]

Subdivision 1. [ADMINISTERING CARRIER.] The association shall contract with a qualified health carrier to operate and administer the association. If there is no available qualified health carrier, or in the event of a termination under subdivision 2, the association may directly operate and administer the reinsurance program. The administering carrier shall perform all administrative functions required by this chapter. The board of directors shall develop administrative functions required by this chapter and written criteria for the selection of an administering carrier. The administering carrier must be selected by the board of directors, subject to approval by the commissioner.

Subd. 2. [TERM.] The administering carrier shall serve for a period of three years, unless the administering carrier requests the termination of its contract and the termination is approved by the board of directors. The board of directors shall approve or deny a request to terminate within 90 days of its receipt after consultation with the commissioner. A failure to make a final decision on a request to terminate within 90 days is considered an approval.

Subd. 3. [DUTIES OF ADMINISTERING CARRIER.] The association shall enter into a written contract with the administering carrier to carry out its duties and responsibilities. The administering carrier shall perform all administrative functions required by this chapter including the:

(1) preparation and submission of an annual report to the commissioner;

(2) preparation and submission of monthly reports to the board of directors;

(3) calculation of all assessments and the notification thereof of members;

(4) payment of claims to health carriers following the submission by health carriers of acceptable claim documentation; and

(5) provision of claim reports to health carriers as determined by the board of directors.

Subd. 4. [BID PROCESS.] The association shall issue a request for proposal for administration of the reinsurance association and shall solicit responses from health carriers participating in the small employer market and from other qualified insurers and reinsurers. Methods of compensation of the administrator must be a part of the bid process. The administering carrier shall substantiate its cost reports consistent with generally accepted accounting principles.

Subd. 5. [AUDITS.] The board of directors may conduct periodic audits to verify the accuracy of financial data and reports submitted by the administering carrier.

Subd. 6. [RECORDS OF ASSOCIATION.] The association shall maintain appropriate records and documentation relating to the activities of the association. All individual patient-identifying claims data and information are confidential and not subject to disclosure of any kind, except that a health carrier shall have access upon request to individual claims data relating to eligible employees and dependents covered by a health benefit plan issued by the health carrier. All records, documents, and work product prepared by the association or by the administering carrier for the association are the property of the association. The commissioner shall have access to the data for the purposes of carrying out the supervisory functions provided for in this chapter.

Sec. 17. [62L.17] [PARTICIPATION IN THE REINSURANCE ASSOCIATION.]

Subdivision 1. [MINIMUM STANDARDS.] The board of directors or the interim board shall establish minimum claim processing and managed care standards which must be met by a health carrier in order to reinsure business.

Subd. 2. [PARTICIPATION.] A health carrier may elect to not participate in the reinsurance association through transferring risk only after filing an application with the commissioner of commerce. The commissioner may approve the application after consultation with the board of directors. In determining whether to approve an application, the commissioner shall consider whether the health carrier meets the following standards:

(1) demonstration by the health carrier of a substantial and established market presence;

(2) demonstrated experience in the small group market and history of rating and underwriting small employer groups;

(3) commitment to comply with the requirements of this chapter for small employers in the state or its service area; and

(4) financial ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance.

Initial application for nonparticipation must be filed with the commissioner no later than October 15, 1992. The commissioner shall make the determination and notify the carrier no later than November 15, 1992.

Subd. 3. [LENGTH OF PARTICIPATION.] A health carrier's initial election is for a period of two years. Subsequent elections of participation are for five-year periods.

Subd. 4. [APPEAL.] A health carrier whose application for nonparticipation has been rejected by the commissioner may appeal the decision. The association may also appeal a decision of the commissioner, if approved by a two-thirds majority of the board. Chapter 14 applies to all appeals.

Subd. 5. [ANNUAL CERTIFICATION.] A health carrier that has received approval to not participate in the reinsurance association shall annually certify to the commissioner on or before December 1 that it continues to meet the standards described in subdivision 2.

Subd. 6. [SUBSEQUENT ELECTION.] Election to participate in the reinsurance association must occur on or before December 31 of each year. If after a period of nonparticipation, the nonparticipating health carrier subsequently elects to participate in the reinsurance association, the health carrier retains the risk it assumed when not participating in the association.

If a participating health carrier subsequently elects to not participate in the reinsurance association, the health carrier shall cease reinsuring through the association all of its small employer business and is liable for any assessment described in section 62L.22 which has been prorated based on the business covered by the reinsurance mechanism during the year of the assessment.

Subd. 7. [ELECTION MODIFICATION.] The commissioner, after consultation with the board, may authorize a health carrier to modify its election to not participate in the association at any time, if the risk from the carrier's existing small employer business jeopardizes the financial condition of the health carrier. If the commissioner authorizes a health carrier to participate in the association, the health carrier shall retain the risk it assumed while not participating in the association. This election option may not be exercised if the health carrier is in rehabilitation.

Sec. 18. [62L.18] [CEDING OF RISK.]

Subdivision 1. [PROSPECTIVE CEDING.] For health benefit plans issued on or after July 1, 1993, all health carriers participating in the association may prospectively reinsure an employee or dependent within a small employer group and entire employer groups of seven or fewer eligible employees. A health carrier must determine whether to reinsure an employee or dependent or entire group within 60 days of the commencement of the coverage of the small employer and must notify the association during that time period.

Subd. 2. [ELIGIBILITY FOR REINSURANCE.] A health carrier may not reinsure existing small employer business through the association. A health carrier may reinsure an employee or dependent who previously had coverage from MCHA who is now eligible for coverage through the small employer group at the time of enrollment as defined in section 62L.03, subdivision 6. A health carrier may not reinsure individuals who have existing individual health care coverage with that health carrier upon replacement of the individual coverage with group coverage as provided in section 62L.04, subdivision 1.

Subd. 3. [REINSURANCE TERMINATION.] A health carrier may terminate reinsurance through the association for an employee or dependent or entire group on the anniversary date of coverage for the small employer. If the health carrier terminates the reinsurance, the health carrier may not subsequently reinsure the individual or entire group.

Subd. 4. [CONTINUING CARRIER RESPONSIBILITY.] A health carrier transferring risk to the association is completely responsible for administering its health benefit plans. A health carrier shall apply its case management and claim processing techniques consistently between reinsured and nonreinsured business. Small employers, eligible employees, and dependents shall not be notified that the health carrier has reinsured their coverage through the association.

Sec. 19. [62L.19] [ALLOWED REINSURANCE BENEFITS.]

A health carrier may reinsure through the association only those benefits described in section 62L.05.

Sec. 20. [62L.20] [TRANSFER OF RISK.]

Subdivision 1. [REINSURANCE THRESHOLD.] A health carrier participating in the association may transfer up to 90 percent of the risk above a reinsurance threshold of $5,000 of eligible charges resulting from issuance of a health benefit plan to an eligible employee or dependent of a small employer group whose risk has

been prospectively ceded to the association. If the eligible charges exceed $50,000, a health carrier participating in the association may transfer 100 percent of the risk each policy year not to exceed 12 months.

Satisfaction of the reinsurance threshold must be determined by the board of directors based on eligible charges. The board may establish an audit process to assure consistency in the submission of charge calculations by health carriers to the association.

Subd. 2. [CONVERSION FACTORS.] The board shall establish a standardized conversion table for determining equivalent charges for health carriers that use alternative provider reimbursement methods. If a health carrier establishes to the board that the carrier's conversion factor is equivalent to the association's standardized conversion table, the association shall accept the health carrier's conversion factor.

Subd. 3. [BOARD AUTHORITY.] The board shall establish criteria for changing the threshold amount or retention percentage. The board shall review the criteria on an annual basis. The board shall provide the members with an opportunity to comment on the criteria at the time of the annual review.

Subd. 4. [NOTIFICATION OF TRANSFER OF RISK.] A participating health carrier must notify the association, within 90 days of receipt of proof of loss, of satisfaction of a reinsurance threshold. After satisfaction of the reinsurance threshold, a health carrier continues to be liable to its providers, eligible employees, and dependents for payment of claims in accordance with the health carrier's health benefit plan. Health carriers shall not pend or delay payment of otherwise valid claims due to the transfer of risk to the association.

Subd. 5. [PERIODIC STUDIES.] The board shall, on a biennial basis, prepare and submit a report to the commissioner of commerce on the effect of the reinsurance association on the small employer market. The first study must be presented to the commissioner no later than January 1, 1995, and must specifically address whether there has been disruption in the small employer market due to unnecessary churning of groups for the purpose of obtaining reinsurance and whether it is appropriate for health carriers to transfer the risk of their existing small group business to the reinsurance association. After two years of operation, the board shall study both the effect of ceding both individuals and entire small groups of seven or fewer eligible employees to the reinsurance association and the composition of the board and determine whether the initial appointments reflect the types of health carriers participating in the reinsurance association and whether the voting power of members of the association should be weighted and recommend any necessary changes.

Sec. 21. [62L.21] [REINSURANCE PREMIUMS.]

Subdivision 1. [MONTHLY PREMIUM.] A health carrier ceding an individual to the reinsurance association shall be assessed a monthly reinsurance coverage premium that is 5.0 times the adjusted average market price. A health carrier ceding an entire group to the reinsurance association shall be assessed a monthly reinsurance coverage premium that is 1.5 times the adjusted average market price. The adjusted average market premium price must be established by the board of directors in accordance with its plan of operation. The board may consider benefit levels in establishing the reinsurance coverage premium.

Subd. 2. [ADJUSTMENT OF PREMIUM RATES.] The board of directors shall establish operating rules to allocate adjustments to the reinsurance premium charge of no more than minus 25 percent of the monthly reinsurance premium for health carriers that can demonstrate administrative efficiencies and cost-effective handling of equivalent risks. The adjustment must be made annually on a retrospective basis. The operating rules must establish objective and measurable criteria which must be met by a health carrier in order to be eligible for an adjustment. These criteria must include consideration of efficiency attributable to case management, but not consideration of such factors as provider discounts.

Subd. 3. [LIABILITY FOR PREMIUM.] A health carrier is liable for the cost of the reinsurance premium and may not directly charge the small employer for the costs. The reinsurance premium may be reflected only in the rating factors permitted in section 62L.08, as provided in section 62L.08, subdivision 10.

Sec. 22. [62L.22] [ASSESSMENTS.]

Subdivision 1. [ASSESSMENT BY BOARD.] For the purpose of providing the funds necessary to carry out the purposes of the association, the board of directors shall assess members as provided in subdivisions 2, 3, and 4 at the times and for the amounts the board of directors finds necessary. Assessments are due and payable on the date specified by the board of directors, but not less than 30 days after written notice to the member. Assessments accrue interest at the rate of six percent per year on or after the due date.

Subd. 2. [INITIAL CAPITALIZATION.] The interim board of directors shall determine the initial capital operating requirements for the association. The board shall assess each licensed health carrier $100 for the initial capital requirements of the association. The assessment is due and payable no later than January 1, 1993.

Subd. 3. [RETROSPECTIVE ASSESSMENT.] On or before July 1 of each year, the administering carrier shall determine the association's net loss, if any, for the previous calendar year, the program

expenses of administration, and other appropriate gains and losses. If reinsurance premium charges are not sufficient to satisfy the operating and administrative expenses incurred or estimated to be incurred by the association, the board of directors shall assess each member participating in the association in proportion to each member's respective share of the total insurance premiums, subscriber contract payments, health maintenance organization payments, and other health benefit plan revenue derived from or on behalf of small employers during the preceding calendar year. The assessments must be calculated by the board of directors based on annual statements and other reports considered necessary by the board of directors and filed by members with the association. The amount of the assessment shall not exceed four percent of the member's small group market premium. In establishing this assessment, the board shall consider a formula based on total small employer premiums earned and premiums earned from newly issued small employer plans. A member's assessment may not be reduced or increased by more than 50 percent as a result of using that formula, which includes a reasonable cap on assessments on any premium category or premium classification. The board of directors may provide for interim assessments as it considers necessary to appropriately carry out the association's responsibilities. The board of directors may establish operating rules to provide for changes in the assessment calculation.

Subd. 4. [ADDITIONAL ASSESSMENTS.] If the board of directors determines that the retrospective assessment formula described in subdivision 3 is insufficient to meet the obligations of the association, the board of directors shall assess each member not participating in the reinsurance association, but which is providing health plan coverage in the small employer market, in proportion to each member's respective share of the total insurance premiums, subscriber contract payments, health maintenance organization payments, and other health benefit plan revenue derived from or on behalf of small employers during the preceding calendar year. The assessment must be calculated by the board of directors based on annual statements and other reports considered necessary by the board of directors and filed by members with the association. The amount of the assessment may not exceed one percent of the member's small group market premium. Members who paid the retrospective assessment described in subdivision 3 are not subject to the additional assessment.

If the additional assessment is insufficient to meet the obligations of the association, the board of directors may assess members participating in the association who paid the retrospective assessment described in subdivision 3 up to an additional one percent of the member's small group market premium.

Subd. 5. [ABATEMENT OR DEFERMENT.] The association may abate or defer, in whole or in part, the retrospective assessment of a

member if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations or the member is placed under an order of rehabilitation, liquidation, receivership, or conservation by a court of competent jurisdiction. In the event that a retrospective assessment against a member is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred may be assessed against other members in accordance with the methodology specified in subdivisions 3 and 4.

Subd. 6. [REFUND.] The board of directors may refund to members, in proportion to their contributions, the amount by which the assets of the association exceed the amount the board of directors finds necessary to carry out its responsibilities during the next calendar year. A reasonable amount may be retained to provide funds for the continuing expenses of the association and for future losses.

Subd. 7. [APPEALS.] A health carrier may appeal to the commissioner of commerce within 30 days of notice of an assessment by the board of directors. A final action or order of the commissioner is subject to judicial review in the manner provided in chapter 14.

Subd. 8. [LIABILITY FOR ASSESSMENT.] Employer liability for other costs of a health carrier resulting from assessments made by the association under this section are limited by the rate spread restrictions specified in section 62L.08.

Sec. 23. [62L.23] [LOSS RATIO STANDARDS.]

Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, each policy or contract form used with respect to a health benefit plan offered, or issued in the small employer market, is subject, beginning July 1, 1993, to section 62A.021.

Sec. 24. [COMMISSIONER OF COMMERCE STUDY.]

The commissioner of commerce shall study and provide a written report and recommendations to the legislature that analyze the effects of this article and future measures that the legislature could enact to achieve the purpose set forth in section 62L.01, subdivision 3. The commissioner shall study, report, and make recommendations on the following:

(1) the effects of this article on availability of coverage, average premium rates, variations in premium rates, the number of uninsured and underinsured residents of this state, the types of health benefit plans chosen by employers, and other effects on the market for health benefit plans for small employers;

(2) the desirability and feasibility of achieving the goal stated in section 62L.01, subdivision 3, in the small employer market by means of the following timetable:

(i) as of July 1, 1994, a reduction of the age rating bands to 30 percent on each side of the index rate, accompanied by a proportional reduction of the general premium rating bands to 15 percent on each side of the index rate;

(ii) as of July 1, 1995, a reduction in the bands described in the preceding clause to 20 percent and ten percent respectively;

(iii) as of July 1, 1996, a reduction in the bands referenced in the preceding clause to ten percent and five percent respectively; and

(iv) as of July 1, 1997, a ban on all rating bands; and

(3) Any other aspects of the small employer market considered relevant by the commissioner.

The commissioner shall file the written report and recommendations with the legislature no later than December 1, 1993.

Sec. 25. [EFFECTIVE DATES.]

Sections 1 to 12 and 23 are effective July 1, 1993. Sections 13 to 22 are effective the day following final enactment.

ARTICLE 3

INSURANCE REFORM: INDIVIDUAL MARKET AND MISCELLANEOUS

Section 1. Minnesota Statutes 1990, section 43A.316, is amended by adding a subdivision to read:

Subd. 11. [NAME.] Effective July 1, 1993, the name of the public employees insurance plan shall be the pooled employers insurance program. The pooled employers insurance program, as described in section 43A.317, is a continuation and expansion of the public employees insurance plan.

Sec. 2. Minnesota Statutes 1990, section 43A.316, is amended by adding a subdivision to read:

Subd. 12. [ELIGIBILITY AND COVERAGE.] Notwithstanding any contrary provision of section 43A.317, any group enrolled in the public employees insurance plan for a term extending beyond June 30, 1993, will become covered by the pooled employers insurance

program pursuant to the terms of the group's participation agreement with the public employees insurance plan. The commissioner of employee relations may provide such a group the option to convert to alternative coverage if available through the pooled employers insurance program. Upon the expiration of the group's participating agreement with the public employees insurance plan, the group may enroll in the pooled employers insurance program under section 43A.317, provided the group continues to meet the eligibility criteria that existed on June 30, 1993.

Sec. 3. Minnesota Statutes 1990, section 43A.316, is amended by adding a subdivision to read:

Subd. 13. [TRUST FUND.] Effective July 1, 1993, all assets and obligations of the public employees insurance trust fund are transferred to the pooled employers insurance trust fund, as described in section 43A.317, subdivision 9.

Sec. 4. [43A.317] [POOLED EMPLOYERS INSURANCE PROGRAM.]

Subdivision 1. [INTENT.] The legislature finds that the creation of a statewide program to provide employers with the advantages of a large pool for insurance purchasing would advance the welfare of the citizens of the state.

Subd. 2. [DEFINITIONS.] (a) [SCOPE.] For the purposes of this section, the terms defined have the meaning given them.

(b) [COMMISSIONER.] "Commissioner" means the commissioner of employee relations.

(c) [ELIGIBLE EMPLOYEE.] "Eligible employee" means an employee eligible to participate in the program under the terms described in subdivision 6.

(d) [ELIGIBLE EMPLOYER.] "Eligible employer" means an employer eligible to participate in the program under the terms described in subdivision 5.

(e) [ELIGIBLE INDIVIDUAL.] "Eligible individual" means a person eligible to participate in the program under the terms described in subdivision 6.

(f) [EMPLOYEE.] "Employee" means a common law employee of an eligible employer.

(g) [EMPLOYER.] "Employer" means a public or private person, firm, corporation, partnership, association, unit of local government,

or other entity actively engaged in business or public services. "Employer" includes both for-profit and nonprofit entities.

(h) [PROGRAM.] "Program" means the pooled employers insurance program created by this section.

(i) [PUBLIC EMPLOYER.] "Public employer" means an employer within the definition of section 179A.03, subdivision 15, that is a town, county, city, or school district as defined in section 120.02; educational cooperative service unit as defined in section 123.58; intermediate district as defined in section 136C.02, subdivision 7; cooperative center for vocational education as defined in section 123.351; regional management information center as defined in section 121.935; an education unit organized under a joint powers action under section 471.59; or another public employer approved by the commissioner.

Subd. 3. [ADMINISTRATION.] The commissioner shall, consistent with the provisions of this section, administer the program and determine its coverage options, funding and premium arrangements, contractual arrangements, and all other matters necessary to administer the program. The commissioner's contracting authority for the program, including authority for competitive bidding and negotiations, is governed by section 43A.23.

Subd. 4. [ADVISORY COMMITTEE.] The commissioner shall establish a ten-member advisory committee that includes five members who represent eligible employers and five members who represent eligible individuals. The committee shall advise the commissioner on issues related to administration of the program. The committee is governed by sections 15.014 and 15.059, and continues to exist while the program remains in operation.

Subd. 5. [EMPLOYER ELIGIBILITY.] (a) [PROCEDURES.] All employers are eligible for coverage through the program subject to the terms of this subdivision. The commissioner shall establish procedures for an employer to apply for coverage through the program.

(b) [TERM.] The initial term of an employer's coverage will be two years from the effective date of the employer's application. After that, coverage will be automatically renewed for additional two-year terms unless the employer gives notice of withdrawal from the program according to procedures established by the commissioner. The commissioner may establish conditions under which an employer may withdraw from the program prior to the expiration of a two-year term, including by reason of a midyear increase in health coverage premiums of 50 percent or more. An employer that withdraws from the program may not reapply for coverage for a period of two years from its date of withdrawal.

(c) [MINNESOTA WORK FORCE.] An employer is not eligible for coverage through the program if five percent or more of its eligible employees work primarily outside Minnesota, except that an employer may apply to the program on behalf of only those employees who work primarily in Minnesota.

(d) [EMPLOYEE PARTICIPATION; AGGREGATION OF GROUPS.] An employer is not eligible for coverage through the program unless its application includes all eligible employees who work primarily in Minnesota, except employees who waive coverage as permitted by subdivision 6. Private entities that are eligible to file a combined tax return for purposes of state tax laws are considered a single employer, except as otherwise approved by the commissioner.

(e) [PRIVATE EMPLOYER.] A private employer is not eligible for coverage unless it has two or more eligible employees in the state of Minnesota. If an employer has only two eligible employees, one employee must not be the spouse, child, sibling, parent, or grandparent of the other.

(f) [MINIMUM PARTICIPATION.] The commissioner may require as a condition of employer eligibility that:

(1) a minimum percentage of eligible employees are covered through the program; and

(2) the employer makes a minimum level of contribution toward the cost of coverage.

(g) [EMPLOYER CONTRIBUTION.] The commissioner may require as a condition of employer eligibility that the employer contribution toward the cost of coverage is structured in a way that promotes price competition among the coverage options available through the program.

(h) [ENROLLMENT CAP.] The commissioner may limit employer enrollment in the program if necessary to avoid exceeding the program's reserve capacity.

Subd. 6. [INDIVIDUAL ELIGIBILITY.] (a) [PROCEDURES.] The commissioner shall establish procedures for eligible employees and other eligible individuals to apply for coverage through the program.

(b) [EMPLOYEES.] An employer shall determine when it applies to the program the criteria its employees must meet to be eligible for coverage under its plan. An employer may subsequently change the criteria annually or at other times with approval of the commissioner. The criteria must provide that new employees become eligible

for coverage after a probationary period of at least 30 days, but no more than 90 days.

(c) [OTHER INDIVIDUALS.] An employer may elect to cover under its plan:

(1) the spouse, dependent children, and dependent grandchildren of a covered employee;

(2) a retiree who is eligible to receive a pension or annuity from the employer and a covered retiree's spouse, dependent children, and dependent grandchildren;

(3) the surviving spouse, dependent children, and dependent grandchildren of a deceased employee or retiree, if the spouse, children, or grandchildren were covered at the time of the death;

(4) a covered employee who becomes disabled, as provided in sections 62A.147 and 62A.148; or

(5) any other categories of individuals for whom group coverage is required by state or federal law.

An employer shall determine when it applies to the program the criteria individuals in these categories must meet to be eligible for coverage. An employer may subsequently change the criteria annually, or at other times with approval of the commissioner. The criteria for dependent children and dependent grandchildren may be no more inclusive than the criteria under section 43A.18, subdivision 2. This paragraph shall not be interpreted as relieving the program from compliance with any federal and state continuation of coverage requirements.

(d) [WAIVER AND LATE ENTRANCE.] An eligible individual may waive coverage at the time the employer joins the program or when coverage first becomes available. The commissioner may establish a preexisting condition exclusion of not more than 18 months for late entrants as defined in section 62L.02, subdivision 19.

(e) [CONTINUATION COVERAGE.] The program shall provide all continuation coverage required by state and federal law.

Subd. 7. [COVERAGE.] Coverage is available through the program beginning on July 1, 1993. At least annually, the commissioner shall solicit bids from carriers regulated under chapters 62A, 62C, and 62D, to provide coverage of eligible individuals. The commissioner shall provide coverage through contracts with carriers, unless the commissioner receives no reasonable bids from carriers.

(a) [HEALTH COVERAGE.] Health coverage is available to all employers in the program. The commissioner shall attempt to establish health coverage options that have strong care management features to control costs and promote quality and shall attempt to make a choice of health coverage options available. Health coverage for a retiree who is eligible for the federal Medicare program must be administered as though the retiree is enrolled in Medicare parts A and B. To the extent feasible as determined by the commissioner and in the best interests of the program, the commissioner shall model coverage after the plan established in section 43A.18, subdivision 2. Health coverage must include at least the benefits required of a carrier regulated under chapter 62A, 62C, or 62D for comparable coverage. Coverage under this paragraph must not be provided as part of the health plans available to state employees.

(b) [OPTIONAL COVERAGES.] In addition to offering health coverage, the commissioner may arrange to offer life, dental, and disability coverage through the program. Employers with health coverage may choose to offer one or more of these optional coverages according to the terms established by the commissioner. Life and disability insurance may be offered only to public employers.

(c) [OPEN ENROLLMENT.] The program must provide periodic open enrollments for eligible individuals for those coverages where a choice exists.

(d) [TECHNICAL ASSISTANCE.] The commissioner may arrange for technical assistance and referrals for eligible employers in areas such as health promotion and wellness, employee benefits structure, tax planning, and health care analysis services as described in section 62J.33.

Subd. 8. [PREMIUMS.] (a) [PAYMENTS.] Employers enrolled in the program shall pay premiums according to terms established by the commissioner. If an employer fails to make the required payments, the commissioner may cancel coverage and pursue other civil remedies.

(b) [RATING METHOD.] The commissioner shall determine the premium rates and rating method for the program. The rating method for eligible small employers must meet or exceed the requirements of chapter 62L. The rating methods must recover in premiums all of the ongoing costs for state administration and for maintenance of a premium stability and claim fluctuation reserve. Premiums must be established so as to recover and repay within three years after July 1, 1993, any direct appropriations received to provide start-up administrative costs. Premiums must be established so as to recover and repay within five years after July 1, 1993, any direct appropriations received to establish initial reserves. Premiums need not recover amounts received under section 353.65, subdivision 7.

(c) [TAX STATUS.] Premiums paid to the program are exempt from the tax imposed by sections 60A.15 and 60A.198. If the program obtains coverage for its enrollees from a carrier that is subject to the tax imposed by those sections, payments to the carrier for the coverage are subject to the tax.

Subd. 9. [POOLED EMPLOYERS INSURANCE TRUST FUND.] (a) [CONTENTS.] The pooled employer insurance trust fund in the state treasury consists of deposits received from eligible employers and individuals, contractual settlements or rebates relating to the program, investment income or losses, and direct appropriations.

(b) [APPROPRIATION.] All money in the fund is appropriated to the commissioner to pay insurance premiums, approved claims, refunds, administrative costs, and other costs necessary to administer the program.

(c) [RESERVES.] For any coverages for which the program does not contract to transfer full financial responsibility, the commissioner shall establish and maintain reserves:

(1) for claims in process, incomplete and unreported claims, premiums received but not yet earned, and all other accrued liabilities; and

(2) to ensure premium stability and the timely payment of claims in the event of adverse claims experience. The reserve for premium stability and claim fluctuations must be established according to the standards of section 62C.09, subdivision 3, except that the reserve may exceed the upper limit under this standard until July 1, 1997.

(d) [INVESTMENTS.] The state board of investment shall invest the fund's assets according to section 11A.24. Investment income and losses attributable to the fund must be credited to the fund.

Subd. 10. [PROGRAM STATUS.] The pooled employers insurance program is a state program to provide the advantages of a large pool for purchasing health coverage, other coverages, and related services from insurance companies, health maintenance organizations, and other organizations. The program and, where applicable, the employers enrolled in it do not constitute insurance within the meaning of state law and are not subject to chapters 60A, 62A, 62C, 62D, 62E, 62H, and 62L, section 471.617, subdivisions 2 and 3, and the bidding requirements of section 471.6161.

Subd. 11. [EVALUATION.] The commissioner shall report to the legislature on December 15, 1995, concerning the success of the program in fulfilling the intent of the legislature.

Sec. 5. [62A.011] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. [HEALTH CARRIER.] "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a fraternal benefit society operating under chapter 64B; or a joint self-insurance employee health plan operating under chapter 62H.

Subd. 3. [HEALTH PLAN.] "Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self-insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified.

Sec. 6. Minnesota Statutes 1990, section 62A.02, subdivision 1, is amended to read:

Subdivision 1. [FILING.] No ~~policy of accident and sickness insurance~~ health plan as defined in section 62A.011 shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection ~~therewith~~ with the health plan, until a copy of ~~the~~ its form ~~thereof~~ and of the classification of risks and the premium rates pertaining ~~thereto~~ to the form have been filed with the commissioner. The filing for nongroup ~~policies~~ health plan forms shall include a statement of actuarial reasons and data to support the ~~need for any premium~~ rate ~~increase~~. For health benefit plans as defined in section 62L.02, and for health plans to be issued to individuals, the health carrier shall file with the commissioner the information required in section 62L.08, subdivision 8. For group health plans for which approval is sought for sales only outside of the small employer market as defined in section 62L.02, this section applies only to policies or contracts of accident and sickness insurance. All forms intended for issuance in the individual or small employer market must be accompanied by a statement as to the expected loss ratio for the form. Premium rates and forms relating to specific insureds or proposed insureds, whether individuals or groups, need not be filed, unless requested by the commissioner.

Sec. 7. Minnesota Statutes 1990, section 62A.02, subdivision 2, is amended to read:

Subd. 2. [APPROVAL.] ~~No such policy~~ The health plan form shall not be issued, nor shall any application, rider, ~~or~~ endorsement, or rate be used in connection ~~therewith~~ with it, until the expiration of 60 days after it has been ~~so~~ filed unless the commissioner ~~shall sooner give written approval thereto~~ approves it before that time.

Sec. 8. Minnesota Statutes 1990, section 62A.02, subdivision 3, is amended to read:

Subd. 3. [STANDARDS FOR DISAPPROVAL.] The commissioner shall, within 60 days after the filing of any form or rate, disapprove the form or rate:

(1) if the benefits provided ~~therein~~ are ~~unreasonable~~ not reasonable in relation to the premium charged;

(2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the ~~policy~~ health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A; ~~or~~

(3) if the proposed premium rate is excessive ~~because the insurer has failed to exercise reasonable cost control~~ or not adequate; or

(4) the actuarial reasons and data submitted do not justify the rate.

The party proposing a rate has the burden of proving by a preponderance of the evidence that it does not violate this subdivision.

In determining the reasonableness of a rate, the commissioner shall also review all administrative contracts, service contracts, and other agreements to determine the reasonableness of the cost of the contracts or agreement and effect of the contracts on the rate. If the commissioner determines that a contract or agreement is not reasonable, the commissioner shall disapprove any rate that reflects any unreasonable cost arising out of the contract or agreement. The commissioner may require any information that the commissioner deems necessary to determine the reasonableness of the cost.

For the purposes of ~~clause (1)~~ this subdivision, the commissioner shall establish by rule a schedule of minimum anticipated loss ratios which shall be based on (i) the type or types of coverage provided, (ii) whether the policy is for group or individual coverage, and (iii) the size of the group for group policies. Except for individual policies of disability or income protection insurance, the minimum anticipated loss ratio shall not be less than 50 percent after the first year that a policy is in force. All applicants for a policy shall be informed in writing at the time of application of the anticipated loss ratio of the

policy. ~~For the purposes of this subdivision,~~ "Anticipated loss ratio" means the ratio at the time of ~~form~~ filing, at the time of notice of withdrawal under subdivision 4a, or at the time of subsequent rate revision of the present value of all expected future benefits, excluding dividends, to the present value of all expected future premiums. ~~Nothing in this paragraph shall prohibit the commissioner from disapproving a form which meets the requirements of this paragraph but which the commissioner determines still provides benefits which are unreasonable in relation to the premium charged.~~

If the commissioner notifies ~~an insurer which~~ a health carrier that has filed any form or rate that ~~the form~~ it does not comply with ~~the provisions of~~ this ~~section or sections 62A.03 to 62A.05 and 72A.20~~ chapter, chapter 62L, or chapter 72A, it shall be unlawful ~~thereafter~~ for the ~~insurer~~ health carrier to issue or use the form or ~~use it in connection with any policy~~ rate. In the notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the ~~insurer~~ health carrier.

The 60-day period within which the commissioner is to approve or disapprove the form or rate does not begin to run until a complete filing of all data and materials required by statute or requested by the commissioner has been submitted.

However, if the supporting data is not filed within 30 days after a request by the commissioner, the rate is not effective and is presumed to be an excessive rate.

Sec. 9. Minnesota Statutes 1990, section 62A.02, is amended by adding a subdivision to read:

Subd. 4a. [WITHDRAWAL OF APPROVAL.] The commissioner may, at any time after a 20-day written notice has been given to the insurer, withdraw approval of any form or rate that has previously been approved on any of the grounds stated in this section. It is unlawful for the health carrier to issue a form or rate or use it in connection with any health plan after the effective date of the withdrawal of approval. The notice of withdrawal of approval must advise the health carrier of the right to a hearing under the contested case procedures of chapter 14, and must specify the matters to be considered at the hearing.

The commissioner may request an health carrier to provide actuarial reasons and data, as well as other information, needed to determine if a previously approved rate continues to satisfy the requirements of this section. If the requested information is not provided within 30 days after request by the commissioner, the rate is presumed to be an excessive rate.

Sec. 10. Minnesota Statutes 1990, section 62A.02, is amended by adding a subdivision to read:

Subd. 5a. [HEARING.] The health carrier must request a hearing before the 20-day notice period has ended, or the commissioner's order is final. A request for hearing stays the commissioner's order until the commissioner notifies the health carrier of the result of the hearing. The commissioner's order may require the modification of any rate or form and may require continued coverage to persons covered under a health plan to which the disapproved form or rate applies.

Sec. 11. Minnesota Statutes 1990, section 62A.02, is amended by adding a subdivision to read:

Subd. 7. [RATES OPEN TO INSPECTION.] All rates and supplementary rate information furnished to the commissioner under this chapter shall, as soon as the rates are approved, be open to public inspection at any reasonable time.

Sec. 12. [62A.021] [HEALTH CARE POLICY RATES.]

Subdivision 1. [LOSS RATIO STANDARDS.] Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, a health care policy form or certificate form shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, 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 not including anticipated refunds or credits, provided under the policy form or certificate form, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of policies issued in the individual market, 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 practices. A health carrier shall demonstrate that the third year loss ratio is greater than or equal to the applicable percentage. The applicable percentage for policy forms and certificate forms issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, until an 80 percent loss ratio is reached on July 1, 1998. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, until a 70 percent loss ratio is reached on July 1, 1998. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

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 form or certificate form shall equal or exceed the appropriate loss ratio standards.

A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form 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 policy forms or certificate forms in force less than three years. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner shall order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

Each sale of a policy or certificate that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

For purposes of this section, health care policies issued as a result of solicitations of individuals through the mail or mass media

advertising, including both print and broadcast advertising, shall be treated as individual policies.

For purposes of this section, (1) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and (2) "health carrier" has the meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

Subd. 2. [COMPLIANCE AUDIT.] The commissioner has the authority to audit any health carrier to assure compliance with this section. Health carriers shall retain at their principal place of business information necessary for the commissioner to perform compliance audits.

Sec. 13. [62A.022] [UNIFORM CLAIMS FORMS AND BILLING PRACTICES.]

By January 1, 1993, the commissioner of commerce, in consultation with the commissioners of health and human services, shall establish and require uniform claims forms and uniform billing and record keeping practices applicable to all policies of accident and health insurance, group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, health maintenance contracts regulated under chapter 62D, and health benefit certificates offered through a fraternal benefit society regulated under chapter 64B, if issued or renewed to provide coverage to Minnesota residents.

Sec. 14. [62A.302] [COVERAGE OF DEPENDENTS.]

Subdivision 1. [SCOPE OF COVERAGE.] This section applies to all health plans as defined in section 62A.011.

Subd. 2. [REQUIRED COVERAGE.] Every health plan included in subdivision 1 that provides dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02.

Sec. 15. [62A.303] [PROHIBITION; SEVERING OF GROUPS.]

Section 62L.12, subdivisions 1, 2, 3, and 4, apply to all employer group health plans, as defined in section 62A.011, regardless of the size of the group.

Sec. 16. 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 issued by a health service plan corporation regulated under chapter 62C, 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;

(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) 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 healty 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.

Sec. 17. [62A.65] [INDIVIDUAL MARKET REGULATION.]

Subdivision 1. [APPLICABILITY.] No health carrier, as defined in chapter 62L, shall offer, sell, issue, or renew any individual policy of accident and sickness coverage, as defined in section 62A.01, subdivision 1, any individual subscriber contract regulated under chapter 62C, any individual health maintenance contract regulated under chapter 62D, any individual health benefit certificate regulated under chapter 64B, or any individual health coverage provided by a multiple employer welfare arrangement, to a Minnesota resident except in compliance with this section. For purposes of this section, "health benefit plan" has the meaning given in chapter 62L, except that the term means individual coverage, including family coverage, rather than employer group coverage. This section does not apply to the comprehensive health association established in section 62E.10 or to coverage described in section 62A.31, subdivision 1, paragraph

(h), or to long-term care policies as defined in section 62A.46, subdivision 2.

Subd. 2. [GUARANTEED RENEWAL.] No health benefit plan may be offered, sold, issued, or renewed to a Minnesota resident unless the health benefit plan provides that the plan is guaranteed renewable at a premium rate that does not take into account the claims experience or any change in the health status of any covered person that occurred after the initial issuance of the health benefit plan to the person. The premium rate upon renewal must also otherwise comply with this section. A health benefit plan may be subject to refusal to renew only under the conditions provided in chapter 62L.

Subd. 3. [PREMIUM RATE RESTRICTIONS.] No health benefit plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the rating and premium restrictions provided under chapter 62L, except the minimum loss ratio applicable to individual coverage is as provided in section 62A.021. All provisions of chapter 62L apply to rating and premium restrictions in the individual market, unless clearly inapplicable to the individual market.

Subd. 4. [GENDER RATING PROHIBITED.] No health benefit plan offered, sold, issued, or renewed to a Minnesota resident may determine the premium rate or any other underwriting decision, including initial issuance, on the gender of any person covered or to be covered under the health benefit plan.

Subd. 5. [PORTABILITY OF COVERAGE.] (a) No health benefit plan may be offered, sold, issued, or renewed to a Minnesota resident that contains a preexisting condition limitation or exclusion, unless the limitation or exclusion would be permitted under chapter 62L. The individual may be treated as a late entrant, as defined in chapter 62L, unless the individual has maintained continuous coverage as defined in chapter 62L. An individual who has maintained continuous coverage may be subjected to a one-time preexisting condition limitation as permitted under chapter 62L for persons who are not late entrants, at the time that the individual first is covered by individual coverage. Thereafter, the person must not be subject to any preexisting condition limitation, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage.

(b) A health carrier must offer individual coverage to any individual previously covered under a group health benefit plan issued by that health carrier, so long as the individual maintained continuous coverage as defined in chapter 62L. Coverage issued under this paragraph must not contain any preexisting condition limitation or exclusion, except for any unexpired limitation or exclusion under the previous coverage. The initial premium rate for the individual

coverage must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2.

Subd. 6. [GUARANTEED ISSUE NOT REQUIRED.] Nothing in this section requires a health carrier to initially issue a health benefit plan to a Minnesota resident, except as otherwise expressly provided in subdivision 4 or 5.

Sec. 18. Minnesota Statutes 1990, section 62E.02, subdivision 23, is amended to read:

Subd. 23. "Contributing member" means those companies ~~operating pursuant to~~ regulated under chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance ~~or~~, health maintenance organizations ~~and~~ regulated under chapter 62D, nonprofit health service plan corporations ~~incorporated~~ regulated under chapter 62C ~~or~~, fraternal benefit ~~society operating~~ societies regulated under chapter 64B, and joint self-insurance plans regulated under chapter 62H. For the purposes of determining liability of contributing members pursuant to section 62E.11 payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization shall be considered to be accident and health insurance premiums.

Sec. 19. Minnesota Statutes 1990, section 62E.10, subdivision 1, is amended to read:

Subdivision 1. [CREATION; TAX EXEMPTION.] There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers, self-insurers, fraternals, joint self-insurance plans regulated under chapter 62H, and health maintenance organizations licensed or authorized to do business in this state. The comprehensive health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

Sec. 20. Minnesota Statutes 1990, section 62E.11, subdivision 9, is amended to read:

Subd. 9. Each contributing member that terminates individual health coverage ~~regulated under chapter 62A, 62C, 62D, or 64B~~ for reasons other than (a) nonpayment of premium; (b) failure to make copayments; (c) enrollee moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership; and does not provide or arrange for replacement coverage that meets the requirements of section 62D.121; shall pay a special assessment to the state plan based upon the number of terminated individuals who join the comprehensive health insurance plan as authorized under section 62E.14, subdivisions 1, paragraph (d), and 6. Such a contributing member shall pay

the association an amount equal to the average cost of an enrollee in the state plan in the year in which the member terminated enrollees multiplied by the total number of terminated enrollees who enroll in the state plan.

The average cost of an enrollee in the state comprehensive health insurance plan shall be determined by dividing the state plan's total annual losses by the total number of enrollees from that year. This cost will be assessed to the contributing member who has terminated health coverage before the association makes the annual determination of each contributing member's liability as required under this section.

In the event that the contributing member is terminating health coverage because of a loss of health care providers, the commissioner may review whether or not the special assessment established under this subdivision will have an adverse impact on the contributing member or its enrollees or insureds, including but not limited to causing the contributing member to fall below statutory net worth requirements. If the commissioner determines that the special assessment would have an adverse impact on the contributing member or its enrollees or insureds, the commissioner may adjust the amount of the special assessment, or establish alternative payment arrangements to the state plan. For health maintenance organizations regulated under chapter 62D, the commissioner of health shall make the determination regarding any adjustment in the special assessment and shall transmit that determination to the commissioner of commerce.

Sec. 21. Minnesota Statutes 1990, section 62E.11, is amended by adding a subdivision to read:

Subd. 12. [FUNDING.] Notwithstanding subdivision 5, the claims expenses and operating and administrative expenses of the association incurred on or after January 1, 1994 shall be paid from the health care access account established in section 16A.724, to the extent appropriated for that purpose by the legislature. Any such expenses not paid from that account shall be paid as otherwise provided in this section. All contributing members shall adjust their premium rates to fully reflect funding provided under this subdivision. The commissioner of commerce shall require contributing members to prove compliance with this rate adjustment requirement.

Sec. 22. [62E.141] [INCLUSION IN EMPLOYER-SPONSORED PLAN.]

No employee, or dependent of an employee, of an employer who offers a health benefit plan, under which the employee or dependent is eligible to enroll under chapter 62L, is eligible to enroll, or continue to be enrolled, in the comprehensive health association,

except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired preexisting condition limitation or exclusion under the employer's health benefit plan. This section does not apply to persons enrolled in the comprehensive health association as of June 30, 1993.

Sec. 23. Minnesota Statutes 1990, section 62H.01, is amended to read:

62H.01 [JOINT SELF-INSURANCE EMPLOYEE HEALTH PLAN.]

Any ~~three~~ two or more employers, excluding the state and its political subdivisions as described in section 471.617, subdivision 1, who are authorized to transact business in Minnesota may jointly self-insure employee health, dental, or short-term disability benefits. Joint plans must have a minimum of ~~250~~ 100 covered employees and meet all conditions and terms of sections 62H.01 to 62H.08. Joint plans covering employers not resident in Minnesota must meet the requirements of sections 62H.01 to 62H.08 as if the portion of the plan covering Minnesota resident employees was treated as a separate plan. A plan may cover employees resident in other states only if the plan complies with the applicable laws of that state.

A multiple employer welfare arrangement as defined in United States Code, title 29, section 1002(40)(a), is subject to this chapter to the extent authorized by the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001 et seq.

Sec. 24. [REQUEST FOR ERISA EXEMPTION.]

The commissioner of commerce shall request and diligently pursue an exemption from the federal preemption of state laws relating to health coverage provided under employee welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1144. The scope of the exemption should permit the state to:

(1) require that employers participate in a state payroll withholding system designed to pay for health coverage for employees and dependents;

(2) regulate self-insured health plans to the same extent as insurance companies; and

(3) enact or adopt other state laws relating to health coverage that would, in the judgment of the commissioner of commerce, further the public policies of this state.

In determining the scope of the exemption request and in request-

ing and pursuing the exemption, the commissioner of commerce shall seek the advice and assistance of the legislative commission on health care access. The commissioner shall report in writing to that commission at least quarterly regarding the status of the exemption request.

Sec. 25. [COMMISSIONER OF COMMERCE STUDY.]

The commissioner of commerce shall study the operation of the individual market and shall file a report and recommendations with the legislature, no later than December 15, 1992. The study, report, and recommendations must:

(1) evaluate the extent to which the individual market and the state's regulation of it can achieve the goals provided in Minnesota Statutes, section 62L.01, subdivision 3;

(2) evaluate the need for and feasibility of a guaranteed issue requirement in the individual market;

(3) make recommendations regarding the future of the comprehensive health association.

Sec. 26. [STUDY OF HEALTHY LIFESTYLE PREMIUM REDUCTIONS.]

The commissioner of commerce shall study and make recommendations to the legislature regarding whether health benefits plans, as defined in section 62L.02, but including both individual and group plans, should be permitted or required to offer premium discounts in recognition of and to encourage healthy lifestyle behaviors. The commissioner shall file the recommendations with the legislature on or before December 15, 1992. The commissioner shall make recommendations regarding:

(1) the types of lifestyle behaviors, including but not limited to, nonuse of tobacco, nonuse of alcohol, and regular exercise appropriate to the person's age and health status, that should be eligible for premium discounts;

(2) the level or amounts of premium discounts that should be permitted or required, including appropriateness of premium discounts of up to 25 percent of the premium;

(3) the actuarial justification that the commissioner should require for premium reductions;

(4) the extent to which health carriers can monitor compliance with promised lifestyle behaviors and whether new legislation could increase the monitoring ability or reduce its cost; and

(5) any favorable or adverse impacts on the individual or small group market. Any data on individuals collected under this section and received by the commissioner, which has not previously been public data, is private data on individuals.

This section shall not be interpreted as prohibiting any premium discounts approved under current law by the commissioner of commerce or by the commissioner of health or permitted under this act.

Sec. 27. [REPEALER.]

(a) Minnesota Statutes 1990, sections 62A.02, subdivisions 4 and 5; 62E.51; 62E.52; 62E.53; 62E.54; and 62E.55, are repealed.

(b) Minnesota Statutes 1990, section 43A.316, subdivisions 1, 2, 3, 4, 5, 6, 7, and 10; and Minnesota Statutes 1991 Supplement, section 43A.316, subdivisions 8 and 9, are repealed effective July 1, 1993.

Sec. 28. [EFFECTIVE DATE.]

Section 16 is effective July 30, 1992. Sections 1 to 12, 14, 15, 17, 22, and 27 are effective July 1, 1993. Sections 24, 25, and 26 are effective the day following final enactment.

ARTICLE 4

CHILDREN'S HEALTH PLAN EXPANSION

Section 1. [256.362] [REPORTS AND IMPLEMENTATION.]

Subdivision 1. [WELLNESS COMPONENT.] The commissioners of human services and health shall recommend to the legislature, by January 1, 1993, methods to incorporate discounts for wellness factors of up to 25 percent into the health right plan premium sliding scale. Beginning October 1, 1992, the commissioner of human services shall inform health right plan enrollees of the future availability of the wellness discount, and shall encourage enrollees to incorporate wellness factors into their lifestyles.

Subd. 2. [FEDERAL HEALTH INSURANCE CREDIT.] By October 1, 1992, the commissioners of human services and revenue shall apply for any federal waivers or approvals necessary to allow enrollees in state health care programs to assign the federal health insurance credit component of the earned income tax credit to the state.

Subd. 3. [COORDINATION OF MEDICAL ASSISTANCE AND THE HEALTH RIGHT PLAN.] The commissioner shall develop and implement a plan to combine medical assistance and health right

plan application and eligibility procedures. The plan may include the following changes: (1) use of a single mail-in application; (2) elimination of the requirement for personal interviews; (3) postponing notification of paternity disclosure requirements; (4) modifying verification requirements for pregnant women and children; (5) using shorter forms for recertifying eligibility; (6) expedited and more efficient eligibility determinations for applicants; (7) expanded outreach efforts, including combined marketing of the two plans; and (8) other changes that improve access to services provided by the two programs. The plan may include seeking the following changes in federal law: (1) extension and expansion of exemptions for different eligibility groups from Medicaid quality control sanctions; (2) changing requirements for the redetermination of eligibility; (3) eliminating asset tests for all children; and (4) other changes that improve access to services provided by the two programs. The commissioner shall seek any necessary federal approvals, and any necessary changes in federal law. The commissioner shall implement each element of the plan as federal approval is received, and shall report to the legislature by January 1, 1993, on progress in implementing this plan.

Subd. 4. [PLAN FOR MANAGED CARE.] By January 1, 1993, the commissioner of human services shall present a plan to the legislature for providing all medical assistance and health right plan services through managed care arrangements. The commissioner shall apply to the secretary of health and human services for any necessary federal waivers or approvals, and shall begin to implement the plan for managed care upon receipt of the federal waivers or approvals.

Subd. 5. [REPORT ON PURCHASES AT FULL COST.] By January 1, 1994, the commissioner shall report to the legislature on the effect on average overall premium cost for the health right plan of allowing families who are not eligible for a subsidy to enroll in the health right plan at 100 percent of premium cost. The commissioner shall recommend whether enrollment for this group should be continued. By January 1, 1995, the commissioner shall report to the legislature on the effect on average overall premium cost for the health right plan of allowing individuals who are not eligible for a subsidy to enroll in the health right plan at 100 percent of premium cost. The commissioner shall recommend whether enrollment for this group should be continued.

Sec. 2. Minnesota Statutes 1990, section 256.936, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] For purposes of this section the following terms shall have the meanings given them:

(a) ~~"Eligible persons" means children who are one year of age or older but less than 18 years of age who have gross family incomes~~

~~that are equal to or less than 185 percent of the federal poverty guidelines and who are not eligible for medical assistance under chapter 256B or general assistance medical care under chapter 256D and who are not otherwise insured for the covered services. The period of eligibility extends from the first day of the month in which the child's first birthday occurs to the last day of the month in which the child becomes 18 years old.~~

~~(b) "Covered services" means children's health services.~~

~~(c) "Children's health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, orthodontic services, medical transportation services, personal care assistant and case management services, hospice care services, nursing home or intermediate care facilities services, inpatient mental health services, outpatient mental health services in excess of $1,000 per enrolled child per 12-month eligibility period, and chemical dependency services. Outpatient mental health services covered under the children's health plan are limited to diagnostic assessments, psychological testing, explanation of findings, and individual, family, and group psychotherapy.~~

~~(d)~~ "Eligible providers" means those health care providers who provide ~~children's~~ covered health services to medical assistance recipients under rules established by the commissioner for that program. Reimbursement under this section shall be at the same rates and conditions established for medical assistance.

~~(e)~~ (b) "Commissioner" means the commissioner of human services.

~~(f)~~ (c) "Gross family income" for farm and nonfarm self-employed means income calculated using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged. Applicants shall report the most recent financial situation of the family if it has changed from the period of time covered by the federal income tax form. The report may be in the form of percentage increase or decrease.

Sec. 3. Minnesota Statutes 1990, section 256.936, subdivision 2, is amended to read:

Subd. 2. [PLAN ADMINISTRATION.] The ~~children's~~ health right plan is established to promote access to appropriate ~~primary~~ health care services to assure healthy children and adults. The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide ~~children's~~ covered health services for eligible persons. Payment for these services shall be

made to all eligible providers. The commissioner ~~may~~ shall adopt rules to administer ~~this section~~ the health right plan. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the department of human services. A toll-free telephone number must be used to provide information about medical programs and to promote access to the covered services. The commissioner shall manage spending for the health right plan in a manner that maintains a minimum reserve equal to five percent of the expected cost of state premium subsidies. The commissioner must make a quarterly assessment of the expected expenditures for the covered services and the appropriation. Based on this assessment the commissioner may limit enrollments and target ~~former aid to families with dependent children recipients~~ specific groups of eligible persons by first limiting enrollment to persons with gross annual incomes at or below 185 percent of the poverty level upon 30-day notice in the State Register. If sufficient money is not available to cover all costs incurred in one quarter, the commissioner may seek an additional authorization for funding from the legislative advisory committee.

The commissioner shall adopt emergency rules to govern implementation of this section. Notwithstanding section 14.35, the emergency rules adopted under this section shall remain in effect for 720 days.

Sec. 4. Minnesota Statutes 1990, section 256.936, is amended by adding a subdivision to read:

Subd. 2a. [COVERED HEALTH SERVICES.] (a) [COVERED SERVICES.] "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, orthodontic services, medical transportation services, personal care assistant and case management services, hospice care services, nursing home or intermediate care facilities services, inpatient mental health services, outpatient mental health services in excess of $1,000 per enrollee per 12-month eligibility period, and chemical dependency services. Outpatient mental health services covered under the health right plan are limited to diagnostic assessments, psychological testing, explanation of findings, and individual, family, and group psychotherapy. Medication management by a physician is not subject to the $1,000 limitation on outpatient mental health services. Covered health services shall be expanded as provided in paragraphs (b) and (c).

(b) [ALCOHOL AND DRUG DEPENDENCY.] Beginning October 1, 1992, covered health services shall include up to ten hours per year of individual outpatient treatment of alcohol or drug depen-

dency by a qualified health professional or outpatient program. Two hours of group treatment count as one hour of individual treatment.

Persons who may need chemical dependency services under the provisions of this chapter shall be assessed by a local agency as defined under section 254B.01, and under the assessment provisions of section 254A.03, subdivision 3. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for consolidated chemical dependency treatment fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

(1) they have exhausted the chemical dependency benefits offered under this chapter; or

(2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

(c) [INPATIENT HOSPITAL SERVICES.] Beginning July 1, 1993, covered health services shall include inpatient hospital services, subject to any copayment or benefit limitations specified by the commissioner, including those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spend-down. The commissioner shall provide enrollees with at least 60 days' notice of coverage for inpatient hospital services and any premium increase associated with the inclusion of this benefit.

(d) [EMERGENCY MEDICAL TRANSPORTATION SERVICES.] Beginning July 1, 1993, covered health services shall include emergency medical transportation services.

(e) [FEDERAL WAIVERS AND APPROVALS.] The commissioner shall coordinate the provision of hospital inpatient services under the health right plan with enrollee eligibility under the medical assistance spend-down, and shall apply to the secretary of health and human services for any necessary federal waivers or approvals.

(f) [COPAYMENTS AND DEDUCTIBLES; PREMIUM LIMITS.] The health right benefit plan shall include a system of copayments and deductibles to limit monthly premiums to no more than: $144 for a household of one, $288 for a household of two, and $432 for a household of three or more.

Sec. 5. Minnesota Statutes 1990, section 256.936, is amended by adding a subdivision to read:

Subd. 2b. [ELIGIBLE PERSONS.] (a) [CHILDREN.] "Eligible persons" means children who are one year of age or older but less

than 18 years of age who have gross family incomes that are equal to or less than 185 percent of the federal poverty guidelines and who are not eligible for medical assistance under chapter 256B and who are not otherwise insured for the covered services. The period of eligibility extends from the first day of the month in which the child's first birthday occurs to the last day of the month in which the child becomes 18 years old. Eligibility for the health right plan shall be expanded as provided in paragraphs (b) to (e). Under paragraphs (b) to (e), parents who enroll in the health right plan must also enroll their children and dependent siblings, if the children and their dependent siblings are eligible. Children and dependent siblings may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. Families cannot choose to enroll only certain uninsured members. For purposes of this subdivision, a "dependent sibling" means an unmarried child who is a full-time student under the age of 25 years who is financially dependent upon his or her parents. Proof of school enrollment will be required.

(b) [FAMILIES WITH CHILDREN.] Beginning October 1, 1992, "eligible persons" means children eligible under paragraph (a), and parents and dependent siblings residing in the same household as a child eligible under paragraph (a). Individuals who initially enroll in the health right plan under the eligibility criteria in this paragraph shall remain eligible for the health right plan, regardless of age, place of residence, or the presence or absence of children in the same household, as long as all other eligibility requirements are met and continuous enrollment in the health right plan is maintained.

(c) [CONTINUATION OF ELIGIBILITY.] Beginning October 1, 1992, individuals who initially enrolled in the health right plan under the eligibility criteria in paragraph (a) or (b) remain eligible even if their gross income after enrollment exceeds 185 percent of the federal poverty guidelines, subject to any premium required under subdivision 4a, as long as all other eligibility requirements are met and continuous enrollment in the health right plan is maintained.

(d) [FAMILIES WITH CHILDREN; ELIGIBILITY BASED ON PERCENTAGE OF INCOME PAID FOR HEALTH COVERAGE.] Beginning January 1, 1993, "eligible persons" means children, parents, and dependent siblings residing in the same household who are not eligible for medical assistance under chapter 256B. These persons are eligible for coverage through the health right plan but must pay a premium as determined under subdivisions 4a and 4b. Individuals and families whose cost of coverage under the health right plan in relation to the family's income is less than the percentage limit established under subdivision 4b may enroll in the

health right plan but are not eligible for a state subsidy and must pay the entire cost of coverage. Individuals who initially enroll in the health right plan under the eligibility criteria in this paragraph remain eligible for the health right plan, regardless of age, place of residence within Minnesota, or the presence or absence of children in the same household, as long as all other eligibility requirements are met and continuous enrollment in the health right plan is maintained.

(e) [ADDITION OF SINGLE ADULTS AND HOUSEHOLDS WITH NO CHILDREN.] Beginning July 1, 1994, "eligible persons" means all families and individuals who are not eligible for medical assistance under chapter 256B. These persons are eligible for coverage through the health right plan but must pay a premium as determined under subdivisions 4a and 4b. Individuals and families whose cost of coverage under the health right plan in relation to their income is less than the percentage determined under subdivision 4b may enroll in the health right plan but are not eligible for subsidized premiums and must pay the entire cost of coverage.

Sec. 6. Minnesota Statutes 1990, section 256.936, subdivision 3, is amended to read:

Subd. 3. [APPLICATION PROCEDURES.] Applications and other information must be made available to provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, and Women, Infants and Children (WIC) program sites. These sites may accept applications, collect the enrollment fee or initial premium fee, and forward the forms and fees to the commissioner. Otherwise, applicants may apply directly to the commissioner. The commissioner ~~may~~ shall use individuals' social security numbers as identifiers for purposes of administering the plan and conduct data matches to verify income. Applicants shall submit evidence of family income, earned and unearned, that ~~will be used~~ is necessary to verify income eligibility. The commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the department of revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the health right plan. The effective date of coverage is the first day of the month following the month in which a complete application is entered to the eligibility file and the first premium payment has been received. Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage. Notwithstanding any other law to the contrary, benefits under this section are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligi-

ble persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

Sec. 7. Minnesota Statutes 1990, section 256.936, subdivision 4, is amended to read:

Subd. 4. [ENROLLMENT AND PREMIUM FEE.] (a) [ENROLLMENT FEE.] Until October 1, 1992, an annual enrollment fee of $25, not to exceed $150 per family, is required from eligible persons for ~~children's~~ covered health services.

(b) [PREMIUM PAYMENTS.] Beginning October 1, 1992, the commissioner shall require health right plan enrollees to pay a premium based on a sliding scale, as established under subdivision 4a. Applicants who are eligible under subdivision 2b, paragraph (a), are exempt from this requirement until July 1, 1993, if the application is received by the health right plan staff on or before September 30, 1992. Before July 1, 1993, these individuals shall continue to pay the annual enrollment fee required by paragraph (a).

(c) [ADMINISTRATION.] Enrollment and premium fees are dedicated to the commissioner for the ~~children's~~ health right plan ~~program~~. The commissioner shall make an annual redetermination of continued eligibility and identify people who may become eligible for medical assistance. The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon changes in enrollee income; and (3) disenroll enrollees from the health right plan for failure to pay required premiums. Premiums are calculated on a calendar month basis and may be paid on a monthly or quarterly basis, with the first quarterly payment due upon notice from the commissioner of the premium amount required. Premium payment is required before enrollment is complete and to maintain eligibility in the health right plan. Nonpayment of the premium will result in disenrollment from the plan within one calendar month after the due date. Persons disenrolled for nonpayment may not reenroll until four calendar months have elapsed.

Sec. 8. Minnesota Statutes 1990, section 256.936, is amended by adding a subdivision to read:

Subd. 4a. [ELIGIBILITY FOR SUBSIDIZED PREMIUMS BASED ON SLIDING SCALE.] (a) [GENERAL REQUIREMENTS.] Families and individuals who enroll on or after October 1, 1992, are eligible for subsidized premium payments based on a sliding scale under subdivision 4b only if the family or individual meets the requirements in paragraphs (b) to (d). Children and families already enrolled in the health right plan as of September 30, 1992, are eligible for subsidized premium payments without meeting these requirements, as long as they maintain continuous coverage in the health right plan or medical assistance.

(b) [MUST NOT HAVE ACCESS TO EMPLOYER-SUBSIDIZED COVERAGE.] To be eligible for subsidized premium payments based on a sliding scale, a family or individual must not have access to subsidized health coverage through an employer, and must not have had access to subsidized health coverage through the current employer for the 18 months prior to application for subsidized coverage under the health right plan. For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee, excluding dependent coverage, or a higher percentage as specified by the commissioner. Children who are eligible for employer-subsidized coverage through either parent, including the noncustodial parent, are not eligible for subsidized premium payments. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans as qualified employer subsidies toward the cost of health coverage for employees for purposes of this paragraph.

(c) [MUST BE A PERMANENT MINNESOTA RESIDENT.] To be eligible for subsidized premium payments based on a sliding scale, families and individuals must be permanent residents of Minnesota. A permanent Minnesota resident is a Minnesota resident who considers Minnesota to be the person's principal place of residence and intends to remain in the state permanently or for a long period of time and not as a temporary or short-term resident. An individual or family that moved to Minnesota primarily to obtain medical treatment or health coverage for a preexisting condition is not a permanent resident and is not entitled to subsidized coverage through the health right plan.

(d) [PERIOD UNINSURED.] To be eligible for subsidized premium payments based on a sliding scale, families and individuals initially enrolled in the health right plan under subdivision 2b, paragraphs (d) and (e), must have had no health coverage for at least four months prior to application. The commissioner may change this eligibility criterion for sliding scale premiums without complying with rulemaking requirements in order to remain within the limits of available appropriations. The requirement of at least four months of no health coverage prior to application for the health right plan does not apply to families, children, and individuals who want to apply for the health right plan upon termination from the medical assistance program, general assistance medical care program, or coverage under a regional demonstration project for the uninsured funded under section 256B.73, the Hennepin county assured care program, or the Group Health, Inc., community health plan. This paragraph does not apply to families and individuals initially enrolled under subdivision 2b, paragraphs (a) and (b).

Sec. 9. Minnesota Statutes 1990, section 256.936, is amended by adding a subdivision to read:

Subd. 4b. [PREMIUMS.] (a) Each individual or family enrolled in the health right plan shall pay a premium determined according to a sliding fee based on the cost of coverage as a percentage of the individual's or family's gross family income.

(b) The commissioner shall establish sliding scales to determine the percentage of gross family income that households at different income levels must pay to obtain coverage through the health right plan. The sliding scale must be based on the enrollee's gross family income, as defined in subdivision 1, paragraph (c), during the previous four months. The sliding scale must provide separate sliding scales for individuals, two-person households, and households of three or more.

(c) Beginning July 1, 1993, the sliding scales begin with a premium of 1.5 percent of gross family income for individuals with incomes below the limits for the medical assistance program set at 133-1/3 percent of the AFDC payment standard and proceed through the following evenly spaced steps: 1.9, 2.5, 3.3, 4.1, 5.2, 6.4, 8.0, and 9.5. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit to a gross monthly income of $1,600 for an individual, $2,160 for a household of two, $2,720 for a household of three, $3,280 for a household of four, $3,840 for a household of five, and $4,400 for households of six or more persons. For the period October 1, 1992 through June 30, 1993, the commissioner shall employ a sliding scale that sets required premiums at percentages of gross family income equal to two-thirds of the percentages specified in this paragraph.

(d) An individual or family whose gross monthly income is above the amount specified in paragraph (c) is not eligible for a subsidy but may enroll in the plan by paying the entire cost of coverage.

(e) The premium for coverage under the health right plan may be collected through wage withholding with the consent of the employer and the employee.

(f) The sliding fee scale and percentages are not subject to the provisions of chapter 14.

Sec. 10. Minnesota Statutes 1991 Supplement, section 256.936, subdivision 5, is amended to read:

Subd. 5. [APPEALS.] If the commissioner suspends, reduces, or terminates eligibility for the ~~children's~~ health right plan, or services provided under the ~~children's~~ health right plan, the commissioner must provide notification according to the laws and rules governing the medical assistance program. A ~~children's~~ health right plan applicant or enrollee aggrieved by a determination of the commissioner has the right to appeal the determination according to section 256.045.

Sec. 11. Minnesota Statutes 1990, section 256B.057, is amended by adding a subdivision to read:

Subd. 2a. [NO ASSET TEST FOR CHILDREN.] Eligibility for medical assistance for a person under age 21 must be determined without regard to asset standards established in section 256B.056.

Sec. 12. [256B.0644] [PARTICIPATION REQUIRED FOR REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.]

Subdivision 1. [PARTICIPATION REQUIREMENT.] A vendor of medical care, as defined in section 256B.02, subdivision 7; a health maintenance organization, as defined in chapter 62D; and a nonprofit health service plan corporation, as defined in chapter 62C, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and the health right plan as a condition of participating as a provider in health insurance plans or contractor for state employees established under section 43A.18, the public employees insurance plan under section 43A.316, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota comprehensive health association under sections 62E.01 to 62E.17. Participation in the medical assistance program means that the providers and contractors do not place limits which would prevent at least 20 percent of their practice to be reimbursed under medical assistance, general assistance medical care, and the health right plan. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program.

Subd. 2. [CONTINGENT EFFECTIVE DATE.] This section becomes effective July 1, 1993, if the commissioner of human services determines that access to health care services by medical assistance recipients has not improved as a result of increased provider reimbursement enacted by the legislature. The commissioner shall report to the legislature on the numbers of physicians and dentists participating in the medical assistance program by geographic regions of the state no later than March 15, 1993.

Sec. 13. [COORDINATION OF STATE HEALTH CARE PURCHASING.]

The commissioner of administration shall convene an interagency task force to develop a plan for coordinating the health care programs administered by state agencies and local governments in order to improve the efficiency and quality of health care delivery

and make the most effective use of the state's market leverage and expertise in contracting and working with health plans and health care providers. The commissioner shall present to the legislature, by January 1, 1994, recommendations to: (1) improve the effectiveness of public health care purchasing; and (2) streamline and consolidate health care delivery, through merger, transfer, or reconfiguration of existing health care and health coverage programs. At the request of the commissioner of administration, the commissioners of other state agencies and units of local government shall provide assistance in evaluating and coordinating existing state and local health care programs.

Sec. 14. [INSTRUCTION TO REVISOR.]

(a) The revisor of statutes is directed to change the words "children's health plan" to "health right plan" wherever they appear in the next edition of Minnesota Statutes.

(b) The revisor of statutes is directed to recodify the subdivisions of Minnesota Statutes, section 256.936 as separate sections in chapter 256, and to recodify paragraphs as subdivisions within these sections.

ARTICLE 5

RURAL HEALTH INITIATIVES

Section 1. Minnesota Statutes 1990, section 16A.124, is amended by adding a subdivision to read:

Subd. 4a. [INVOICE ERRORS; DEPARTMENT OF HUMAN SERVICES.] For purposes of department of human services payments to hospitals receiving reimbursement under the medical assistance and general assistance medical care programs, if an invoice is incorrect, defective, or otherwise improper, the department of human services must notify the hospital of all errors, within 30 days of discovery of the errors.

Sec. 2. Minnesota Statutes 1990, section 43A.17, subdivision 9, is amended to read:

Subd. 9. [POLITICAL SUBDIVISION SALARY LIMIT.] The salary of a person employed by a statutory or home rule charter city, county, town, school district, metropolitan or regional agency, or other political subdivision of this state, or employed under section 422A.03, may not exceed 95 percent of the salary of the governor as set under section 15A.082, except as provided in this subdivision. Deferred compensation and payroll allocations to purchase an individual annuity contract for an employee are included in determining the employee's salary. The salary of a medical doctor or doctor of

osteopathy occupying a position that the governing body of the political subdivision has determined requires an M.D. or D.O. degree is excluded from the limitation in this subdivision. The commissioner may increase the limitation in this subdivision for a position that the commissioner has determined requires special expertise necessitating a higher salary to attract or retain a qualified person. The commissioner shall review each proposed increase giving due consideration to salary rates paid to other persons with similar responsibilities in the state. The commissioner may not increase the limitation until the commissioner has presented the proposed increase to the legislative commission on employee relations and received the commission's recommendation on it. The recommendation is advisory only. If the commission does not give its recommendation on a proposed increase within 30 days from its receipt of the proposal, the commission is deemed to have recommended approval.

Sec. 3. [144.1481] [RURAL HEALTH ADVISORY COMMITTEE.]

Subdivision 1. [ESTABLISHMENT; MEMBERSHIP.] The commissioner of health shall establish a 15-member rural health advisory committee. The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

(1) two members from the house of representatives of the state of Minnesota, one from the majority party and one from the minority party;

(2) two members from the senate of the state of Minnesota, one from the majority party and one from the minority party;

(3) a volunteer member of an ambulance service based outside the seven-county metropolitan area;

(4) a representative of a hospital located outside the seven-county metropolitan area;

(5) a representative of a nursing home located outside the seven-county metropolitan area;

(6) a medical doctor or doctor of osteopathy licensed under chapter 147;

(7) a midlevel practitioner;

(8) a registered nurse or licensed practical nurse;

(9) a licensed health care professional from an occupation not otherwise represented on the committee;

(10) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; and

(11) three consumers, at least one of whom must be an advocate for persons who are mentally ill or developmentally disabled.

The commissioner will make recommendations for committee membership. Committee members will be appointed by the governor. In making appointments, the governor shall ensure that appointments provide geographic balance among those areas of the state outside the seven-county metropolitan area. The chair of the committee shall be elected by the members. The terms, compensation, and removal of members are governed by section 15.059.

Subd. 2. [DUTIES.] The advisory committee shall:

(1) advise the commissioner and other state agencies on rural health issues;

(2) provide a systematic and cohesive approach toward rural health issues and rural health care planning, at both a local and statewide level;

(3) develop and evaluate mechanisms to encourage greater cooperation among rural communities and among providers;

(4) recommend and evaluate approaches to rural health issues that are sensitive to the needs of local communities; and

(5) develop methods for identifying individuals who are underserved by the rural health care system.

Subd. 3. [STAFFING; OFFICE SPACE; EQUIPMENT.] The commissioner shall provide the advisory committee with staff support, office space, and access to office equipment and services.

Sec. 4. [144.1482] [OFFICE OF RURAL HEALTH.]

Subdivision 1. [DUTIES.] The office of rural health in conjunction with the University of Minnesota medical schools and other organizations in the state which are addressing rural health care problems shall:

(1) establish and maintain a clearinghouse for collecting and disseminating information on rural health care issues, research findings, and innovative approaches to the delivery of rural health care;

(2) coordinate the activities relating to rural health care that are carried out by the state to avoid duplication of effort;

(3) identify federal and state rural health programs and provide technical assistance to public and nonprofit entities, including community and migrant health centers, to assist them in participating in these programs;

(4) assist rural communities in improving the delivery and quality of health care in rural areas and in recruiting and retaining health professionals; and

(5) carry out the duties assigned in section 144.1483.

Subd. 2. [CONTRACTS.] To carry out these duties, the office may contract with or provide grants to public and private, nonprofit entities.

Sec. 5. [144.1483] [RURAL HEALTH INITIATIVES.]

The commissioner of health, through the office of rural health, and consulting as necessary with the commissioner of human services, the commissioner of commerce, the higher education coordinating board, and other state agencies, shall:

(1) develop a detailed plan regarding the feasibility of coordinating rural health care services by organizing individual medical providers and smaller hospitals and clinics into referral networks with larger rural hospitals and clinics that provide a broader array of services;

(2) develop and implement a program to assist rural communities in establishing community health centers, as required by section 144.1486;

(3) administer the program of financial assistance established under section 144.1484 for rural hospitals in isolated areas of the state that are in danger of closing without financial assistance, and that have exhausted local sources of support;

(4) develop recommendations regarding health education and training programs in rural areas, including but not limited to a physician assistants' training program, continuing education programs for rural health care providers, and rural outreach programs for nurse practitioners within existing training programs;

(5) develop a statewide, coordinated recruitment strategy for health care personnel and maintain a data base on health care personnel as required under section 144.1485;

(6) develop and administer technical assistance programs to assist rural communities in: (i) planning and coordinating the delivery of local health care services; and (ii) hiring physicians, nurse practitioners, public health nurses, physician assistants, and other health personnel;

(7) study and recommend changes in the regulation of health care personnel, such as nurse practitioners and physician assistants, related to scope of practice, the amount of on-site physician supervision, and dispensing of medication, to address rural health personnel shortages;

(8) support efforts to ensure continued funding for medical and nursing education programs that will increase the number of health professionals serving in rural areas;

(9) support efforts to secure higher reimbursement for rural health care providers from the Medicare and medical assistance programs;

(10) coordinate the development of a statewide plan for emergency medical services, in cooperation with the emergency medical services advisory council; and

(11) carry out other activities necessary to address rural health problems.

Sec. 6. [144.1484] [RURAL HOSPITAL FINANCIAL ASSISTANCE GRANTS.]

Subdivision 1. [SOLE COMMUNITY HOSPITAL FINANCIAL ASSISTANCE GRANTS.] The commissioner of health shall award financial assistance grants to rural hospitals in isolated areas of the state. To qualify for a grant, a hospital must: (1) be eligible to be classified as a sole community hospital according to the criteria in Code of Federal Regulations, title 42, section 412.92; (2) have experienced net income losses in the two most recent consecutive hospital fiscal years for which audited financial information is available; (3) consist of 20 or fewer licensed beds; and (4) have exhausted local sources of support. Before applying for a grant, the hospital must have developed a strategic plan. The commissioner shall award grants in equal amounts.

Subd. 2. [GRANTS TO AT-RISK RURAL HOSPITALS TO OFFSET THE IMPACT OF THE HOSPITAL TAX.] The commissioner of health shall award financial assistance grants to rural hospitals that would otherwise close as a direct result of the hospital tax in article 10, section 4. To be eligible for a grant, a hospital must have 100 or fewer beds and must not be located in a city of the first class. To receive a grant, the hospital must demonstrate to the satisfaction of the commissioner of health that the hospital will close in the

absence of state assistance under this subdivision and that the hospital tax is the principal reason for the closure. The amount of the grant must not exceed the amount of the tax the hospital would pay under article 10, section 4, based on the previous year's hospital revenues.

Sec. 7. [144.1485] [DATA BASE ON HEALTH PERSONNEL.]

The commissioner of health shall develop and maintain a data base on health services personnel. The commissioner shall use this information to assist local communities and units of state government to develop plans for the recruitment and retention of health personnel. Information collected in the data base must include, but is not limited to, data on levels of educational preparation, specialty, and place of employment. The commissioner may collect information through the registration and licensure systems of the state health licensing boards.

Sec. 8. [144.1486] [RURAL COMMUNITY HEALTH CENTERS.]

The commissioner of health shall develop and implement a program to establish community health centers in rural areas of Minnesota that are underserved by health care providers. The program shall provide rural communities and community organizations with technical assistance, capital grants for start-up costs, and short-term assistance with operating costs. The technical assistance component of the program must provide assistance in review of practice management, market analysis, practice feasibility analysis, medical records system analysis, and scheduling and patient flow analysis. The program must: (1) include a local match requirement for state dollars received; (2) require local communities, through nonprofit boards comprised of local residents, to operate and own their community's health care program; (3) encourage the use of midlevel practitioners; and (4) incorporate a quality assurance strategy that provides regular evaluation of clinical performance and allows peer review comparisons for rural practices. The commissioner shall report to the legislature on implementation of the program by February 15, 1994.

Sec. 9. Minnesota Statutes 1990, section 144.581, subdivision 1, is amended to read:

Subdivision 1. [NONPROFIT CORPORATION POWERS.] A municipality, political subdivision, state agency, or other governmental entity that owns or operates a hospital authorized, organized, or operated under chapters 158, 250, 376, and 397, or under sections 246A.01 to 246A.27, 412.221, 447.05 to 447.13, 447.31, or 471.59, or under any special law authorizing or establishing a hospital or hospital district shall, relative to the delivery of health care services, have, in addition to any authority vested by law, the authority and

legal capacity of a nonprofit corporation under chapter 317A, including authority to

(a) enter shared service and other cooperative ventures,

(b) join or sponsor membership in organizations intended to benefit the hospital or hospitals in general,

(c) enter partnerships,

(d) incorporate other corporations,

(e) have members of its governing authority or its officers or administrators serve as directors, officers, or employees of the ventures, associations, or corporations,

(f) own shares of stock in business corporations,

(g) offer, directly or indirectly, products and services of the hospital, organization, association, partnership, or corporation to the general public, and

(h) ~~provide funds for payment of educational expenses of up to $20,000 per individual, if the hospital or hospital district has at least $1,000,000 in reserve and depreciation funds at the time of payment, and these reserve and depreciation funds were obtained solely from the operating revenues of the hospital or hospital district, and~~

~~(i) provide funds of up to $50,000 per year per individual for a maximum of two years to supplement the incomes of family practice physicians, up to a maximum of $100,000 in annual income, if the hospital or hospital district has at least $250,000 in reserve and depreciation funds at the time of payment, and these reserve and depreciation funds were obtained solely from the operating revenues of the hospital or hospital district~~ expend funds, including public funds in any form, or devote the resources of the hospital or hospital district to recruit or retain physicians whose services are necessary or desirable for meeting the health care needs of the population, and for successful performance of the hospital or hospital district's public purpose of the promotion of health. Allowable uses of funds and resources include the retirement of medical education debt, payment of one-time amounts in consideration of services rendered or to be rendered, payment of recruitment expenses, payment of moving expenses, and the provision of other financial assistance necessary for the recruitment and retention of physicians, provided that the expenditures in whatever form are reasonable under the facts and circumstances of the situation.

Sec. 10. Minnesota Statutes 1990, section 144.581, is amended by adding a subdivision to read:

Subd. 6. [WORKERS' COMPENSATION POOLS.] Notwithstanding subdivision 2, and any other law to the contrary, public hospitals or organizations established under this section, and nursing homes, including those owned and operated by the state, a county, a municipality, or other governmental entity, may join with one another and with private hospitals or nursing homes to form and operate a group workers' compensation self-insured pool. A group self-insured pool that includes both governmental and private employers as authorized by this section is deemed to be organized and under the authority of sections 79A.03 and 176.181 and the administrative rules relating to private self-insured employers and groups. In the case of governmental employers, the joint and several liability of the employers shall be limited to the earned revenue and assets of the hospital or nursing home and shall not to any greater extent be a liability of the governmental entity or subject to its full faith and credit. In the event of the financial inability of the self-insured group to pay its claims, claims attributable to private hospital or nursing home employers shall be covered by the self-insurers' security fund and claims attributable to governmental hospital or nursing home employers shall be covered by the special compensation fund. Only private employers covered by this section shall be subject to assessment by the self-insurers' security fund.

Sec. 11. Minnesota Statutes 1990, section 447.31, subdivision 1, is amended to read:

Subdivision 1. [RESOLUTIONS.] Any ~~four~~ two or more cities and towns, however organized, except cities of the first class, may create a hospital district. They must do so by resolutions adopted by their respective governing bodies or electors. A hospital district may be reorganized according to sections 447.31 to 447.37. Reorganization must be by resolutions adopted by the district's hospital board and the governing body or voters of each city and town in the district.

Sec. 12. Minnesota Statutes 1990, section 447.31, subdivision 3, is amended to read:

Subd. 3. [CONTENTS OF RESOLUTION.] A resolution under subdivision 1 must state that a hospital district is authorized to be created under sections 447.31 to 447.37, or that an existing hospital district is authorized to be reorganized under sections 447.31 to 447.37, in order to acquire, improve, and run hospital and nursing home facilities that the hospital board decides are necessary and expedient in accordance with sections 447.31 to 447.37. The resolution must name the ~~four~~ two or more cities or towns included in the district. The resolution must be adopted by a two-thirds majority of the members-elect of the governing body or board acting on it, or by the voters of the city or town as provided in this section.

Each resolution adopted by the governing body of a city or town must be published in its official newspaper and takes effect 40 days after publication, unless a petition for referendum on the resolution is filed with the governing body within 40 days. A petition for referendum must be signed by at least five percent of the number of voters voting at the last election of officers. If a petition is filed, the resolution does not take effect until approved by a majority of voters voting on it at a regular municipal election or a special election which the governing body may call for that purpose.

The resolution may also be initiated by petition filed with the governing body of the city or town, signed by at least ten percent of the number of voters voting at the last general election. A petition must present the text of the proposed resolution and request an election on it. If the petition is filed, the governing body shall call a special election for the purpose, to be held within 30 days after the filing of the petition, or may submit the resolution to a vote at a regular municipal election that is to be held within the 30-day period. The resolution takes effect if approved by a majority of voters voting on it at the election. Only one election shall be held within any given 12-month period upon resolutions initiated by petition. The notice of the election and the ballot used must contain the text of the resolution, followed by the question: "Shall the above resolution be approved?"

Sec. 13. [SPECIAL STUDIES.]

(a) The commissioner of health, through the office of rural health, shall:

(1) investigate the adequacy of access to perinatal services in rural Minnesota and report findings and recommendations to the legislature by January 15, 1994; and

(2) study the impact of current reimbursement provisions for midlevel practitioners on the use of midlevel practitioners in rural practice settings, examining reimbursement provisions in state programs, federal programs, and private sector health plans, and report findings and recommendations to the legislature by January 1, 1993.

(b) The commissioner of administration, through the statewide telecommunications access routing program and its advisory council, and in cooperation with the commissioner of health and the rural health advisory committee, shall investigate and develop recommendations regarding the use of advanced telecommunications technologies to improve rural health education and health care delivery. The commissioner of administration shall report findings and recommendations to the legislature by January 15, 1994.

Sec. 14. [REPORT ON RURAL HOSPITAL FINANCIAL ASSISTANCE GRANTS.]

The commissioner of health shall examine the eligibility criteria for rural hospital financial assistance grants under Minnesota Statutes, section 144.1484, and report to the legislature by February 1, 1993, on any needed modifications.

Sec. 15. [EFFECTIVE DATE.]

Section 1 relating to invoice errors is effective for the department of human services July 1, 1993, or on the implementation date of the upgrade to the Medicaid management information system, whichever is later.

Section 3 creating the rural health advisory committee is effective January 1, 1993.

ARTICLE 6

HEALTH PROFESSIONAL EDUCATION

Section 1. Minnesota Statutes 1990, section 136A.1355, subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY.] To be eligible to participate in the program, a prospective physician must submit a letter of interest to the higher education coordinating board ~~while attending medical school. Before completing the first year of residency,~~. A student or resident who is accepted must sign a contract to agree to serve at least three of the first five years following residency in a designated rural area.

Sec. 2. Minnesota Statutes 1990, section 136A.1355, subdivision 3, is amended to read:

Subd. 3. [LOAN FORGIVENESS.] Prior to June 30, 1992, the higher education coordinating board may accept up to eight applicants who are fourth year medical students, up to eight applicants who are first year residents, and up to eight applicants who are second year residents for participation in the loan forgiveness program. For the period July 1, 1992 through June 30, 1995, the higher education coordinating board may accept up to eight applicants who are fourth year medical students per fiscal year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. Applicants chosen to participate in the loan forgiveness program may designate for each year of medical school, up to a maximum of four years, an agreed amount, not to exceed $10,000, as a qualified loan. For each year that a participant serves as a physician in a designated rural area, up to a

maximum of four years, the higher education coordinating board shall annually pay an amount equal to one year of qualified loans ~~and the interest accrued on these loans~~. Participants who move their practice from one designated rural area to another remain eligible for loan repayment. In addition, if a resident participating in the loan forgiveness program serves at least four weeks during a year of residency substituting for a rural physician to temporarily relieve the rural physician of rural practice commitments to enable the rural physician to take a vacation, engage in activities outside the practice area, or otherwise be relieved of rural practice commitments, the participating resident may designate up to an additional $2,000, above the $10,000 maximum, for each year of residency during which the resident substitutes for a rural physician for four or more weeks.

Sec. 3. [136A.1356] [MIDLEVEL PRACTITIONER EDUCATION ACCOUNT.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following definitions apply:

(a) "Designated rural area" has the definition developed in rule by the higher education coordinating board.

(b) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

(c) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advance practice as nurse-midwives.

(d) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advance practice as nurse practitioners.

(e) "Physician assistant" means a person meeting the definition in Minnesota Rules, part 5600.2600, subpart 11.

Subd. 2. [CREATION OF ACCOUNT.] A midlevel practitioner education account is established. The higher education coordinating board shall use money from the account to establish a loan forgiveness program for midlevel practitioners agreeing to practice in designated rural areas.

Subd. 3. [ELIGIBILITY.] To be eligible to participate in the program, a prospective midlevel practitioner must submit a letter of interest to the higher education coordinating board prior to or while attending a program of study designed to prepare the individual for service as a midlevel practitioner. Before completing the first year of

this program, a midlevel practitioner must sign a contract to agree to serve at least two of the first four years following graduation from the program in a designated rural area.

Subd. 4. [LOAN FORGIVENESS.] The higher education coordinating board may accept up to eight applicants per year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. Applicants chosen to participate in the loan forgiveness program may designate for each year of midlevel practitioner study, up to a maximum of two years, an agreed amount, not to exceed $7,000, as a qualified loan. For each year that a participant serves as a midlevel practitioner in a designated rural area, up to a maximum of four years, the higher education coordinating board shall annually repay an amount equal to one-half a qualified loan. Participants who move their practice from one designated rural area to another remain eligible for loan repayment.

Subd. 5. [PENALTY FOR NONFULFILLMENT.] If a participant does not fulfill the service commitment required under subdivision 4 for full repayment of all qualified loans, the higher education coordinating board shall collect from the participant 100 percent of any payments made for qualified loans and interest at a rate established according to section 270.75. The higher education coordinating board shall deposit the money collected in the midlevel practitioner education account. The board shall allow waivers of all or part of the money owed the board if emergency circumstances prevented fulfillment of the required service commitment.

Sec. 4. [137.38] [EDUCATION AND TRAINING OF PRIMARY CARE PHYSICIANS.]

Subdivision 1. [CONDITION.] If the board of regents accepts the funding appropriated for sections 137.38 to 137.40, it shall comply with the duties for which the appropriations are made.

Subd. 2. [PRIMARY CARE.] For purposes of sections 137.38 to 137.40, "primary care" means a type of medical care delivery that assumes ongoing responsibility for the patient in both health maintenance and illness treatment. It is personal care involving a unique interaction and communication between the patient and the physician. It is comprehensive in scope, and includes all the overall coordination of the care of the patient's health care problems including biological, behavioral, and social problems. The appropriate use of consultants and community resources is an important aspect of effective primary care.

Subd. 3. [GOALS.] The regents of the University of Minnesota, through the University of Minnesota medical school, shall implement the initiatives required by sections 137.38 to 137.40 in order to increase the number of graduates of residency programs of the medical school who practice primary care by 20 percent over an

eight-year period. The initiatives must be designed to encourage newly graduated primary care physicians to establish practices in areas of rural Minnesota that are medically underserved.

Subd. 4. [GRANTS.] The board of regents shall seek grants from private foundations and other nonstate sources for the initiatives outlined in sections 137.38 to 137.40.

Subd. 5. [REPORTS.] The board of regents shall report annually to the legislature on progress made in implementing sections 137.38 to 137.40, beginning January 15, 1993, and each succeeding January 15.

Sec. 5. [137.39] [MEDICAL SCHOOL INITIATIVES.]

Subdivision 1. [MODIFIED SCHOOL INITIATIVES.] The University of Minnesota medical school shall study the demographic characteristics of students that are associated with a primary care career choice. The medical school is requested to modify the selection process for medical students based on the results of this study, in order to increase the number of medical school graduates choosing careers in primary care.

Subd. 2. [DESIGN OF CURRICULUM.] The medical school shall ensure that its curriculum provides students with early exposure to primary care physicians and primary care practice. The medical school shall also support premedical school educational initiatives that provide students with greater exposure to primary care physicians and practices.

Subd. 3. [CLINICAL EXPERIENCES IN PRIMARY CARE.] The medical school, in consultation with medical school faculty at the University of Minnesota, Duluth, shall develop a program to provide students with clinical experiences in primary care settings in internal medicine and pediatrics. The program must provide training experiences in medical clinics in rural Minnesota communities, as well as in community clinics and health maintenance organizations in the Twin Cities metropolitan area.

Sec. 6. [137.40] [RESIDENCY AND OTHER INITIATIVES.]

Subdivision 1. [PRIMARY CARE AND RURAL ROTATIONS.] The medical school shall increase the opportunities for general medicine, pediatrics, and family practice residents to serve rotations in primary care settings. These settings must include community clinics, health maintenance organizations, and practices in rural communities.

Subd. 2. [RURAL RESIDENCY TRAINING PROGRAM IN FAMILY PRACTICE.] The medical school shall establish a rural resi-

dency training program in family practice. The program shall provide an initial year of training in a metropolitan-based hospital and family practice clinic. The second and third years of the residency program shall be based in rural communities, utilizing local clinics and community hospitals, with specialty rotations in nearby regional medical centers.

Subd. 3. [CONTINUING MEDICAL EDUCATION.] The medical school shall develop continuing medical education programs for primary care physicians that are comprehensive, community-based, and accessible to primary care physicians in all areas of the state.

Sec. 7. [136A.1357] [EDUCATION ACCOUNT FOR NURSES WHO AGREE TO PRACTICE IN A NURSING HOME.]

Subdivision 1. [CREATION OF THE ACCOUNT.] An education account in the general fund is established for a loan forgiveness program for nurses who agree to practice nursing in a nursing home. The account consists of money appropriated by the legislature and repayments and penalties collected under subdivision 4. Money from the account must be used for a loan forgiveness program.

Subd. 2. [ELIGIBILITY.] To be eligible to participate in the loan forgiveness program, a person planning to enroll or enrolled in a program of study designed to prepare the person to become a registered nurse or licensed practical nurse must submit a letter of interest to the board before completing the first year of study of a nursing education program. Before completing the first year of study, the applicant must sign a contract in which the applicant agrees to practice nursing for at least one of the first two years following completion of the nursing education program providing nursing services in a licensed nursing home.

Subd. 3. [LOAN FORGIVENESS.] The board may accept up to ten applicants a year. Applicants are responsible for securing their own loans. For each year of nursing education, for up to two years, applicants accepted into the loan forgiveness program may designate an agreed amount, not to exceed $3,000, as a qualified loan. For each year that a participant practices nursing in a nursing home, up to a maximum of two years, the board shall annually repay an amount equal to one year of qualified loans. Participants who move from one nursing home to another remain eligible for loan repayment.

Subd. 4. [PENALTY FOR NONFULFILLMENT.] If a participant does not fulfill the service commitment required under subdivision 3 for full repayment of all qualified loans, the commissioner shall collect from the participant 100 percent of any payments made for qualified loans and interest at a rate established according to section 270.75. The board shall deposit the collections in the general fund to be credited to the account established in subdivision 1. The board

may grant a waiver of all or part of the money owed as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the required service commitment.

Subd. 5. [RULES.] The board shall adopt rules to implement this section.

Sec. 8. [STUDY OF OBSTETRICAL ACCESS.]

The commissioner of health shall study access to obstetrical services in Minnesota and report to the legislature by January 1, 1993. The study must examine the number of physicians discontinuing obstetrical care in recent years and the effects of high malpractice costs and low government program reimbursement for obstetrical services, and must identify areas of the state where access to obstetrical services is most greatly affected. The commissioner shall recommend ways to reduce liability costs and to encourage physicians to continue to provide obstetrical services.

Sec. 9. [GRANT PROGRAM FOR MIDLEVEL PRACTITIONER TRAINING.]

The higher education coordinating board may award grants to Minnesota schools or colleges that educate, or plan to educate midlevel practitioners, in order to establish and administer midlevel practitioner training programs in areas of rural Minnesota with the greatest need for midlevel practitioners. The program must address rural health care needs, and incorporate innovative methods of bringing together faculty and students, such as the use of telecommunications, and must provide both clinical and lecture components.

Sec. 10. [GRANTS FOR CONTINUING EDUCATION.]

The higher education coordinating board shall establish a competitive grant program for schools of nursing and other providers of continuing nurse education, in order to develop continuing education programs for nurses working in rural areas of the state. The programs must complement, and not duplicate, existing continuing education activities, and must specifically address the needs of nurses working in rural practice settings. The board shall award two grants for the fiscal year ending June 30, 1993.

ARTICLE 7

DATA COLLECTION AND RESEARCH INITIATIVES

Section 1. [62J.30] [HEALTH CARE ANALYSIS UNIT.]

Subdivision 1. [DEFINITIONS.] For purposes of sections 62J.30 to 62J.34, the following definitions apply:

(a) "Practice parameter" means a statement intended to guide the clinical decision making of health care providers and patients that is supported by the results of appropriately designed outcomes research studies, including those studies sponsored by the federal agency for health care policy and research, or has been adopted for use by a national medical society.

(b) "Outcomes research" means research designed to identify and analyze the outcomes and costs of alternative interventions for a given clinical condition, in order to determine the most appropriate and cost-effective means to prevent, diagnose, treat, or manage the condition, or in order to develop and test methods for reducing inappropriate or unnecessary variations in the type and frequency of interventions.

Subd. 2. [ESTABLISHMENT.] The commissioner of health, in consultation with the Minnesota health care commission, shall establish a health care analysis unit to conduct data and research initiatives in order to improve the efficiency and effectiveness of health care in Minnesota.

Subd. 3. [GENERAL DUTIES; IMPLEMENTATION DATE.] The commissioner, through the health care analysis unit, shall:

(1) conduct applied research using existing and newly established health care data bases, and promote applications based on existing research;

(2) establish the condition-specific data base required under section 62J.31;

(3) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health carriers, as defined in section 62L.02, subdivision 16;

(4) work closely with health carriers and health care providers to promote improvements in health care efficiency and effectiveness;

(5) participate as a partner or sponsor of private sector initiatives that promote publicly disseminated applied research on health care delivery, outcomes, costs, quality, and management;

(6) provide technical assistance to health plan and health care purchasers, as required by section 62J.33;

(7) develop outcome-based practice parameters as required under section 62J.34; and

(8) provide technical assistance as needed to the health planning advisory committee and the regional coordinating boards.

Subd. 4. [CRITERIA FOR UNIT INITIATIVES.] Data and research initiatives by the health care analysis unit must:

(1) serve the needs of the general public, public sector health care programs, employers and other purchasers of health care, health care providers, including providers serving large numbers of low-income people, and health carriers;

(2) promote a significantly accelerated pace of publicly disseminated, applied research on health care delivery, outcomes, costs, quality, and management;

(3) conduct research and promote health care applications based on scientifically sound and statistically valid methods;

(4) be statewide in scope, in order to benefit health care purchasers and providers in all parts of Minnesota and to ensure a broad and representative data base for research, comparisons, and applications;

(5) emphasize data that is useful, relevant, and nonredundant of existing data. The initiatives may duplicate existing private activities, if this is necessary to ensure that the data collected will be in the public domain;

(6) be structured to minimize the administrative burden on health carriers, health care providers, and the health care delivery system, and minimize any privacy impact on individuals; and

(7) promote continuous improvement in the efficiency and effectiveness of health care delivery.

Subd. 5. [CRITERIA FOR PUBLIC SECTOR HEALTH CARE PROGRAMS.] Data and research initiatives related to public sector health care programs must:

(1) assist the state's current health care financing and delivery programs to deliver and purchase health care in a manner that promotes improvements in health care efficiency and effectiveness;

(2) assist the state in its public health activities, including the analysis of disease prevalence and trends and the development of public health responses;

(3) assist the state in developing and refining its overall health policy, including policy related to health care costs, quality, and access; and

(4) provide a data source that allows the evaluation of state health care financing and delivery programs.

Subd. 6. [DATA COLLECTION PROCEDURES.] The health care analysis unit shall collect data from health care providers, health carriers, and individuals in the most cost-effective manner, which does not unduly burden providers. The unit may require health care providers and health carriers to collect and provide patient health records, provide mailing lists of patients who have consented to release of data, and cooperate in other ways with the data collection process. For purposes of this chapter, the health care analysis unit shall assign, or require health care providers and health carriers to assign, a unique identification number to each patient to safeguard patient identity.

Subd. 7. [DATA CLASSIFICATION.] (a) Data collected through the large-scale data base initiatives of the health care analysis unit required by section 62J.31 that identify individuals are private data on individuals. Data not on individuals are nonpublic data. The commissioner may release private data on individuals and nonpublic data to researchers affiliated with university research centers or departments who are conducting research on health outcomes, practice parameters, and medical practice style; researchers working under contract with the commissioner; and individuals purchasing health care services for health carriers and groups. Prior to releasing any nonpublic or private data under this paragraph that identify or relate to a specific health carrier, medical provider, or health care facility, the commissioner shall provide at least 30 days' notice to the subject of the data, including a copy of the relevant data, and allow the subject of the data to provide a brief explanation or comment on the data which must be released with the data. To the extent reasonably possible, release of private or confidential data under this chapter shall be made without releasing data that could reveal the identity of individuals and should instead be released using the identification numbers required by subdivision 6.

(b) Summary data derived from data collected through the large-scale data base initiatives of the health care analysis unit may be provided under section 13.05, subdivision 7, and may be released in studies produced by the commissioner.

(c) The commissioner shall adopt rules to establish criteria and procedures to govern access to and the use of data collected through the initiatives of the health care analysis unit.

Subd. 8. [DATA COLLECTION ADVISORY COMMITTEE.] The commissioner shall convene a 15-member data collection advisory committee consisting of health service researchers, health care providers, health carrier representatives, representatives of businesses that purchase health coverage, and consumers. Six members of this committee must be physicians. The advisory committee shall

evaluate methods of data collection and shall recommend to the commissioner methods of data collection that minimize administrative burdens, address data privacy concerns, and meet the needs of health service researchers. The advisory committee is governed by section 15.059.

Subd. 9. [FEDERAL AND OTHER GRANTS.] The commissioner shall seek federal funding, and funding from private and other nonstate sources, for the initiatives of the health care analysis unit.

Subd. 10. [CONTRACTS AND GRANTS.] To carry out the duties assigned in sections 62J.30 to 62J.34, the commissioner may contract with or provide grants to private sector entities. Any contract or grant must require the private sector entity to maintain the data on individuals which it receives according to the statutory provisions applicable to the data.

Subd. 11. [RULEMAKING.] The commissioner may adopt permanent and emergency rules to implement sections 62J.30 to 62J.34.

Sec. 2. [62J.31] [LARGE-SCALE DATA BASE.]

Subdivision 1. [ESTABLISHMENT.] The health care analysis unit shall establish a large-scale data base for a limited number of health conditions. This initiative must meet the requirements of this section.

Subd. 2. [SPECIFIC HEALTH CONDITIONS.] (a) The data must be collected for specific health conditions, rather than specific procedures, types of health care providers, or services. The health care analysis unit shall designate a limited number of specific health conditions for which data shall be collected during the first year of operation. For subsequent years, data may be collected for additional specific health conditions. The number of specific conditions for which data is collected is subject to the availability of appropriations.

(b) The initiative must emphasize conditions that account for significant total costs, when considering both the frequency of a condition and the unit cost of treatment. The initial emphasis must be on the study of conditions commonly treated in hospitals on an inpatient or outpatient basis, or in freestanding outpatient surgical centers. As improved data collection and evaluation techniques are incorporated, this emphasis shall be expanded to include entire episodes of care for a given condition, whether or not treatment includes use of a hospital or a freestanding outpatient surgical center.

Subd. 3. [INFORMATION TO BE COLLECTED.] The data collected must include information on health outcomes, including

information on mortality, morbidity, patient functional status and quality of life, symptoms, and patient satisfaction. The data collected must include information necessary to measure and make adjustments for differences in the severity of patient condition across different health care providers, and may include data obtained directly from the patient or from patient medical records. The data must be collected in a manner that allows comparisons to be made between providers, health carriers, public programs, and other entities.

Subd. 4. [DATA COLLECTION AND REVIEW.] Data collection for any one condition must continue for a sufficient time to permit: adequate analysis by researchers and appropriate providers, including providers who will be impacted by the data; feedback to providers; and monitoring for changes in practice patterns. The health care analysis unit shall annually review all specific health conditions for which data is being collected, in order to determine if data collection for that condition should be continued.

Subd. 5. [USE OF EXISTING DATA BASES.] (a) The health care analysis unit shall negotiate with private sector organizations currently collecting data on specific health conditions of interest to the unit, in order to obtain required data in a cost-effective manner and minimize administrative costs. The unit shall attempt to establish linkages between the large scale data base established by the unit and existing private sector data bases and shall consider and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

(b) The health care analysis unit shall use existing public sector data bases, such as those existing for medical assistance and Medicare, to the greatest extent possible. The unit shall establish linkages between existing public sector data bases and consider and implement methods to streamline public sector data collection in order to reduce public and private sector administrative costs.

Sec. 3. [62J.32] [ANALYSIS AND USE OF DATA COLLECTED THROUGH THE LARGE-SCALE DATA BASE.]

Subdivision 1. [DATA ANALYSIS.] The health care analysis unit shall analyze the data collected on specific health conditions using existing practice parameters and newly researched practice parameters, including those established through the outcomes research studies of the federal government. The unit may use the data collected to develop new practice parameters, if development and refinement is based on input from and analysis by practitioners, particularly those practitioners knowledgeable about and impacted by practice parameters. The unit may also refine existing practice parameters, and may encourage or coordinate private sector research efforts designed to develop or refine practice parameters.

Subd. 2. [EDUCATIONAL EFFORTS.] The health care analysis unit shall maintain and improve the quality of health care in Minnesota by providing practitioners in the state with information about practice parameters. The unit shall promote, support, and disseminate parameters for specific, appropriate conditions, and the research findings on which these parameters are based, to all practitioners in the state who diagnose or treat the medical condition.

Subd. 3. [PEER REVIEW.] The unit may require peer review by the Minnesota medical association for specific medical conditions for which medical practice in all or part of the state deviates from practice parameters. The commissioner may also require peer review by the Minnesota medical association for specific medical conditions for which there are large variations in treatment method or frequency of treatment in all or part of the state. Peer review may be required for all medical practitioners statewide, or limited to medical practitioners in specific areas of the state. The peer review must determine whether the procedures conducted by medical practitioners are medically necessary and appropriate, and within acceptable and prevailing practice parameters that have been disseminated by the health care analysis unit in conjunction with the appropriate professional organizations. If a medical practitioner continues to perform procedures that are medically inappropriate, even after educational efforts by the review panel, the practitioner may be reported to the appropriate professional licensing board.

Subd. 4. [PRACTICE PARAMETER ADVISORY COMMITTEE.] The commissioner shall convene a 15-member practice parameter advisory committee comprised of eight physicians, other health care professionals, and representatives of the medical research community and the medical technology industry. The committee shall present recommendations on the adoption of practice parameters to the commissioner and the Minnesota health care commission and provide technical assistance as needed to the commissioner and the commission. The advisory committee is governed by section 15.059, but does not expire.

Sec. 4. [62J.33] [TECHNICAL ASSISTANCE FOR PURCHASERS.]

The health care analysis unit shall provide technical assistance to health plan and health care purchasers. The unit shall collect information about:

(1) premiums, benefit levels, managed care procedures, health care outcomes, and other features of popular health plans and health carriers; and

(2) prices, outcomes, provider experience, and other information

for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses.

The commissioner shall publicize this information in an easily understandable format.

Sec. 5. [62J.34] [OUTCOME-BASED PRACTICE PARAMETERS.]

The health care analysis unit may develop, adopt, revise, and disseminate practice parameters, and disseminate research findings, that are supported by medical literature and appropriately controlled studies to minimize unnecessary, unproven, or ineffective care. The development, adoption, revision, and dissemination of practice parameters under this chapter are not subject to chapter 14. Among other appropriate activities relating to the development of practice parameters, the health care analysis unit shall:

(1) determine uniform specifications for the collection, transmission, and maintenance of health outcomes data; and

(2) conduct studies and research on the following subjects:

(i) new and revised practice parameters to be used in connection with state health care programs and other settings;

(ii) the comparative effectiveness of alternative modes of treatment, medical equipment, and drugs;

(iii) the relative satisfaction of participants with their care, determined with reference to both provider and mode of treatment;

(iv) the cost versus the effectiveness of health care treatments; and

(v) the impact on cost and effectiveness of health care of the management techniques and administrative interventions used in the state health care programs and other settings.

Sec. 6. Minnesota Statutes 1991 Supplement, section 145.61, subdivision 5, is amended to read:

Subd. 5. "Review organization" means a nonprofit organization acting according to clause (k) or a committee whose membership is limited to professionals, administrative staff, and consumer directors, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of professionals, by an organization of professionals from a particular area or medical institution, by a health maintenance organization as defined in chapter 62D, by a nonprofit health service plan corporation as defined in chapter 62C, by a professional standards review organization established pursuant to

United States Code, title 42, section 1320c-1 et seq., or by a medical review agent established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b), or by the department of human services, to gather and review information relating to the care and treatment of patients for the purposes of:

(a) evaluating and improving the quality of health care rendered in the area or medical institution;

(b) reducing morbidity or mortality;

(c) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(d) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(e) developing and publishing guidelines designed to keep within reasonable bounds the cost of health care;

(f) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations, health service plans, and insurance companies;

(g) acting as a professional standards review organization pursuant to United States Code, title 42, section 1320c-1 et seq.;

(h) determining whether a professional shall be granted staff privileges in a medical institution, membership in a state or local association of professionals, or participating status in a nonprofit health service plan corporation, health maintenance organization, or insurance company, or whether a professional's staff privileges, membership, or participation status should be limited, suspended or revoked;

(i) reviewing, ruling on, or advising on controversies, disputes or questions between:

(1) health insurance carriers, nonprofit health service plan corporations, or health maintenance organizations and their insureds, subscribers, or enrollees;

(2) professional licensing boards ~~acting under their powers including disciplinary, license revocation or suspension procedures~~ and health providers licensed by them ~~when the matter is referred to a review committee by the professional licensing board~~;

(3) professionals and their patients concerning diagnosis, treatment or care, or the charges or fees therefor;

(4) professionals and health insurance carriers, nonprofit health service plan corporations, or health maintenance organizations concerning a charge or fee for health care services provided to an insured, subscriber, or enrollee;

(5) professionals or their patients and the federal, state, or local government, or agencies thereof;

(j) providing underwriting assistance in connection with professional liability insurance coverage applied for or obtained by dentists, or providing assistance to underwriters in evaluating claims against dentists;

(k) acting as a medical review agent under section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b); ~~or~~

(l) providing recommendations on the medical necessity of a health service, or the relevant prevailing community standard for a health service; or

(m) reviewing a provider's professional practice as requested by the health care analysis unit under section 62J.32.

Sec. 7. Minnesota Statutes 1991 Supplement, section 145.64, subdivision 2, is amended to read:

Subd. 2. [PROVIDER DATA.] The restrictions in subdivision 1 shall not apply to professionals requesting or seeking through discovery, data, information, or records relating to their medical staff privileges, membership, or participation status. However, any data so disclosed in such proceedings shall not be admissible in any other judicial proceeding than those brought by the professional to challenge an action relating to the professional's medical staff privileges or participation status.

Sec. 8. [214.16] [DATA COLLECTION; HEALTH CARE PROVIDER TAX.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Board" means the boards of medical practice, chiropractic examiners, nursing, optometry, dentistry, pharmacy, and podiatry.

(b) "Regulated person" means a licensed physician, chiropractor, nurse, optometrist, dentist, pharmacist, or podiatrist.

Subd. 2. [BOARD COOPERATION REQUIRED.] The board shall assist the commissioner of health and the data analysis unit in data collection activities required under this article and shall assist the

commissioner of health and the commissioner of revenue in activities related to collection of the health care provider tax required under article 10. Upon the request of the commissioner, the data analysis unit, or the commissioner of revenue, the board shall make available names and addresses of current licensees and provide other information or assistance as needed.

Subd. 3. [GROUNDS FOR DISCIPLINARY ACTION.] The board shall take disciplinary action against a regulated person for:

(1) failure to provide the commissioner of health with data on gross patient revenue as required under section 62J.04;

(2) failure to provide the health care analysis unit with data as required under this article;

(3) failure to provide the commissioner of revenue with data on gross revenue and other information required for the commissioner to implement sections 295.50 to 295.56; and

(4) failure to pay the health care provider tax required under section 295.52.

Sec. 9. [STUDY OF ADMINISTRATIVE COSTS.]

The health care analysis unit shall study costs and requirements incurred by health carriers, group purchasers, and health care providers that are related to the collection and submission of information to the state and federal government, insurers, and other third parties. The unit shall recommend to the commissioner of health and the Minnesota health care commission by January 1, 1994, any reforms that may reduce these costs without compromising the purposes for which the information is collected.

ARTICLE 8

MEDICAL MALPRACTICE

Section 1. Minnesota Statutes 1990, section 145.682, subdivision 4, is amended to read:

Subd. 4. [IDENTIFICATION OF EXPERTS TO BE CALLED.] (a) The affidavit required by subdivision 2, clause (2), must be signed by each expert listed in the affidavit and by the plaintiff's attorney and state the identity of each person whom plaintiff expects to call as an expert witness at trial to testify with respect to the issues of malpractice or causation, the substance of the facts and opinions to which the expert is expected to testify, and a summary of the grounds for each opinion. Answers to interrogatories that state the information required by this subdivision satisfy the requirements of

this subdivision if they are signed by the plaintiff's attorney and by each expert listed in the answers to interrogatories and served upon the defendant within 180 days after commencement of the suit against the defendant.

(b) The parties or the court for good cause shown, may by agreement, provide for extensions of the time limits specified in subdivision 2, 3, or this subdivision. Nothing in this subdivision may be construed to prevent either party from calling additional expert witnesses or substituting other expert witnesses.

(c) In any action alleging medical malpractice, all expert interrogatory answers must be signed by the attorney for the party responding to the interrogatory and by each expert listed in the answers. The court shall include in a scheduling order a deadline prior to the close of discovery for all parties to answer expert interrogatories for all experts to be called at trial. No additional experts may be called by any party without agreement of the parties or by leave of the court for good cause shown.

Sec. 2. [604.20] [MEDICAL MALPRACTICE CASES.]

Subdivision 1. [DISCOVERY.] Pursuant to the time limitations set forth in the Minnesota rules of civil procedure, the parties to any medical malpractice action may exchange the uniform interrogatories in subdivision 3 and ten additional nonuniform interrogatories. Any subparagraph of a nonuniform interrogatory will be treated as one nonuniform interrogatory. By stipulation of the parties, or by leave of the court upon a showing of good cause, more than ten additional nonuniform interrogatories may be propounded by a party. In addition, the parties may submit a request for production of documents pursuant to rule 34 of the Minnesota rules of civil procedure.

Subd. 2. [ALTERNATIVE DISPUTE RESOLUTION.] At the time a trial judge orders a case for trial, the court shall require the parties to discuss and determine whether a form of alternative dispute resolution would be appropriate or likely to resolve some or all of the issues in the case. Alternative dispute resolution may include arbitration, mediation, summary jury trial, or other alternatives suggested by the court or parties, and may be either binding or nonbinding. All parties must agree unanimously before alternative dispute resolution proceeds.

Subd. 3. [UNIFORM INTERROGATORIES.] (a) Uniform plaintiff's interrogatories to the defendant are as follows:

PLAINTIFF'S INTERROGATORIES TO DEFENDANT

INTERROGATORY NO. 1:

Please attach a complete curriculum vitae for Dr. (.....), M.D., which should include, but is not limited to, the following information:

a. Name;

b. Office address;

c. Name of practice;

d. Identities of partners or associates, including their names, specialties, and how long they have been associated with Dr. (.....);

e. Specialty of Dr. (.....);

f. Age;

g. The names and dates of attendance at any medical schools;

h. Full information as to internship or residency, including the place and dates of the internship or residency as well as any specialized fields of practice engaged in during such internship or residency;

i. The complete history of the practice of Dr. (.....) from and after medical school, setting forth the places where Dr. (.....) practiced medicine, the persons with whom Dr. (.....) was associated, the dates of the practice, and the reasons for leaving the practice;

j. Full information as to any board certifications Dr. (.....) may hold, including the field of specialty and the dates of the certifications and any recertifications;

k. Identifying the medical societies and organizations to which Dr. (.....) belongs, giving full information as to any offices held in the organizations;

l. Identifying all professional journal articles, treatises, textbooks, abstracts, speeches, or presentations which Dr. (.....) has authored or contributed to; and

m. Any other information which describes or explains the training and experience of Dr. (.....) for the practice of medicine.

INTERROGATORY NO. 2:

Has Dr. (.....) been the subject of any professional disciplinary actions of any kind and, if so:

State whether Dr. (.....'s) license to practice medicine has ever been revoked or publicly limited in any way and, if so, give the date and the reasons for such revocation or restriction.

INTERROGATORY NO. 3:

Please set forth a listing by author, title, publisher, and date of publication of all the medical texts referred to by Dr. (.....) with respect to the practice of medicine during the past five years.

INTERROGATORY NO. 4:

Please set forth a complete listing of the medical and professional journals to which Dr. (.....) subscribes or has subscribed within the past five years.

INTERROGATORY NO. 5:

As to each expert whom you expect to call as a witness at trial, please state:

a. The expert's name, address, occupation, and title;

b. The expert's field of expertise, including subspecialties, if any;

c. The expert's education background;

d. The expert's work experience in the field of expertise;

e. All professional societies and associations of which the expert is a member;

f. All hospitals at which the expert has staff privileges of any kind;

g. All written publications of which the expert is the author, giving the title of the publication and when and where it was published.

INTERROGATORY NO. 6:

With respect to each person identified in answer to the foregoing interrogatory, state:

a. The subject matter on which the person is expected to testify;

b. The substance of the facts and opinions to which the person is expected to testify; and

c. A summary of the grounds for each opinion, including the specific factual data upon which the opinion will be based.

INTERROGATORY NO. 7:

Please state whether there is any policy of insurance that will provide coverage to the defendant should liability attach on the basis of the allegations contained in the plaintiff's Complaint. If so, state with regard to each policy applicable:

a. The name and address of the insurer;

b. The exact limits of coverage applicable;

c. Whether any reservation of rights or controversy or coverage dispute exists between you and the insurance company.

Please attach copies of each policy to your Answers.

INTERROGATORY NO. 8:

State the full name, present address, occupation, age, present employer, and the present employer's address of each physician, nurse, or other medical personnel in the employ of the defendant or defendant's professional association who treated, cared for, examined, or otherwise attended (name) from (date 1), through (date 2). With regard to every individual, please state:

a. Each date upon which the individual attended (name);

b. The nature of the treatment or care rendered (name) on each date;

c. The qualifications and area of specialty of each individual; and

d. The present address of each individual.

In responding to this interrogatory, referring plaintiff's counsel to medical records will not be deemed to be a sufficient answer as plaintiff's counsel has reviewed the medical records and is not able to determine the identity of the individuals.

INTERROGATORY NO. 9: (Hospital defendant only)

Please state the name, address, telephone number, and last known employer of the nursing supervisor for the shifts set forth in the preceding interrogatory.

INTERROGATORY NO. 10:

Please identify by name and current or last known address and telephone number each and every person who has or claims to have knowledge of any facts relevant to the issues in this lawsuit, stating in detail all facts each person has or claims to have knowledge of.

INTERROGATORY NO. 11:

a. Have any statements been taken from nonparties or the plaintiff(s) pertaining to this claim? For purposes of this request, a statement previously made is (1) a written statement signed or otherwise adopted or approved by the person making it, or (2) a stenographic, mechanical, electrical, or other recording, or a transcription thereof, which is a substantial verbatim recital or an oral statement by the person making it and contemporaneously recorded. With regard to each statement, state:

1. The name and address of each person making a statement;

2. The date on which the statement was made;

3. The name and address of the person or persons taking each statement; and

4. The subject matter of each statement.

b. Attach a copy of each statement to the answers to these interrogatories.

c. If you claim that any information, document, or thing sought or requested is privileged, protected by the work product doctrine, or otherwise not discoverable, please:

1. Identify each document or thing by date, author, subject matter, and recipient;

2. State in detail the legal and factual basis for asserting said privilege, work product protection, or objection, or refusing to provide discovery as requested.

INTERROGATORY NO. 12:

Do you or anyone acting on your behalf know of any photographs, films, or videotapes depicting [.....]? If so, state:

a. The number of photographs or feet of film or videotape;

b. The places, objects, or persons photographed, filmed, or videotaped;

c. The date the photographs, film, or videotapes were taken;

d. The name, address, and telephone number of each person who has the original or copy.

Please attach copies of any photographs or videotapes.

INTERROGATORY NO. 13:

If you claim that injuries to plaintiff complained of in plaintiff's Complaint were contributed to or caused by plaintiff or any other person, including any other physician, hospital, nurse, or other health care provider, please state:

a. The facts upon which you base the claim;

b. The name, current address, and current employer of each person whom you allege was or may have been negligent.

INTERROGATORY No. 14:

Please state the name or names of the individuals supplying the information contained in your Answers to these Interrogatories. In addition, please state these individuals' current addresses, places of employment, and their current position at their place of employment.

INTERROGATORY NO. 15:

Does defendant have knowledge of any conversations or statements made by the plaintiff(s) concerning any subject matter relative to this action? If so, please state:

a. The name and last known address of each person who claims to have heard such conversations or statements;

b. The date of such conversations or statements;

c. The summary or the substance of each conversation or statement.

INTERROGATORY NO. 16:

Did the defendant, the defendant's agents, or employees conduct a surveillance of the plaintiff(s)? If so, state:

a. Name, address, and occupation of the person who conducted each surveillance;

b. Name and address of the person who requested each surveillance to be made;

c. Date or dates on which each surveillance was conducted;

d. Place or places where each surveillance was performed;

e. Information or facts discovered in the surveillance;

f. Name and address of the person now having custody of each written report, photographs, videotapes, or other documents concerning each surveillance.

INTERROGATORY NO. 17:

Are you aware of any person you may call as a witness at the trial of this action who may have or claims you have any information concerning the medical, mental, or physical condition of the plaintiff(s) prior to the incident in question? ..... If so, state:

a. The name and last know address of each person and your means of ascertaining the present whereabouts of each person;

b. The occupation and employer of each person;

c. The subject and substance of the information each person claims to have.

INTERROGATORY NO. 18:

As to any affirmative defenses you allege, state the factual basis of and describe each affirmative defense, the evidence which will be offered at trial concerning any alleged affirmative defense, including the names of any witnesses who will testify in support thereof, and the descriptions of any exhibits which will be offered to establish each affirmative defense.

INTERROGATORY NO. 19:

Do you contend that any entries in the answering defendant's medical/hospital records are incorrect or inaccurate? If so, state:

a. The precise entry(ies) that you think are incorrect or inaccurate;

b. What you contend the correct or accurate entry(ies) should have been;

c. The name, address, and employer of each and every person who has knowledge pertaining to a. and b.;

d. A description, including the author and title of each and every document that you claim supports your answer to a. and b.;

e. The name, address, and telephone number of each and every person you intend to call as a witness in support of your contention.

(b) Uniform defendant's interrogatories to the plaintiff for personal injury cases are as follows:

DEFENDANT'S INTERROGATORIES TO PLAINTIFF
(PERSONAL INJURY)

1. State your full name, address, date of birth, marital status, and social security number.

2. If you have been employed at any time in the past ten years, with respect to this period state the names and addresses of each of your employers, describe the nature of your work, and state the approximate dates of each employment.

3. If you have ever been a party to a lawsuit where you claimed damages for injury to your person, state the title of the suit, the court file number, the date of filing, the name and address of any involved insurance carrier, the kind of claim, and the ultimate disposition of the same. (This is meant to include workers' compensation and social security disability claims.)

4. Identify by name and address each and every physician, surgeon, medical practitioner, or other health care practitioner whom you consulted or who provided advice, treatment, or care for you at any time within the last ten years and, with respect to each contract, consultation, treatment, or advice, describe the same with particularity and indicate the reasons for the same.

5. State the name and address of each and every hospital, treatment facility, or institution in which plaintiff has been confined for any reason at any time, and set forth with particularity the reasons for each confinement and/or treatment and the dates of each.

6. Itemize all special damages which you claim in this case and specify, where appropriate, the basis and reason for your calculation as to each item of special damages.

7. List all payments related to the injury or disability in question that have been made to you, or on your behalf, from "collateral sources" as that term is defined in Minnesota Statutes, section 548.36.

8. List all amounts that have been paid, contributed, or forfeited

by, or on behalf of, you or members of your immediate family for the two-year period immediately before the accrual of this action to secure the right to collateral source benefits that have been made to you or on your behalf.

9. Do you contend any of the following:

a. That defendant did not possess that degree of skill and learning which is normally possessed and used by medical professionals in good standing in a similar practice and under like circumstances;

b. That defendant did not exercise that degree of skill and learning which is normally used by medical professionals in good standing in a similar practice and under like circumstances.

10. If your answer to any part of the foregoing interrogatory is yes, with respect to each answer:

a. Specify in detail each contention;

b. Specify in detail each act or omission of defendant which you contend was a departure from the degree of skill and learning normally used by medical professionals in a similar practice and under like circumstances;

c. Specify in detail the conduct of defendant as you claim it should have been;

d. Specify in detail each fact known to you and your attorneys upon which you base your answers to interrogatories 9 and 10.

11. If you claim defendant failed to disclose to you any risk concerning the involved medical care and treatment which, if disclosed, would have resulted in your refusing to consent to the medical care or treatment, then:

a. State in detail each and every thing defendant did tell you concerning the risks of the involved medical care and treatment, giving the approximate dates thereof and identifying all persons in attendance;

b. Describe each and every risk which you claim defendant should have, but failed to, disclose to you;

c. Describe in detail precisely what you claim defendant should have said to you, but failed to say, concerning the risks of the involved medical care and treatment;

d. Explain in detail all facts and reasons upon which you base the

claim that, if the foregoing risks were explained to you, you would not have consented to the involved medical care and treatment.

12. Please identify by name and current or last known address and telephone number each and every person who has or claims to have any knowledge of any facts relevant to the issues in this lawsuit, stating in detail all facts each person has or claims to have knowledge of.

13. As to each expert whom you expect to call as a witness at trial, please state:

a. The expert's name, address, occupation, and title;

b. The expert's field of expertise, including subspecialties, if any;

c. The expert's education background;

d. The expert's work experience in the field of expertise;

e. All professional societies and associations of which the expert is a member;

f. All hospitals at which the expert has staff privileges of any kind;

g. All written publications of which the expert is the author, giving the title of the publication and when and where it was published.

14. With respect to each person identified in answer to the foregoing interrogatory, state:

a. The subject matter on which the expert is expected to testify;

b. The substance of the facts and opinions to which the expert is expected to testify; and

c. A summary of the grounds for each opinion, including the specific factual data upon which the opinion will be based.

15. Have any statements been taken from any defendant or nonparty pertaining to this claim? For purposes of this request, a statement previously made is: (1) a written statement signed or otherwise adopted or approved by the person making it, or (2) a stenographic, mechanical, electrical, or other recording, or a transcription thereof, which is a substantial verbatim recital or an oral statement by the person making it and contemporaneously recorded. With regard to each statement, state:

a. The name and address of each person making a statement;

b. The date on which the statement was made;

c. The name and address of the person or persons taking each statement; and

d. The subject matter of the statement;

e. Attach a copy of each statement to the answers to these interrogatories.

f. If you claim that any information, document, or thing sought or requested is privileged, protected by the work product doctrine, or otherwise not discoverable, please:

1. Identify each document or thing by date, author, subject matter, and recipient;

2. State in detail the legal and factual basis for asserting said privilege, work product protection, or objection, or refusing to provide discovery as requested.

(c) Uniform defendant's interrogatories to the plaintiff for wrongful death cases are as follows:

DEFENDANT'S INTERROGATORIES TO PLAINTIFF
(WRONGFUL DEATH)

1. State the full name, age, present occupation, business address, present residence address, and address for a period of ten years prior to the present date for each heir or next of kin (including the Trustee) on whose behalf this action has been commenced.

2. Set forth the date of birth and place of birth of the decedent.

3. Set forth the date of birth and place of birth of the decedent's surviving spouse.

4. Set forth the names, date of birth, and places of birth of any children of decedent.

5. Set forth the names, addresses, and dates of birth of all heirs and next of kin of decedent and set forth the relationship of each individual to decedent.

6. Set forth the date of marriage between decedent and decedent's surviving spouse and the place of the marriage.

7. Set forth whether or not there were any proceedings for a legal separation or divorce instituted between decedent and decedent's surviving spouse and, if so, set forth the dates that the proceedings were instituted, the result of the proceedings, and the court in which the proceedings were instituted.

8. Set forth whether or not decedent was ever married to anyone other than decedent's surviving spouse and if so, set forth the names of any other spouse or spouses and the inclusive dates of any other marriages.

9. Set forth whether or not decedent's surviving spouse has ever been married to anyone other than decedent and, if so, set forth the names of any other spouses and the inclusive dates of any other marriages.

10. If you claim defendant failed to disclose to you any risk concerning the involved medical care and treatment which, if disclosed, would have resulted in the decedent's refusing to consent to the medical care or treatment, then:

a. State in detail each and every thing defendant did tell you concerning the risks of the involved medical care and treatment, giving the approximate dates thereof and identify all persons in attendance;

b. Describe each and every risk which you claim defendants should have, but failed to, disclose to you;

c. Describe in detail precisely what you claim defendant should have said to you, but failed to say, concerning the risks of the involved medical care and treatment;

d. Explain in detail all facts and reasons upon which you base the claim that, if the foregoing risks were explained to you, you would not have consented to the involved medical care and treatment.

11. Was the deceased employed at the time of death?

12. If the answer to Interrogatory No. 10 is yes, indicate the following:

a. The name and address of the deceased's employer and the nature of the employment;

b. The amount of earnings from the employment;

c. Defendant requests copies of the decedent's federal and state income tax return for the past five years.

13. If decedent was self-employed for any period of time during the ten-year period of time immediately preceding decedent's death, set forth the following:

a. The inclusive dates of the self-employment;

b. A specific and detailed description of the nature of the self-employment;

c. The business name and address under which decedent operated; and

d. A specific and detailed description of decedent's earnings from the self-employment.

14. Set forth in detail a chronological education history of decedent including the name and address of each school attended, the inclusive dates of attendance, the date of graduation, a description of any degrees awarded, a description of the major area of study and the grade point average upon graduation.

15. Did the decedent make any contribution of money, property, or other items having a money worth toward the support, maintenance, or well-being of any next of kin and, if so, please itemize the following:

a. The amount and nature of the contribution;

b. The date(s) upon which each contribution was made;

c. The persons(s) receiving each contribution;

d. The period of time over which the contributions were made;

e. The regularity or irregularity of the contributions;

f. Identify by date, author, type, recipient, and present custodian each and every document referring to or otherwise evidencing each contribution.

16. Identify by name and address each and every physician, surgeon, medical practitioner, or other health care practitioner whom the decedent consulted or who provided advice, treatment, or care for the decedent at any time within ten years prior to death and, with respect to the contact, consultation, treatment, or advice, describe the same with particularity and indicate the reasons for the same.

17. State the name and address of each and every hospital, treatment facility, or institution in which the decedent has been

confined for any reason at any time, and set forth with particularity the reasons for each confinement and/or treatment and the dates of each.

18. Itemize all special damages which you claim in this case and specify, where appropriate, the basis and reason for your calculation as to each item of special damages.

19. List any payment related to the injury or disability in question made to you, or on your behalf, from "collateral sources" as that term is defined in Minnesota Statutes, section 548.36.

20. List all amounts that have been paid, contributed or forfeited by, or on behalf of, you or members of your immediate family for the two-year period immediately before the accrual of this action to secure the right to collateral source benefits that have been made to you or on your behalf.

21. Do you contend any of the following:

a. That any of the defendants did not possess that degree of skill and learning which is normally possessed and used by medical professionals in good standing in a similar practice and under like circumstances? If so, identify the defendants;

b. That any of the defendants did not exercise that degree of skill and learning which is normally used by medical professionals in good standing in a similar practice and under like circumstances? If so, identify the defendants.

22. If your answer to any part of the foregoing interrogatory is yes, with respect to each answer:

a. Specify in detail your contention;

b. Specify in detail each act or omission of each defendant which you contend was a departure from that degree of skill and learning normally used by medical professionals in a similar practice and under like circumstances.

23. Please identify by name and current or last known address and telephone number of each and every person who has or claims to have any knowledge of any facts relevant to the issues in this lawsuit, stating in detail all facts each person has or claims to have knowledge of.

24. As to each expert whom you expect to call as a witness at trial, please state:

a. The expert's name, address, occupation, and title;

b. The expert's field of expertise, including subspecialties, if any;

c. The expert's education background;

d. The expert's work experience in the field of expertise;

e. All professional societies and associations of which the expert is a member;

f. All hospitals at which the expert has staff privileges of any kind;

g. All written publications of which the expert is the author, giving the title of the publication and when and where it was published.

25. With respect to each person identified in the foregoing interrogatory, state:

a. The subject matter on which the expert is expected to testify;

b. The substance of the facts and opinions to which the expert is expected to testify; and

c. A summary of the grounds for each opinion, including the specific factual data upon which the opinion will be based.

26. Set forth in detail anything said or written by which plaintiff claims to be relevant to any of the issues in this lawsuit, identifying the time and place of each statement, who was present, and what was said by each person who was present.

27. Have any statements been taken from any defendant or nonparty pertaining to this claim? For purposes of this request, a statement previously made is: (1) a written statement signed or otherwise adopted or approved by the person making it, or (2) a stenographic, mechanical, electrical, or other recording, or a transcription thereof, which is a substantial verbatim recital or an oral statement by the person making it and contemporaneously recorded. With regard to each statement, state:

a. The name and address of each person making a statement;

b. The date on which the statement was made;

c. The name and address of the person or persons taking each statement; and

d. The subject matter of each statement;

e. Attach a copy of each statement to the answers to these interrogatories;

f. If you claim that any information, document or thing sought or requested is privileged, protected by the work product doctrine, or otherwise not discoverable, please:

1. Identify each document or thing by date, author, subject matter, and recipient;

2. State in detail the legal and factual basis for asserting said privilege, work product protection, or objection, or refusing to provide discovery as requested.

ARTICLE 9

TRANSFER OF REGULATORY AUTHORITY FOR HEALTH MAINTENANCE ORGANIZATIONS

Section 1. [TRANSFER OF AUTHORITY.]

The commissioner of commerce has sole authority over the financial aspects of health maintenance organizations, and the commissioner of health has sole authority over the health care aspects of health maintenance organizations. Minnesota Statutes, section 15.039, applies to this section.

Sec. 2. [EFFECTIVE DATE.]

Section 1 is effective January 1, 1993.

ARTICLE 10

FINANCING

Section 1. [16A.724] [HEALTH CARE ACCESS ACCOUNT.]

A health care access account is created in the general fund. The commissioner shall deposit to the credit of the account money made available to the account.

Sec. 2. Minnesota Statutes 1990, section 290.01, subdivision 19b, is amended to read:

Subd. 19b. [SUBTRACTIONS FROM FEDERAL TAXABLE INCOME.] For individuals, estates, and trusts, there shall be subtracted from federal taxable income:

(1) interest income on obligations of any authority, commission, or

instrumentality of the United States to the extent includable in taxable income for federal income tax purposes but exempt from state income tax under the laws of the United States;

(2) if included in federal taxable income, the amount of any overpayment of income tax to Minnesota or to any other state, for any previous taxable year, whether the amount is received as a refund or as a credit to another taxable year's income tax liability;

(3) the amount paid to others not to exceed $650 for each dependent in grades kindergarten to 6 and $1,000 for each dependent in grades 7 to 12, for tuition, textbooks, and transportation of each dependent in attending an elementary or secondary school situated in Minnesota, North Dakota, South Dakota, Iowa, or Wisconsin, wherein a resident of this state may legally fulfill the state's compulsory attendance laws, which is not operated for profit, and which adheres to the provisions of the Civil Rights Act of 1964 and chapter 363. As used in this clause, "textbooks" includes books and other instructional materials and equipment used in elementary and secondary schools in teaching only those subjects legally and commonly taught in public elementary and secondary schools in this state. "Textbooks" does not include instructional books and materials used in the teaching of religious tenets, doctrines, or worship, the purpose of which is to instill such tenets, doctrines, or worship, nor does it include books or materials for, or transportation to, extracurricular activities including sporting events, musical or dramatic events, speech activities, driver's education, or similar programs. In order to qualify for the subtraction under this clause the taxpayer must elect to itemize deductions under section 63(e) of the Internal Revenue Code;

(4) to the extent included in federal taxable income, distributions from a qualified governmental pension plan, an individual retirement account, simplified employee pension, or qualified plan covering a self-employed person that represent a return of contributions that were included in Minnesota gross income in the taxable year for which the contributions were made but were deducted or were not included in the computation of federal adjusted gross income. The distribution shall be allocated first to return of contributions until the contributions included in Minnesota gross income have been exhausted. This subtraction applies only to contributions made in a taxable year prior to 1985;

(5) income as provided under section 290.0802;

(6) the amount of unrecovered accelerated cost recovery system deductions allowed under subdivision 19g; ~~and~~

(7) to the extent included in federal adjusted gross income, income realized on disposition of property exempt from tax under section 290.491.; and

(8) to the extent not deducted in determining federal taxable income, the amount paid for health insurance of self-employed individuals as determined under section 162(l) of the Internal Revenue Code, except that the 25 percent limit does not apply. If the taxpayer deducted insurance payments under section 213 of the Internal Revenue Code of 1986, the subtraction under this clause must be reduced by the lesser of:

(i) the total itemized deductions allowed under section 63(d) of the Internal Revenue Code, less state, local, and foreign income taxes deductible under section 164 of the Internal Revenue Code and the standard deduction under section 63(c) of the Internal Revenue Code; or

(ii) the lesser of (A) the amount of insurance qualifying as "medical care" under section 213(d) of the Internal Revenue Code to the extent not deducted under section 162(1) of the Internal Revenue Code or excluded from income or (B) the total amount deductible for medical care under section 213(a).

HOSPITALS AND HEALTH CARE PROVIDERS

Sec. 3. [295.50] [DEFINITIONS.]

Subdivision 1. [DEFINITIONS.] For purposes of sections 295.50 to 295.56, the following terms have the meanings given.

Subd. 2. [COMMISSIONER.] "Commissioner" is the commissioner of revenue.

Subd. 3. [GROSS REVENUES.] "Gross revenues" are the total amount received, in money or otherwise,

(1) by a hospital for inpatient or outpatient services; and

(2) by a health care provider for health care services.

Subd. 4. [HEALTH CARE PROVIDER.] "Health care provider" is a provider qualifying for reimbursement under the medical assistance program, but excludes a hospital.

Subd. 5. [HMO.] "Health maintenance organization" is a nonprofit corporation licensed and operated as provided in chapter 62D.

Subd. 6. [HOME HEALTH CARE SERVICES.] "Home health care services" are services:

(1) defined under the state medical assistance program as home health agency services, personal care services and supervision of

personal care services, private duty nursing services, and waivered services; and

(2) provided at a recipient's residence, if the recipient does not live in a hospital, nursing facility, or intermediate care facility for persons with mental retardation.

Subd. 7. [HOSPITAL.] "Hospital" is a hospital licensed under chapter 144 or a surgical center.

Subd. 8. [SURGICAL CENTER.] "Surgical center" is an outpatient surgical center as defined in Minnesota Rules, chapter 4675.

Sec. 4. [295.51] [HOSPITAL TAX IMPOSED.]

A tax is imposed on each hospital equal to two percent of its gross revenues.

Sec. 5. [295.52] [HEALTH CARE PROVIDER TAX.]

Subdivision 1. [TAX IMPOSED.] A tax is imposed on each health care provider equal to the following percentages of gross revenues:

(1) for services provided after December 31, 1993, and before January 1, 1995, one percent;

(2) for services provided after December 31, 1994, and before January 1, 1996, 1.5 percent;

(3) for services provided after December 31, 1995, two percent.

Subd. 2. [HMOS; SPECIAL RULES.] (a) In determining the tax under this section, a health maintenance organization may deduct from gross revenues:

(1) amounts paid to hospitals for services that are subject to the tax under section 295.51;

(2) amounts paid to other health care providers that are subject to the tax under this section; and

(3) an allowance for administrative and underwriting services.

(b) The commissioner of health, in consultation with the commissioners of commerce and revenue, shall establish by rule under chapter 14 the percentage or percentages of health maintenance revenues that will be allowed as a deduction for administrative and underwriting expenses. The commissioner of health shall determine the percentage allowances based on the average expenses of health

maintenance organizations for expenses that are equivalent to the claims administration and other underwriting services of third party payors. These expenses do not include the portion of health maintenance organization costs that are similar to the administrative costs of direct health care providers, rather than third party payors. The commissioner of health may adopt emergency rules.

Sec. 6. [295.53] [EXEMPTIONS; ITEMIZATION.]

Subdivision 1. [EXEMPTIONS.] The gross revenues from the listed services are not subject to the hospital or health care provider taxes under sections 295.50 to 295.56:

(1) payments received from the federal government for services provided under the Medicare program, excluding enrollee deductible and coinsurance payments;

(2) medical assistance payments;

(3) payments received for nursing home services, services provided in an intermediate care facility for persons with mental retardation, and home care services.

Subd. 2. [RESTRICTION ON ITEMIZATION.] A hospital or health care provider may increase the amount of its charges to reflect the tax imposed under sections 295.50 to 295.56, but may not separately state or itemize the amount of the tax in billing patients or third party payors.

Sec. 7. [295.54] [PAYMENT OF TAX.]

Subdivision 1. [SCOPE.] The provisions of this section apply to the taxes imposed under sections 295.50 to 295.56.

Subd. 2. [ESTIMATED TAX.] (a) Each taxpayer must make estimated payments of the taxes for the calendar year in quarterly installments to the commissioner by April 15, July 15, October 15, and January 15 of the following calendar year.

(b) Estimated tax payments are not required if the tax for the calendar year is less than $500.

(c) Underpayment of estimated installments bear interest at the rate specified in section 270.75, from the due date of the payment until paid or until the due date of the annual return at the rate specified in section 270.75. An underpayment of an estimated installment is, in addition, subject to a penalty equal to the greater of $50 or ten percent of the underpayment. An underpayment of an estimated installment is the difference between the amount paid and the lesser of 90 percent of (1) one-quarter of the tax for the

calendar year or (2) the tax for the actual gross revenues received during the quarter.

Subd. 3. [ANNUAL RETURN.] The hospital or health care provider must file an annual return, reconciling the quarterly estimated payments by March 15 of the following calendar year.

Subd. 4. [FORM OF RETURNS.] The estimated payments and annual return must contain the information and be in the form prescribed by the commissioner.

Sec. 8. [295.55] [COLLECTION AND ENFORCEMENT; SALES TAX PROVISIONS APPLY.]

Unless specifically provided by sections 295.50 to 295.56, the enforcement, collection, interest, and penalty provisions, including criminal penalties, for the general sales tax under chapters 289A and 297A apply to a liability for the taxes imposed under sections 295.50 to 295.56 as if it were a sales tax liability.

Sec. 9. [295.56] [DEPOSIT OF REVENUES.]

The commissioner shall deposit the tax, interest, and penalties paid under sections 295.50 to 295.56 in the health care access account in the general fund.

Sec. 10. Minnesota Statutes 1991 Supplement, section 297.02, subdivision 1, is amended to read:

Subdivision 1. [RATES.] A tax is hereby imposed upon the sale of cigarettes in this state or having cigarettes in possession in this state with intent to sell and upon any person engaged in business as a distributor thereof, at the following rates, subject to the discount provided in section 297.03:

(1) On cigarettes weighing not more than three pounds per thousand, ~~21.5~~ 24 mills on each such cigarette;

(2) On cigarettes weighing more than three pounds per thousand, ~~43~~ 48 mills on each such cigarette.

Sec. 11. [TEMPORARY DEPOSIT OF CIGARETTE TAX REVENUES.]

Notwithstanding the provisions of Minnesota Statutes, section 297.13, the revenue provided by 2.5 mills of the tax on cigarettes weighing not more than three pounds a thousand and five mills of the tax on cigarettes weighing more than three pounds a thousand must be credited to the health care access account in the general fund. This section applies only to revenue collected for sales after

June 30, 1992 and before January 1, 1994. Revenue includes revenue from the tax, interest, and penalties collected under the provisions of Minnesota Statutes, section 297.01 to 297.13.

This section expires June 30, 1994.

Sec. 12. [EFFECTIVE DATE.]

Section 2 is effective for taxable years beginning after December 31, 1991. Section 4 is effective for gross revenues received after December 31, 1992. Section 10 is effective for cigarettes sold or possessed after June 30, 1992.

ARTICLE 11

APPROPRIATIONS

Section 1. APPROPRIATIONS

Subdivision 1. The amounts specified in this section are appropriated from the health care access account in the general fund to the agencies and for the purposes indicated in articles 1 to 10, to be available until June 30, 1993.

Subd. 2. Commissioner of Commerce	$ 25,000
Subd. 3. Commissioner of Health	1,529,000
Subd. 4. Commissioner of Human Services	12,992,000
Subd. 5. Higher Education Coordinating Board	166,000
Subd. 6. Commissioner of Employee Relations	1,700,000
Subd. 7. Minnesota Health Care Commission	1,451,000
Subd. 8. Board of Regents of the University of Minnesota	2,200,000
Subd. 9. Commissioner of Revenue	350,000
Subd. 10. Administration	514,000"

Delete the title and insert:

"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 16A.124, by adding a subdivision; 43A.17, subdivision 9; 43A.316, by adding subdivisions; 62A.02, subdivisions 1, 2, 3, and by adding subdivisions; 62E.02, subdivision 23; 62E.10, subdivision 1; 62E.11, subdivision 9, and by adding a subdivision; 62H.01; 136A.1355, subdivisions 2 and 3; 144.581, subdivision 1, and by adding a subdivision; 145.682, subdivision 4; 256.936, subdivisions 1, 2, 3, 4, and by adding subdivisions; 256B.057, by adding a subdivision; 290.01, subdivision 19b; and 447.31, subdivisions 1 and 3; 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; 43A; 62A; 62E; 62J; 136A; 137; 144; 214; 256; 256B; 295; and 604; proposing coding for new law as Minnesota Statutes, chapter 62L; repealing Minnesota Statutes 1990, sections 43A.316, subdivisions 1, 2, 3, 4, 5, 6, 7, and 10; 62A.02, subdivisions 4 and 5; 62E.51; 62E.52; 62E.53; 62E.54; and 62E.55; Minnesota Statutes 1991 Supplement, section 43A.316, subdivisions 8 and 9."

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

The report was adopted.

SPECIAL ORDERS

Welle moved that the bills on Special Orders 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

Erhardt moved that the name of Hufnagle be added as an author on H. F. No. 2935. The motion prevailed.

Orfield moved that the following statement be printed in the Permanent Journal of the House:

"It was my intention to vote in the affirmative on Thursday, April 2, 1992, on the second Krueger amendment to H. F. No. 2121, as amended." The motion prevailed.

Pelowski moved that the following statement be printed in the Permanent Journal of the House:

"It was my intention to vote in the affirmative on Thursday, April 2, 1992, on the Lynch amendment to H. F. No. 2121, as amended." The motion prevailed.

Begich moved that H. F. No. 1951 be returned to its author. The motion prevailed.

Pellow moved that H. F. No. 2664 be returned to its author. The motion prevailed.

ANNOUNCEMENTS BY THE SPEAKER

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 2031:

Olson, E.; Schreiber and Jacobs.

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 2121:

Nelson, K.; Bauerly; McEachern; Hausman and Weaver.

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 2608:

O'Connor, Sarna and Anderson, R.

ADJOURNMENT

Welle moved that when the House adjourns today it adjourn until 1:00 p.m., Wednesday, April 8, 1992. The motion prevailed.

Welle moved that the House adjourn. The motion prevailed, and the Speaker declared the House stands adjourned until 1:00 p.m., Wednesday, April 8, 1992.

EDWARD A. BURDICK, Chief Clerk, House of Representatives