STATE OF MINNESOTA

SEVENTY-SEVENTH SESSION—1992

NINETY-SIXTH DAY

SAINT PAUL, MINNESOTA, FRIDAY, APRIL 10, 1992

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

Prayer was offered by Wendell Frerichs, Professor at Luther Northwestern Seminary, Roseville, Minnesota.

The roll was called and the following members were present:

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

A quorum was present.

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

REPORTS OF CHIEF CLERK

S. F. No. 2213 and H. F. No. 1680, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Skoglund moved that the rules be so far suspended that S. F. No. 2213 be substituted for H. F. No. 1680 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2314 and H. F. No. 2302, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Rice moved that the rules be so far suspended that S. F. No. 2314 be substituted for H. F. No. 2302 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2396 and H. F. No. 2474, 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. 2396 be substituted for H. F. No. 2474 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2434 and H. F. No. 2601, which had been referred to the Chief Clerk for comparison, were examined and found to be identical.

Simoneau moved that S. F. No. 2434 be substituted for H. F. No. 2601 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 2743 and H. F. No. 1791, which had been referred to the

Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

SUSPENSION OF RULES

Skoglund moved that the rules be so far suspended that S. F. No. 2743 be substituted for H. F. No. 1791 and that the House File be indefinitely postponed. The motion prevailed.

REPORTS OF STANDING COMMITTEES

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 769, A bill for an act relating to agriculture; providing for a central computerized filing system for effective financing statements and farm products statutory lien notices; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 336A; repealing Minnesota Statutes 1990, sections 223A.02; 223A.03; 223A.04; 223A.05; 223A.06; and 223A.07.

Reported the same back with the following amendments:

Page 1, after line 9, insert:

"Section 1. Minnesota Statutes 1991 Supplement, section 336.9-413, is amended to read:

336.9-413 [UNIFORM COMMERCIAL CODE ACCOUNT.]

(a) The uniform commercial code account is established as an account in the state treasury.

(b) The filing officer with whom a financing statement, amendment, assignment, statement of release, or continuation statement is filed, or to whom a request for search is made, shall collect a $4 surcharge on each filing or search, except that the surcharge is $5 during the fiscal year ending June 30, 1993. By the 15th day following the end of each fiscal quarter, each county recorder shall forward the receipts from the surcharge accumulated during that fiscal quarter to the secretary of state. The surcharge does not apply to a search request made by a natural person who is the subject of the data to be searched except when a certificate is requested as a part of the search.

(c) The surcharge amounts received from county recorders and the surcharge amounts collected by the secretary of state's office must be deposited in the state treasury and credited to the general fund,

except that the additional surcharge of $1 collected during the fiscal year ending June 30, 1993, must be credited to the farm products filing account.

(d) Fees that are not expressly set by statute but are charged by the secretary of state to offset the costs of providing a service under sections 336.9-411 to 336.9-413 must be deposited in the state treasury and credited to the uniform commercial code account.

(e) Fees that are not expressly set by statute but are charged by the secretary of state to offset the costs of providing information contained in the computerized records maintained by the secretary of state must be deposited in the state treasury and credited to the uniform commercial code account.

(f) Money in the uniform commercial code account is continuously appropriated to the secretary of state to implement and maintain the computerized uniform commercial code filing system under section 336.9-411 and to provide electronic-view-only access to other computerized records maintained by the secretary of state."

Page 15, line 16, after "state" insert "for implementation and maintenance of the computerized farm products filing and notification system"

Page 15, line 33, delete "$....." and insert "$100,000"

Page 15, line 35, delete everything after "account" and insert a period

Page 15, delete line 36

Page 16, delete line 1

Page 16, line 3, delete "....." and insert "5"

Renumber the sections in sequence

Correct internal references

Amend the title as follows:

Page 1, line 4, after the semicolon insert "establishing a certain temporary surcharge;"

Page 1, line 5, after the semicolon insert "amending Minnesota Statutes 1991 Supplement, section 336.9-413;"

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2050, A bill for an act relating to public health; providing for the reporting and monitoring of certain licensed health care workers who are infected with the human immunodeficiency virus or hepatitis B virus; authorizing rulemaking for certain health-related licensing boards; providing penalties; appropriating money; amending Minnesota Statutes 1990, sections 144.054; 144.55, subdivision 3; 147.091, subdivision 1; 148.261, subdivision 1; 150A.08, subdivision 1; 153.19, subdivision 1; and 214.12; proposing coding for new law in Minnesota Statutes, chapters 150A; and 214.

Reported the same back with the following amendments:

Pages 22 and 23, delete section 18

Page 23, line 8, delete "19" and insert "18"

Amend the title as follows:

Page 1, line 7, delete "appropriating money;"

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2283, A bill for an act relating to the legislature; declaring a state policy for children, youth, and their families; amending the responsibilities of the legislative commission on children, youth, and their families; appropriating money; amending Minnesota Statutes 1991 Supplement, section 3.873, subdivisions 1, 4, 5, and by adding a subdivision.

Reported the same back with the following amendments:

Page 2, delete section 3

Page 2, line 30, delete "Sec. 4." and insert "Sec. 3."

Page 3, delete section 5

Amend the title as follows:

Page 1, line 5, delete "appropriating"

Page 1, line 6, delete "money;"

Page 1, line 7, delete "4,"

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2643, A bill for an act relating to energy; providing that energy providers may solicit contributions from customers for fuel funds that distribute emergency energy assistance to low-income households; establishing a statewide fuel fund in the department of jobs and training; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 268.

Reported the same back with the following amendments:

Page 3, after line 3, insert:

"Sec. 2. Minnesota Statutes 1990, section 383C.044, is amended to read:

383C.044 [TRANSFER OF EMPLOYEES.]

The civil service director may at any time authorize the transfer of any employee in the classified service from one position to another position in the same class or grade and not otherwise; provided, however, that persons who are not members of the classified service under the provisions of sections 383C.03 to 383C.059 shall not be entitled to transfer. Transfers shall be permitted only with the consent of the civil service director and the department concerned. The civil service commission shall adopt rules to govern the transfer of an employee from a city to the county, when the employee is performing Community Development Block Grant services for the county pursuant to a contract between the city and county."

Amend the title as follows:

Page 1, line 2, delete the first "energy" and insert "public services"

Page 1, line 6, after the semicolon insert "permitting certain civil service transfers by St. Louis county;"

Page 1, line 7, after the semicolon insert "amending Minnesota Statutes 1990, section 383C.044;"

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2717, A bill for an act relating to water; requiring maintenance of a statewide nitrate data base; modifying requirements relating to well disclosure certificates and sealing of wells; establishing a well sealing account; requiring a report on environmental consulting services; appropriating money; amending Minnesota Statutes 1990, sections 103I.301, subdivision 4; 103I.315; and 103I.341, subdivisions 1 and 5; Minnesota Statutes 1991 Supplement, sections 16B.92, by adding a subdivision; 103I.222; 103I.235; and 103I.301, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 103A and 103I.

Reported the same back with the following amendments:

Page 1, line 19, delete "2" and insert "4"

Page 1, after line 19, insert:

"Sec. 2. Minnesota Statutes 1990, section 32.394, is amended by adding a subdivision to read:

Subd. 11. [WAIVER OF RULES; WATER WELL SETBACK.] Notwithstanding any rule of the department of health or agriculture to the contrary, a dairy farmer who wishes to be permitted to produce grade A milk may not be denied the grade A permit solely because of provisions in the well code stipulating a minimum setback of the water well from the dairy barn. To be eligible for a grade A permit, the following conditions must be met:

(1) the water well must have been in place prior to January 1, 1974;

(2) the water well must comply with all aspects of the current well code other than minimum setback; and

(3) water from the well must be tested at least once each six months in compliance with guidelines established by the commissioner of agriculture.

Sec. 3. Minnesota Statutes 1990, section 32.394, is amended by adding a subdivision to read:

Subd. 12. [WATER TESTING GUIDELINES.] The commissioner of agriculture, in consultation with the commissioner of health, must establish guidelines for the types of testing or analysis to be performed on water samples from a well receiving a permit under subdivision 11. The guidelines are not subject to chapter 14."

Page 8, delete lines 31 to 34

Renumber sections in sequence

Correct internal references

Amend the title as follows:

Page 1, line 2, after the semicolon insert "providing that well setback rules may be waived for dairy farmers;"

Page 1, line 7, delete "appropriating money;"

Page 1, line 8, after "sections" insert "32.394, by adding subdivisions;"

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2723, A bill for an act relating to motor fuels; weights and measures; regulating octane and oxygenated fuels; appropriating money; amending Minnesota Statutes 1990, sections 41A.09, subdivision 2, and by adding a subdivision; 239.75; 239.79; 239.80; 296.01, subdivisions 1, 2, 3, 4, 4a, 4b, 15, 24, and by adding subdivisions; 296.02, subdivisions 1, 2, and 7; Minnesota Statutes 1991 Supplement, section 239.05, subdivision 1, and by adding subdivisions; proposing coding for new law in Minnesota Statutes,

chapter 239; repealing Minnesota Statutes 1990, sections 239.75, subdivisions 3 and 4; 239.76, as amended; 239.79, subdivisions 1 and 2; 296.01, subdivision 2a; and 325E.09.

Reported the same back with the following amendments:

Page 2, after line 32, insert:

"Sec. 6. Minnesota Statutes 1991 Supplement, section 239.05, is amended by adding a subdivision to read:

Subd. 2c. [ATTESTATION ENGAGEMENT.] "Attestation engagement" means a standard auditing procedure prescribed by the Association of Independent Certified Public Accountants."

Page 2, line 36, delete the second "a" and insert "an oxygenated gasoline"

Page 4, lines 7 and 20, delete "registered" and insert "approved"

Page 7, line 2, delete "waiver to" and insert "temporary exemption from"

Page 10, line 3, delete "and decimal fractions"

Page 13, line 2, after "with" insert "a detergent additive,"

Page 13, line 3, delete "with"

Page 13, line 11, delete "provided" and insert "or the gasoline base stock from which a gasoline-ethanol blend was produced must comply with ASTM specification D 4814-90a;"

Page 13, delete lines 12 to 16

Page 13, line 20, after "gasoline" insert "after the gasoline-ethanol blend has been sold, transferred, or otherwise removed from a refinery or terminal"

Page 15, line 2, after the period insert "This subdivision does not apply to the measurement of petroleum products transferred, sold, or traded between refineries, between refineries and terminals, or between terminals."

Page 16, line 16, delete everything after "commission"

Page 16, delete lines 17 and 18

Page 16, line 19, delete everything before the period and insert "an attestation engagement performed by a certified public accountant to investigate compliance with this section and with EPA oxygenated fuel requirements"

Page 16, line 22, delete "30" and insert "120"

Page 17, line 16, delete "15 through February 15" and insert "1 through January 31"

Page 21, line 35, delete "registered" and insert "approved"

Page 26, delete section 53

Renumber the sections in sequence

Correct internal references

Amend the title as follows:

Page 1, line 3, delete "appropriating"

Page 1, line 4, delete "money;"

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2734, A bill for an act relating to agriculture; the Minnesota rural finance authority; providing for establishment of an agricultural improvement loan program for grade B dairy producers; appropriating money and authorizing the issuance of state bonds to fund the program; amending Minnesota Statutes 1990, section 41B.02, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 41B.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 1991 Supplement, section 18E.03, subdivision 5, is amended to read:

Subd. 5. [FEE AFTER 1990.] (a) The response and reimbursement fee for calendar years after calendar year 1990 consists of the surcharges in this subdivision and shall be collected by the commissioner. The amount of the response and reimbursement fee shall be determined and imposed annually as required under subdivision 3. The amount of the surcharges shall be proportionate to the surcharges in subdivision 4.

(b) The commissioner shall impose a surcharge on pesticides registered under chapter 18B to be collected as a surcharge on the registration application fee under section 18B.26, subdivision 3, as a percent of gross sales of the pesticide in the state and sales of the pesticide for use in the state during the previous calendar year, except the surcharge may not be imposed on pesticides that are sanitizers or disinfectants as determined by the commissioner. No surcharge is required if the surcharge amount based upon percent of annual gross sales is less than $10. Corrective action costs incurred in responding to incidents involving sanitizers or disinfectants are ineligible for reimbursement or payment under this chapter. The registrant shall determine when and which pesticides are sold or used in this state. The registrant shall secure sufficient sales information of pesticides distributed into this state from distributors and dealers, regardless of distributor location, to make a determination. Sales of pesticides in this state and sales of pesticides for use in this state by out-of-state distributors are not exempt and must be included in the registrant's annual report, as required under section 18B.26, subdivision 3, paragraph (c), and fees shall be paid by the registrant based upon those reported sales. Sales of pesticides in the state for use outside of the state are exempt from the surcharge in this paragraph if the registrant properly documents the sale locations and the distributors.

(c) The commissioner shall impose a fee per ton surcharge on the inspection fee under section 18C.425, subdivision 6, for fertilizers, soil amendments, and plant amendments.

(d) The commissioner shall impose a surcharge on the application fee of persons licensed under chapters 18B and 18C consisting of:

(1) a surcharge for each site where pesticides are stored or distributed, to be imposed as a surcharge on pesticide dealer application fees under section 18B.31, subdivision 5;

(2) a surcharge for each site where a fertilizer, plant amendment, or soil amendment is distributed, to be imposed on persons licensed under sections 18C.415 and 18C.425;

(3) a surcharge to be imposed on a structural pest control applicator license application under section 18B.32, subdivision 6, for business license applications only;

(4) a surcharge to be imposed on commercial applicator license application fees under section 18B.33, subdivision 7;

(5) a surcharge to be imposed on noncommercial applicator license application fees under section 18B.34, subdivision 5, except a surcharge may not be imposed on a noncommercial applicator that is a state agency, a political subdivision of the state, the federal government, or an agency of the federal government; and

(6) a surcharge for licensed lawn service applicators under chapter 18B or 18C, to be imposed on license application fees.

(e) If a person has more than one license for a site, only one surcharge may be imposed to cover all the licenses for the site.

(f) A $1,000 fee shall be imposed on each site where pesticides are stored and sold for use outside of the state unless:

(1) the distributor properly documents that it has less than $2,000,000 per year in wholesale value of pesticides stored and transferred through the site; or

(2) the registrant pays the surcharge under paragraph (b) and the registration fee under section 18B.26, subdivision 3, for all of the pesticides stored at the site and sold for use outside of the state.

Sec. 2. Minnesota Statutes 1990, section 32.21, is amended to read:

32.21 [ADULTERATED ~~MILK AND CREAM~~ DAIRY PRODUCTS.]

Subdivision 1. [PURCHASE AND SALE PROHIBITION.] A person may not sell or knowingly buy adulterated ~~milk or cream~~ dairy products.

Subd. 2. [MANUFACTURE OF FOOD FOR HUMAN CONSUMPTION FROM ADULTERATED MILK OR CREAM PROHIBITED.] An article of food for human consumption may not be manufactured from adulterated milk or cream, except as provided in section 32.22 or the federal Food, Drug, and Cosmetic Act, United States Code, title 21, section 301 et seq., and related federal regulations.

Prior to processing milk, all bulk milk pickup tankers must be tested for the presence of beta lactum drug residues and for other residues as determined necessary by the commissioner. Test methods must be those approved by the Association of Analytical Chemists (AOAC) or under the AOAC C2 program. Bulk milk tankers testing positive must be reported to the commissioner or the commissioner's agent within 24 hours. This report must include how and where the

milk was disposed of, the volume, the responsible producer, and the possible cause of the violative residue. All milk sample residue results must be recorded and retained for examination by the commissioner or the commissioner's agent for six months by the receiving plant. Milk received from a producer in other than a bulk milk pickup tanker is also subject to this section.

Subd. 3. [ADULTERATED MILK ~~OR CREAM~~.] For purposes of this section and section 32.22, milk ~~or cream~~ is adulterated if it:

(1) ~~milk~~ is drawn in a filthy or unsanitary place;

(2) ~~milk~~ is drawn from unhealthy or diseased cows;

(3) ~~milk~~ is drawn from cows that are fed garbage or an unwholesome animal or vegetable substance;

(4) ~~milk~~ is drawn from cows within 15 days before calving, or five days after calving;

(5) ~~milk or cream~~ contains water in excess of that normally found in milk;

(6) contains a substance that is not a normal constituent of the milk ~~or cream, as determined by laboratory procedures established by rule or~~ except as allowed in this chapter;

~~(6) milk contains water in excess of that normally present in milk;~~ or

(7) ~~milk or cream~~ contains ~~antibiotics~~ drug residues or other ~~bacterial inhibitory~~ chemical or biological substances in amounts above the ~~actionable~~ tolerances or safe levels established by rule or under section 32.415.

Subd. 4. [PENALTIES.] (a) A person, other than a milk producer, who violates this section is guilty of a misdemeanor or subject to a civil penalty up to $1,000.

(b) A milk producer may not change milk plants within 30 days, without permission of the commissioner, after receiving notification from the commissioner under paragraph (c) or (d) that the milk producer has violated this section.

(c) A milk producer who violates ~~this section shall be subject to a civil penalty of $100. The commissioner must notify the person violating this section by certified mail stating:~~

~~(1) the milk producer violating this section is on probation for one year after the date of violation; and~~

~~(2) the $100 civil penalty is suspended unless the milk producer violates this section during the probation period, including changing milk plants within 30 days after the violation.~~

~~(d) A milk producer who violates this section a second time within a 12-month period is subject to a $200 civil penalty. The commissioner must notify the milk producer violating this section stating:~~

~~(1) the milk producer is still on probation;~~

~~(2) the $200 civil penalty is suspended, unless the milk producer violates this section during the probation period, including changing milk plants within 30 days after the violation; and~~

~~(3) the consequences of a third violation.~~

~~(e) A milk producer who violates this section three or more times within a 12-month period is subject to a fine of $300.~~

~~(f) Penalties collected under this section shall be deposited in the milk inspection service account created in section 32.394, subdivision 9.~~ subdivision 3, clause (1), (2), (3), (4), or (5), is subject to clauses (1) to (3) of this paragraph.

(1) Upon notification of the first violation, the producer must meet with the dairy plant field service representative to initiate corrective action within 30 days.

(2) Upon the second violation within a 12-month period, the producer is subject to a civil penalty of $300. The commissioner shall notify the producer by certified mail stating the penalty is payable in 30 days, the consequences of failure to pay the penalty, and the consequences of future violations.

(3) Upon the third violation within a 12-month period, the producer is subject to an additional civil penalty of $300 and possible revocation of the producer's permit or certification. The commissioner shall notify the producer by certified mail that all civil penalties owed must be paid within 30 days and that the commissioner is initiating administrative procedures to revoke the producer's permit or certification to sell milk for at least 30 days.

(d) The producer's shipment of milk must be immediately suspended if the producer is identified as an individual source of milk containing residues in violation of subdivision 3, clause (6) or (7). Shipment may resume only after subsequent milk has been sampled by the commissioner or the commissioner's agent and found to contain no residues above established tolerances or safe levels. A milk producer who violates subdivision 3, clause (6) or (7), is subject to clauses (1) to (3) of this paragraph.

(1) For the first violation in a 12-month period, a producer shall not receive payment for any milk contaminated or the equivalent of at least the value of two days' milk production on that farm. Milk purchased for use from the producer during the two-day penalty period will be assessed a civil penalty equal to the minimum value of that milk and is payable to the commissioner by the dairy plant or marketing organization who purchases the milk. The producer remains eligible only for manufacturing grade until the producer completes the "Milk and Dairy Beef Residue Prevention Protocol" with a licensed veterinarian, displays the signed certificate in the milkhouse, and sends verification to the commissioner. To maintain a permit or certification to market milk, this program must be completed within 30 days.

(2) For the second violation in a 12-month period, a producer shall not receive payment for any milk contaminated or the equivalent of at least the value of four days' milk production on that farm. Milk purchased for use from the producer during the four-day penalty period will be assessed a civil penalty equal to the minimum value of that milk and is payable to the commissioner by the dairy plant or marketing organization who purchases the milk. The producer remains eligible only for manufacturing grade until the producer reviews the "Milk and Dairy Beef Residue Prevention Protocol" with a licensed veterinarian, displays the updated certificate in the milkhouse, and sends verification to the commissioner. To maintain a permit or certification to market milk, this program must be reviewed within 30 days.

(3) For the third violation in a 12-month period, a producer shall not receive payment for any milk contaminated or the equivalent of at least the value of four days' milk production on that farm. Milk purchased for use from the producer during the four-day penalty period will be assessed a civil penalty equal to the minimum value of that milk and is payable to the commissioner by the dairy plant or marketing organization who purchases the milk. The producer remains eligible only for manufacturing grade until the producer reviews the "Milk and Dairy Beef Residue Prevention Protocol" with a licensed veterinarian, displays the updated certificate in the milkhouse, and sends verification to the commissioner. To maintain a permit or certification to market milk, this program must be reviewed within 30 days. The commissioner shall also notify the producer by certified mail that the commissioner is initiating administrative procedures to revoke the producer's permit or certification to sell milk for a minimum of 30 days.

(e) A milk producer that has been certified as completing the "Milk and Dairy Beef Residue Prevention Protocol" within 12 months of the first violation of subdivision 3, clause (7), need only review the cause of the violation with a field service representative within three days to maintain shipping status if all other requirements of this section are met.

(f) Civil penalties collected under this section must be deposited in the milk inspection services account established in this chapter.

Sec. 3. Minnesota Statutes 1990, section 41B.02, is amended by adding a subdivision to read:

Subd. 19. [AGRICULTURAL IMPROVEMENTS.] "Agricultural improvements" means improvements to a farm, including the purchase and construction or installation of improvements to land, buildings, and other permanent structures, including equipment incorporated in or permanently affixed to the land, buildings, or structures, which are useful for and intended to be used for the purpose of farming. "Agricultural improvements" does not include equipment not affixed to real estate or improvements or additions to that equipment.

Sec. 4. [41B.043] [AGRICULTURAL IMPROVEMENT LOAN PROGRAM.]

Subdivision 1. [ESTABLISHMENT.] The authority may establish, adopt rules for, and implement an agricultural improvement loan program to finance agricultural improvements. Loans may be made to borrowers who meet the requirements of section 41B.03, subdivision 1, clauses (1) and (2), and who are actively engaged in farming. In the first two years of the program, only projects in the first and second priority categories may be funded. First priority for all loans must be given to grade B dairy farmers wishing to upgrade to grade A. Second priority must be for financing waste management facilities for livestock operations.

Subd. 2. [SPECIFICATIONS.] No loan may exceed $20,000, or be made to refinance an existing debt. Each loan must be secured by a mortgage on real property comprising all or part of the farm on which the improvements are made, and such other security as the authority may require.

Subd. 3. [APPLICATION AND ORIGINATION FEE.] The authority may impose a reasonable nonrefundable application fee for each application and an origination fee for each loan issued under the agricultural improvement loan program. The origination fee initially shall be set at 1.5 percent and the application fee at $50. The authority may review the fees annually and make adjustments as necessary. The fees must be deposited in a special account and appropriated to the commissioner for administrative expenses for the agricultural improvement loan program.

Subd. 4. [INTEREST RATE.] Unless the authority determines that it is not in the best interests of the agricultural improvement loan program, the interest rate per annum on the agricultural improvement loan must be that rate of interest determined by the authority to be necessary to provide for the timely payment of

principal and interest when due on bonds or other obligations of the authority issued pursuant to chapter 41B to provide financing for loans made under the agricultural improvement loan program, and to provide for reasonable and necessary costs of issuing, carrying, administering, and securing the bonds or notes and to pay the costs incurred and to be incurred by the authority in the implementation of the agricultural improvement loan program.

Sec. 5. [AGRICULTURAL IMPROVEMENT LOAN PROGRAM FUNDING.]

Subdivision 1. [APPROPRIATION.] $5,000,000 is appropriated to the Minnesota rural finance authority from the bond proceeds fund to fund the agency's agricultural improvement loan program.

Subd. 2. [BONDS.] The appropriation made under subdivision 1 must be funded by the issuance of general obligation bonds as provided in Minnesota Statutes, section 41B.19. The $5,000,000 authorized in subdivision 1 is part of the $50,000,000 bond authorization provided for in Minnesota Statutes, section 41B.19, subdivision 1. The bonds must be issued and sold in the manner, upon the terms, and with the effect prescribed by Minnesota Statutes, sections 16A.631 to 16A.675, and the Minnesota Constitution, article XI. Bond maturity should be matched to the terms of the loans made under this program. The legislature determines that the bonds are being issued to develop the state's agricultural resources by extending credit on real estate security.

Sec. 6. [EFFECTIVE DATE.]

Sections 3 to 5 are effective the day following final enactment. Section 2 is effective July 1, 1992."

Delete the title and insert:

"A bill for an act relating to agriculture; the Minnesota rural finance authority; providing for establishment of an agricultural improvement loan program for grade B dairy producers; changing pesticide reimbursement provisions; regulating adulterated dairy products; imposing civil penalties; appropriating money and authorizing the issuance of state bonds to fund the program; amending Minnesota Statutes 1990, sections 32.21; and 41B.02, by adding a subdivision; Minnesota Statutes 1991 Supplement, section 18E.03, subdivision 5; proposing coding for new law in Minnesota Statutes, chapter 41B."

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2950, A bill for an act relating to commerce; regulating the real estate, education, research, and recovery fund; amending Minnesota Statutes 1990, sections 80A.14, subdivision 4; 82.19, by adding a subdivision; and 82.34, subdivisions 3, 4, 7, 9, 11, 13, and 14; repealing Minnesota Statutes 1990, section 82.34, subdivision 20.

Reported the same back with the following amendments:

Pages 1 and 2, delete section 1 and insert:

"Section 1. [80A.041] [EXEMPTION.]

A real estate broker or agent licensed under chapter 82 who arranges for the sale of a contract for deed is exempt from the license requirement of section 80A.04 if the real estate broker or agent receives no additional compensation and represents the seller, buyer, lessor, or lessee in the sale, lease, or exchange of the subject property."

Amend the title as follows:

Page 1, lines 4 and 5, delete "80A.14, subdivision 4;"

Page 1, line 6, after the semicolon insert "proposing coding for new law in Minnesota Statutes, chapter 80A;"

With the recommendation that when so amended the bill pass.

The report was adopted.

SECOND READING OF HOUSE BILLS

H. F. Nos. 769, 2050, 2283, 2643, 2717, 2723, 2734 and 2950 were read for the second time.

SECOND READING OF SENATE BILLS

S. F. Nos. 2213, 2314, 2396, 2434 and 2743 were read for the second time.

INTRODUCTION AND FIRST READING OF HOUSE BILLS

The following House File was introduced:

Dille and Trimble introduced:

H. F. No. 3039, A resolution memorializing the United States Environmental Protection Agency to replace its regulation for testing water wells with one that gives states the freedom to run their own safe drinking water programs.

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

HOUSE ADVISORIES

The following House Advisory was introduced:

Abrams introduced:

H. A. No. 47, A proposal to study ways to improve the audio system in the House chambers.

The advisory was referred to the Committee on Rules and Legislative Administration.

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 Files, herewith returned:

H. F. No. 2647, A bill for an act relating to Minnesota Statutes; correcting erroneous, ambiguous, and omitted text and obsolete references; eliminating certain redundant, conflicting, and superseded provisions; making miscellaneous technical corrections to statutes and other laws; amending Minnesota Statutes 1990, sections 11A.23, subdivision 2; 13.791; 82B.20, subdivision 2; 86B.115; 86B.601, subdivision 1; 88.45; 103I.112; 115A.63, subdivision 3; 115A.82; 116J.70, subdivision 2a; 176.1041, subdivision 1; 176.361, subdivision 2; 177.23, subdivision 7; 183.38, subdivision 1; 214.01, subdivision 2; 268A.09, subdivision 7; 290.10; 297A.15, subdivision 5; 298.402; 298.405, subdivision 1; 326.405; 326.43; 348.13; 352.116,

subdivision 3b; 352B.10, subdivision 5; 352B.105; 356.24; 356.82; 466.131; 504.02; 514.53; 517.08, subdivision 1c; and 609.0331; Minnesota Statutes 1991 Supplement, sections 3.873, subdivision 6; 16B.122, subdivision 2; 60D.20, subdivision 1; 60G.01, subdivision 2; 116.072, subdivision 1; 116J.693, subdivision 2; 124.19, subdivision 1; 124.479; 169.983; 171.06, subdivision 3; 179A.10, subdivision 2; 256.969, subdivisions 2 and 3a; 256B.74, subdivision 2; 256H.03, subdivision 5; 272.01, subdivision 2; 272.02, subdivision 1; 275.50, subdivision 5; 340A.4055; 457A.01, subdivision 5; 473.845, subdivision 3; and 611A.02, subdivision 2; reenacting Minnesota Statutes 1991 Supplement, section 256B.431, subdivision 3f; repealing Minnesota Statutes 1990, section 326.01, subdivision 20; Laws 1989, chapter 282, article 2, section 188; Laws 1991, chapters 182, section 1; and 305, section 10.

H. F. No. 2756, A bill for an act relating to the city of Virginia; authorizing annual increases in survivor benefits payable by the Virginia firefighters relief association.

PATRICK E. FLAHAVEN, Secretary of the Senate

Madam Speaker:

I hereby announce that the Senate accedes to the request of the House for the appointment of a Conference Committee on the amendments adopted by the Senate to the following House File:

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 Senate has appointed as such committee:

Messrs. Spear, Kelly and McGowan; Ms. Ranum and Mr. Marty.

Said House File is herewith returned to the House.

PATRICK E. FLAHAVEN, Secretary of 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. 2113, A bill for an act relating to traffic regulations; authorizing the operation of flashing lights and stop arms on school buses transporting persons age 18 and under to and from certain

activities; authorizing revolving safety lights on rural mail carrier vehicles; requiring school bus sign on school bus providing such transportation; amending Minnesota Statutes 1991 Supplement, sections 169.441, subdivision 3; 169.443, subdivision 3, and by adding a subdivision; and 169.64, by adding a subdivision.

PATRICK E. FLAHAVEN, Secretary of the Senate

Orenstein moved that the House refuse to concur in the Senate amendments to H. F. No. 2113, 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 that the Senate refuses to concur in the House amendments to the following Senate File:

S. F. No. 2257, A bill for an act relating to agricultural development; redefining agricultural business enterprise for purposes of the Minnesota agricultural development act; amending Minnesota Statutes 1991 Supplement, section 41C.02, subdivision 2.

The Senate respectfully requests that a Conference Committee be appointed thereon. The Senate has appointed as such committee:

Messrs. Sams, Davis and Renneke.

Said Senate File is herewith transmitted to the House with the request that the House appoint a like committee.

PATRICK E. FLAHAVEN, Secretary of the Senate

Winter moved that the House accede to the request of the Senate and that the Speaker appoint a Conference Committee of 3 members of the House to meet with a like committee appointed by the Senate on the disagreeing votes of the two houses on S. F. No. 2257. The motion prevailed.

Madam Speaker:

I hereby announce that the Senate refuses to concur in the House amendments to the following Senate File:

S. F. No. 2728, A bill for an act relating to agriculture; establishing a state over-order premium milk price for dairy farmers for

certain milk; proposing coding for new law in Minnesota Statutes, chapter 32A.

The Senate respectfully requests that a Conference Committee be appointed thereon. The Senate has appointed as such committee:

Messrs. Sams, Waldorf and Renneke.

Said Senate File is herewith transmitted to the House with the request that the House appoint a like committee.

PATRICK E. FLAHAVEN, Secretary of the Senate

Wenzel moved that the House accede to the request of the Senate and that the Speaker appoint a Conference Committee of 3 members of the House to meet with a like committee appointed by the Senate on the disagreeing votes of the two houses on S. F. No. 2728. The motion prevailed.

Madam Speaker:

I hereby announce that the Senate refuses to concur in the House amendments to the following Senate File:

S. F. No. 2430, A bill for an act relating to the environment; adding sanctions and procedures relating to petroleum tank release consultants and contractors; amending Minnesota Statutes 1990, sections 115C.02, by adding subdivisions; 115C.03, by adding a subdivision; 116.48, by adding a subdivision; Minnesota Statutes 1991 Supplement, section 115C.09, subdivision 7; proposing coding for new law in Minnesota Statutes, chapter 115C.

The Senate respectfully requests that a Conference Committee be appointed thereon. The Senate has appointed as such committee:

Messrs. Sams, Finn and Novak.

Said Senate File is herewith transmitted to the House with the request that the House appoint a like committee.

PATRICK E. FLAHAVEN, Secretary of the Senate

Krueger moved that the House accede to the request of the Senate and that the Speaker appoint a Conference Committee of 3 members of the House to meet with a like committee appointed by the Senate on the disagreeing votes of the two houses on S. F. No. 2430. The motion prevailed.

Madam Speaker:

I hereby announce that the Senate refuses to concur in the House amendments to the following Senate File:

S. F. No. 1722, A bill for an act relating to state lands; providing for the release of a state interest in certain property in the city of Minneapolis.

The Senate respectfully requests that a Conference Committee be appointed thereon. The Senate has appointed as such committee:

Messrs. Kroening, Merriam and Gustafson.

Said Senate File is herewith transmitted to the House with the request that the House appoint a like committee.

PATRICK E. FLAHAVEN, Secretary of the Senate

Jefferson moved that the House accede to the request of the Senate and that the Speaker appoint a Conference Committee of 3 members of the House to meet with a like committee appointed by the Senate on the disagreeing votes of the two houses on S. F. No. 1722. The motion prevailed.

Madam Speaker:

I hereby announce that the Senate refuses to concur in the House amendments to the following Senate File:

S. F. No. 2136, A bill for an act relating to labor; protecting interests of employees following railroad acquisitions; imposing a penalty; amending Minnesota Statutes 1990, sections 222.86, subdivision 3; 222.87, by adding a subdivision; and 222.88.

The Senate respectfully requests that a Conference Committee be appointed thereon. The Senate has appointed as such committee:

Messrs. Mondale, Solon and Halberg.

Said Senate File is herewith transmitted to the House with the request that the House appoint a like committee.

PATRICK E. FLAHAVEN, Secretary of the Senate

Farrell moved that the House accede to the request of the Senate and that the Speaker appoint a Conference Committee of 3 members of the House to meet with a like committee appointed by the Senate

on the disagreeing votes of the two houses on S. F. No. 2136. The motion prevailed.

CONSIDERATION UNDER RULE 1.10

Pursuant to rule 1.10, Ogren requested immediate consideration of H. F. No. 2800.

H. F. No. 2800 was reported to the House.

Ogren, Greenfield, Welle, Long, Gruenes, Stanius and Dempsey moved to amend H. F. No. 2800, the third engrossment, as follows:

Page 2, after line 9, insert:

"Subd. 2. [CLINICAL EFFECTIVENESS.] "Clinical effectiveness" means that the use of a particular medical technology improves patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology demonstrates a clinical advantage over alternative technologies."

Page 2, after line 14, insert:

"Subd. 4. [COST-EFFECTIVENESS.] "Cost effectiveness" means that the economic costs of using a particular technology to achieve improvement in a patient's health outcome are justified given a comparison to both the economic costs and the improvement in patient health outcome resulting from the use of alternative technologies."

Page 2, after line 28, insert:

"Subd. 5. [IMPROVEMENT IN HEALTH OUTCOME.] "Improvement in health outcome" means an improvement in patient clinical status, and an improvement in patient quality-of-life status, as measured by ability to function, ability to return to work, and other variables."

Renumber the subdivisions in sequence.

Page 4, line 16, delete "designate" and insert "develop"

Page 6, line 36, delete "standards" and insert "parameters"

Page 7, line 26, after "NUMBER" insert "; GENDER AND GEOGRAPHIC BALANCE"

Page 7, line 29, after the period, insert "The governor and legislature shall coordinate appointments under this subdivision to ensure gender balance and ensure that geographic areas of the state are represented in proportion to their population."

Page 8, line 4, delete "council of hospital corporations" and insert "Council of Hospital Corporations"

Page 10, line 13, after "new" insert ", high cost"

Page 10, line 14, before the semicolon insert ", excluding wearable or implantable medical devices that have been approved by the United States Food and Drug Administration"

Page 10, line 16, after "new" insert ", high cost"

Page 13, line 1, delete "and" and insert "of"; after "health" insert "and"; after "Minnesota" insert "health"

Page 13, delete lines 3 to 23

Renumber the subdivisions in sequence.

Page 14, line 17, after "other" insert "high cost"; before "health" insert "high cost"

Page 14, line 18, before the first comma insert ", excluding wearable or implantable medical devices that have been approved by the United States Food and Drug Administration"

Page 14, after line 22, insert:

"(1) make recommendations on the types of high cost technologies, procedures, and capital expenditures for which a plan for statewide use and distribution should be made;"

Renumber the clauses in sequence.

Page 14, line 23, after "new" insert ", high cost"

Page 14, line 25, delete everything after "consideration" and insert "clinical effectiveness, cost-effectiveness, and health outcome;"

Page 14, delete lines 26 and 27

Page 14, line 30, after "existing" insert "high cost"

Page 15, lines 7 to 8, delete "An important factor contributing" and insert "One of the factors that is believed to contribute"

Page 17, line 19, before the period insert ", excluding wearable or implantable medical devices"

Page 18, line 12, after "cost-effective" insert ", clinically effective, and do not improve health outcomes,"

Page 18, line 13, delete "recommend" and insert "require those health care providers to follow the procedures for prospective review and approval established in subdivision 6.

Subd. 6. [PROSPECTIVE REVIEW AND APPROVAL.] (a) The commissioner shall prohibit those health care providers subject to prospective review and approval under subdivision 5 from making future major spending commitments or capital expenditures that are required to be reported under subdivision 4 for a period of up to five years, unless: (1) the provider has filed an application to proceed with the major spending commitment or capital expenditure with the commissioner and provided supporting documentation and evidence requested by the commissioner; and (2) the commissioner determines, based upon this documentation and evidence, that the spending commitment or capital expenditure is appropriate. The commissioner shall make a decision on a completed application within 60 days after an application is submitted. The Minnesota health care commission shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, and health care expenditures to review applications and make recommendations to the commissioner and the commission.

(b) A provider may make a major spending commitment to replace existing equipment with comparable equipment, if the old equipment will no longer be used in the state. A provider may make a major spending commitment to repair, remodel, or replace existing buildings or fixtures if, in the judgment of the commissioner, the project does not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

(c) This subdivision does not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided."

Page 18, delete lines 14 to 27

Page 71, line 26, before the period, insert "or a similar tax on

premiums imposed upon entities operating under chapter 62C or 62D"

Page 71, line 28, delete "the tax imposed by those sections" and insert "a tax described in this paragraph"

Page 72, line 29, before the period, insert ", except that the program is and must remain a contributing member of the comprehensive health association established in section 62E.10"

Page 77, line 26, delete "65" and insert "75"

Page 78, line 6, delete "a 70" and insert "an 80"

Page 86, line 17, after the comma, insert "the pooled employers insurance program established in section 43A.317,"

Page 86, line 30, after the comma, insert "the pooled employers insurance program established in section 43A.317,"

Page 98, line 33, delete everything after "whose"

Page 98, line 34, delete everything before "income"; delete "less" and insert "greater"

Page 98, line 35, delete "percentage limit" and insert "limits"

Page 99, line 14, delete everything after "whose"

Page 99, line 15, delete everything before "income"; delete "less" and insert "greater"; delete "percentage determined" and insert "limits established"

Page 110, line 22, before "The" insert "Subdivision 1. [SOLE COMMUNITY HOSPITAL FINANCIAL ASSISTANCE GRANTS.]"

Page 110, after line 33, insert:

"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."

Pages 199 to 202, delete sections 3 to 9 and insert:

"HOSPITALS AND HEALTH CARE PROVIDERS

Sec. 3. [295.50] [DEFINITIONS.]

Subdivision 1. [DEFINITIONS.] For purposes of sections 295.50 to 295.58, the following terms have the meanings given.

Subd. 2. [COMMISSIONER.] "Commissioner" is the commissioner of revenue.

Subd. 3. [GROSS REVENUES.] "Gross revenues" are total amounts received in money or otherwise by:

(1) a resident hospital for inpatient or outpatient services as defined in Minnesota Rules, part 4650.0102, subparts 21 and 29;

(2) a nonresident hospital for inpatient or outpatient services as defined in Minnesota Rules, part 4650.0102, subparts 21 and 29, provided to patients domiciled in Minnesota;

(3) a resident health care provider, other than a health maintenance organization, for covered services listed in section 256B.0625;

(4) a nonresident health care provider for covered services listed in section 256B.0625 provided to an individual domiciled in Minnesota;

(5) a wholesale drug distributor for sale or distribution of prescription drugs that are delivered in Minnesota by the distributor or a common carrier, unless the prescription drugs are delivered to another wholesale drug distributor; and

(6) a health maintenance organization as gross premiums for enrollees, carrier copayments, and other fees for services provided.

Subd. 4. [HEALTH CARE PROVIDER.] "Health care provider" is a vendor of medical care qualifying for reimbursement under the medical assistance program provided under chapter 256B, and includes health maintenance organizations but excludes hospitals and pharmacies.

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, as defined in section 62A.46, subdivision 3, or intermediate care facility for persons with mental retardation as defined in section 256B.055, subdivision 12, paragraph (d).

Subd. 7. [HOSPITAL.] "Hospital" is a hospital licensed under chapter 144, a hospital providing inpatient or outpatient services licensed by any other state or province or territory of Canada or a surgical center.

Subd. 8. [NONRESIDENT HEALTH CARE PROVIDER.] "Nonresident health care provider" means a health care provider that is not a resident health care provider.

Subd. 9. [NONRESIDENT HOSPITAL.] "Nonresident hospital" means a hospital physically located outside Minnesota.

Subd. 10. [PHARMACY.] "Pharmacy" means a pharmacy, as defined in section 151.01, if the only goods or services the pharmacy sells that qualify for reimbursement under the medical assistance program under chapter 256B are drugs and prosthetics.

Subd. 11. [RESIDENT HEALTH CARE PROVIDER.] "Resident health care provider" means a health care provider whose principal place of dispensing health care is in Minnesota.

Subd. 12. [RESIDENT HOSPITAL.] "Resident hospital" means a hospital physically located inside Minnesota.

Subd. 13. [SURGICAL CENTER.] "Surgical center" is an outpatient surgical center as defined in Minnesota Rules, chapter 4675 or a similar facility located in any other state or province or territory of Canada.

Subd. 14. [WHOLESALE DRUG DISTRIBUTOR.] "Wholesale drug distributor" means a wholesale drug distributor required to be licensed under sections 151.42 to 151.51.

Sec. 4. [295.51] [MINIMUM CONTACTS REQUIRED FOR JURISDICTION TO TAX GROSS REVENUE.]

Subdivision 1. [BUSINESS TRANSACTIONS IN MINNESOTA.] A hospital or health care provider is subject to tax under sections 295.50 to 295.58 if it is "transacting business in Minnesota." A hospital or health care provider is transacting business in Minnesota only if it:

(1) maintains an office in Minnesota;

(2) has employees, representatives, or independent contractors conducting business in Minnesota;

(3) regularly sells covered services to customers that receive the covered services in Minnesota;

(4) regularly solicits business from potential customers in Minnesota;

(5) regularly performs services outside Minnesota the benefits of which are consumed in Minnesota;

(6) owns or leases tangible personal or real property physically located in Minnesota; or

(7) receives medical assistance payments from the state of Minnesota.

Subd. 2. [PRESUMPTION.] A hospital or health care provider is presumed to regularly solicit business within Minnesota if it receives gross receipts for covered services from 20 or more patients domiciled in Minnesota in a calendar year.

Sec. 5. [295.52] [TAXES IMPOSED.]

Subdivision 1. [HOSPITAL TAX.] A tax is imposed on each hospital equal to two percent of its gross revenues.

Subd. 2. [PROVIDER TAX.] A tax is imposed on each health care provider equal to two percent of its gross revenues.

Subd. 3. [WHOLESALE DRUG DISTRIBUTOR TAX.] A tax is imposed on each wholesale drug distributor equal to two percent of its gross revenues.

Subd. 4. [USE TAX; PRESCRIPTION DRUGS.] A person that receives prescription drugs for resale or use in Minnesota, other than from a wholesale drug distributor that paid the tax under subdivision 3, is subject to a tax equal to two percent of the price paid. Liability for the tax is incurred when prescription drugs are received in Minnesota by the person.

Sec. 6. [295.53] [EXEMPTIONS; SPECIAL RULES.]

Subdivision 1. [EXEMPTIONS.] The following payments are excluded from the gross revenues subject to the hospital or health care provider taxes under sections 295.50 to 295.57:

(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 services performed by a nursing home licensed under chapter 144A, services provided in an intermediate care facility for persons with mental retardation, and home health care services;

(4) payments received from hospitals for services that are subject to tax under section 295.52;

(5) payments received from health care providers for services that are subject to tax under section 295.52;

(6) amounts paid for prescription drugs to a wholesale drug distributor reduced by reimbursements received for prescription drugs under clauses (1), (2), (7), and (8);

(7) payments received under the general assistance medical care program; and

(8) payments received for providing services under the health right program under article 4.

Subd. 2. [DEDUCTIONS FOR HMOS.] (a) In addition to the exemptions allowed under subdivision 1, a health maintenance organization may deduct from its gross revenues for the year:

(1) amounts added to reserves, if total reserves do not exceed 25 percent of gross revenues for the prior year;

(2) assessments for the comprehensive health insurance plan under section 62E.11 paid during the year; and

(3) an allowance for administration and underwriting.

(b) The commissioner of commerce, in consultation with the commissioners of health and revenue, shall establish by rule under chapter 14 the percentage of health maintenance revenue that will be allowed as a deduction for administrative and underwriting expenses. The commissioner of commerce shall determine the per-

centage allowance based on the average expenses of health maintenance organizations 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, and do not include costs deductible under paragraph (a), clauses (1) and (2). The commissioner of commerce may adopt emergency rules.

Subd. 3. [RESTRICTION ON ITEMIZATION.] A hospital or health care provider must not separately state the tax obligation under section 295.52 on bills provided to individual patients.

Sec. 7. [295.54] [CREDIT FOR TAXES PAID TO ANOTHER STATE.]

A resident hospital or resident health care provider who is liable for taxes payable to another state or province or territory of Canada measured by gross receipts and is subject to tax under section 295.52 is entitled to a credit for the tax paid to another state or province or territory of Canada to the extent of the lesser of (1) the tax actually paid to the other state or province or territory of Canada, or (2) the amount of tax imposed by Minnesota on the gross receipts subject to tax in the other taxing jurisdictions.

Sec. 8. [295.55] [PAYMENT OF TAX.]

Subdivision 1. [SCOPE.] The provisions of this section apply to the taxes imposed under sections 295.50 to 295.58.

Subd. 2. [ESTIMATED TAX; HOSPITALS.] (a) Each hospital must make estimated payments of the taxes for the calendar year in monthly installments to the commissioner within ten days after the end of the month.

(b) Estimated tax payments are not required if the tax for the calendar year is less than $500 or if the hospital has been allowed a grant under section 144.1484, subdivision 2 for the year.

(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 the difference between the amount paid and the lesser of (1) 90 percent of one-twelfth of the tax for the calendar year or (2) the tax for the actual gross revenues received during the month.

Subd. 3. [ESTIMATED TAX; OTHER TAXPAYERS.] (a) Each taxpayer, other than a hospital, 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 the difference between the amount paid and the lesser of (1) 90 percent of one-quarter of the tax for the calendar year or (2) the tax for the actual gross revenues received during the quarter.

Subd. 4. [ELECTRONIC FUNDS TRANSFER PAYMENTS.] A taxpayer with an aggregate tax liability of $60,000 or more during a calendar quarter ending the last day of March, June, September, or December must thereafter remit all liabilities by means of a funds transfer as defined in section 336.4A-104, paragraph (a). The funds transfer payment date, as defined in section 336.4A-401, is on or before the date the tax is due. If the date the tax is due is not a funds-transfer business day, as defined in section 336.4A-105, paragraph (a), clause (4), the payment date is on or before the first funds-transfer business day after the date the tax is due.

Subd. 5. [ANNUAL RETURN.] The taxpayer must file an annual return reconciling the quarterly estimated payments by March 15 of the following calendar year.

Subd. 6. [FORM OF RETURNS.] The estimated payments and annual return must contain the information and be in the form prescribed by the commissioner.

Sec. 9. [295.57] [COLLECTION AND ENFORCEMENT; RULEMAKING; APPLICATION OF OTHER CHAPTERS.]

Unless specifically provided by sections 295.50 to 295.58, the enforcement, interest, and penalty provisions under chapter 294, appeal and criminal penalty provisions under chapter 289A, and collection and rulemaking provisions under chapter 270, apply to a liability for the taxes imposed under sections 295.50 to 295.58.

Sec. 10. [295.58] [DEPOSIT OF REVENUES.]

The commissioner shall deposit all revenues, including penalties and interest, derived from the taxes imposed by sections 295.50 to 295.57 in the health care access account in the general fund.

Sec. 11. [295.59] [SEVERABILITY.]

If any section, subdivision, clause, or phrase of sections 295.50 to 295.58 is for any reason held to be unconstitutional or in violation of federal law, the decision shall not affect the validity of the remaining portions of sections 295.50 to 295.58. The legislature declares that it would have passed sections 295.50 to 295.58 and each section, subdivision, sentence, clause, and phrase thereof, irrespective of the fact that any one or more sections, subdivisions, sentences, clauses, or phrases is declared unconstitutional.

Sec. 12. 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. 13. Minnesota Statutes 1991 Supplement, section 297.03, subdivision 5, is amended to read:

Subd. 5. [SALE OF STAMPS.] The commissioner shall sell stamps to any person licensed as a distributor at a discount of ~~1.1~~ 1.0 percent from the face amount of the stamps for the first $1,500,000 of such stamps purchased in any fiscal year; and at a discount of ~~.65~~ .60 percent on the remainder of such stamps purchased in any fiscal year. The commissioner shall not sell stamps to any other person. The commissioner may prescribe the method of shipment of the stamps to the distributor as well as the quantities of stamps purchased.

Sec. 14. [FLOOR STOCKS TAX.]

Subdivision 1. [CIGARETTES.] A floor stocks tax is imposed on every person engaged in business in this state as a distributor, retailer, subjobber, vendor, manufacturer, or manufacturer's representative of cigarettes, on the stamped cigarettes in the person's possession or under the person's control at 12:01 a.m. on July 1, 1992. The tax is imposed at the following rates, subject to the discounts in section 297.03:

(1) on cigarettes weighing not more than three pounds a thousand, 2.5 mills on each cigarette; and

(2) on cigarettes weighing more than three pounds a thousand, five mills on each cigarette.

Each distributor, by July 8, 1992, shall file a report with the commissioner, in the form the commissioner prescribes, showing the cigarettes on hand at 12:01 a.m. on July 1, 1992, and the amount of tax due on the cigarettes. The tax imposed by this section is due and payable by August 1, 1992, and after that date bears interest at the rate of one percent a month.

Each retailer, subjobber, vendor, manufacturer, or manufacturer's representative shall file a return with the commissioner, in the form the commissioner prescribes, showing the cigarettes on hand at 12:01 a.m. on July 1, 1992, and pay the tax due thereon by August 1, 1992. Tax not paid by the due date bears interest at the rate of one percent a month.

Subd. 2. [AUDIT AND ENFORCEMENT.] The tax imposed by this section is subject to the audit, assessment, and collection provisions applicable to the taxes imposed under chapter 297C. The commissioner may require a distributor to receive and maintain copies of floor stock tax returns filed by all persons requesting a credit for returned cigarettes.

Subd. 3. [DEPOSIT OF PROCEEDS.] The revenue from the tax imposed under this section shall be deposited by the commissioner in the state treasury and credited to the health care access account in the general fund.

Sec. 15. [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, sections 297.01 to 297.13.

This section expires June 30, 1994.

Sec. 16. [TRANSITION PROVISION; HOSPITAL TAX.]

For gross revenues taxable under section 5, subdivision 1, for calendar year 1993, the exclusions under section 6, subdivision 1, clauses (5) and (6) do not apply.

Sec. 17. [EFFECTIVE DATE.]

Section 2 is effective for taxable years beginning after December 31, 1992. Section 5, subdivision 1, is effective for gross revenues generated by services performed and goods sold after December 31, 1992. Section 5, subdivisions 2 to 4, are effective for gross revenues generated by services performed and goods sold after December 31, 1993. Sections 12 and 13 are effective July 1, 1992. Section 14 is effective the day following final enactment."

Amend the title accordingly

Ogren moved to amend the Ogren et al amendment to H. F. No. 2800, the third engrossment, as follows:

Page 3, after line 2 of the Ogren et al amendment, insert:

"Page 17, after line 23, insert:

(g) [NATIONAL REFERRAL CENTERS.] A major spending commitment may be made by a provider if the provider projects that at least 40 percent of the patients who will benefit from and pay for the capital expenditure, equipment purchase, or new specialized service are residents of another state based on historical patient service data."

A roll call was requested and properly seconded.

The question was taken on the amendment to the amendment and the roll was called. There were 98 yeas and 34 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Garcia	Krambeer	Onnen	Solberg
Battaglia	Girard	Krueger	Orfield	Sparby
Bauerly	Greenfield	Lasley	Ostrom	Stanius
Beard	Gruenes	Lieder	Ozment	Steensma
Begich	Gutknecht	Lourey	Pauly	Sviggum
Bertram	Hanson	Mariani	Pellow	Tompkins
Bettermann	Hartle	Marsh	Pelowski	Trimble
Bishop	Hasskamp	McEachern	Peterson	Tunheim
Bodahl	Hausman	McGuire	Pugh	Uphus
Carlson	Henry	McPherson	Reding	Vellenga
Carruthers	Jacobs	Milbert	Rest	Wagenius
Clark	Jefferson	Morrison	Rodosovich	Waltman
Cooper	Johnson, A.	Murphy	Runbeck	Weaver
Dauner	Johnson, R.	Nelson, K.	Sarna	Wejcman
Davids	Johnson, V.	Nelson, S.	Schafer	Welle
Dawkins	Kahn	Newinski	Schreiber	Wenzel
Dille	Kalis	O'Connor	Seaberg	Winter
Dorn	Kelso	Ogren	Segal	Spk. Long
Frederick	Kinkel	Olson, E.	Simoneau	
Frerichs	Knickerbocker	Olson, K.	Skoglund	

Those who voted in the negative were:

Abrams	Erhardt	Janezich	Macklin	Rukavina
Anderson, R.	Farrell	Jennings	Munger	Smith
Anderson, R. H.	Goodno	Koppendrayer	Olsen, S.	Swenson
Blatz	Haukoos	Krinkie	Omann	Thompson
Boo	Heir	Leppik	Orenstein	Valento
Brown	Hufnagle	Limmer	Osthoff	Welker
Dempsey	Hugoson	Lynch	Rice	

The motion prevailed and the amendment to the amendment was adopted.

Ogren moved to amend the Ogren et al amendment, as amended, to H. F. No. 2800, the third engrossment, as follows:

Page 4, line 1 of the Ogren et al amendment, after "capacity" insert "in the state"

The motion prevailed and the amendment to the amendment, as amended, was adopted.

Bishop moved to amend the Ogren et al amendment, as amended, to H. F. No. 2800, the third engrossment, as follows:

Page 8, line 30 of the Ogren et al amendment, delete "and"

Page 8, line 32 of the Ogren et al amendment, delete the period and insert "; and"

Page 8, after line 32 of the Ogren et al amendment, insert:

"(9) revenues equal to qualified net expenditures by a not-for-profit hospital or health care provider for research programs and accredited education programs. Qualified net expenditures for purposes of this exemption are the product of the net expenditures multiplied by the percentage of gross revenues derived from Minnesota residents to the gross revenues of the entity. Net expenditures are total expenditures of the entity for research and education less the revenues, other than gross revenues, received for research and education."

The motion did not prevail and the amendment to the amendment, as amended, was not adopted.

Janezich requested a division of the Ogren et al amendment, as amended, to H. F. No. 2800, the third engrossment.

The first portion of the Ogren et al amendment, as amended, to H. F. No. 2800, the third engrossment, reads as follows:

Page 2, after line 9, insert:

"Subd. 2. [CLINICAL EFFECTIVENESS.] "Clinical effectiveness" means that the use of a particular medical technology improves patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology demonstrates a clinical advantage over alternative technologies."

Page 2, after line 14, insert:

"Subd. 4. [COST-EFFECTIVENESS.] "Cost effectiveness" means that the economic costs of using a particular technology to achieve improvement in a patient's health outcome are justified given a comparison to both the economic costs and the improvement in patient health outcome resulting from the use of alternative technologies."

Page 2, after line 28, insert:

"Subd. 5. [IMPROVEMENT IN HEALTH OUTCOME.] "Improvement in health outcome" means an improvement in patient clinical status, and an improvement in patient quality-of-life status, as measured by ability to function, ability to return to work, and other variables."

Renumber the subdivisions in sequence.

Page 4, line 16, delete "designate" and insert "develop"

Page 6, line 36, delete "standards" and insert "parameters"

Page 7, line 26, after "NUMBER" insert "; GENDER AND GEOGRAPHIC BALANCE"

Page 7, line 29, after the period, insert "The governor and legislature shall coordinate appointments under this subdivision to ensure gender balance and ensure that geographic areas of the state are represented in proportion to their population."

Page 8, line 4, delete "council of hospital corporations" and insert "Council of Hospital Corporations"

Page 10, line 13, after "new" insert ", high cost"

Page 10, line 14, before the semicolon insert ", excluding wearable or implantable medical devices that have been approved by the United States Food and Drug Administration"

Page 10, line 16, after "new" insert ", high cost"

Page 13, line 1, delete "and" and insert "of"; after "health" insert "and"; after "Minnesota" insert "health"

Page 13, delete lines 3 to 23

Renumber the subdivisions in sequence.

Page 14, line 17, after "other" insert "high cost"; before "health" insert "high cost"

Page 14, line 18, before the first comma insert ", excluding wearable or implantable medical devices that have been approved by the United States Food and Drug Administration,"

Page 14, after line 22, insert:

"(1) make recommendations on the types of high cost technologies, procedures, and capital expenditures for which a plan for statewide use and distribution should be made;"

Renumber the clauses in sequence.

Page 14, line 23, after "new" insert ", high cost"

Page 14, line 25, delete everything after "consideration" and insert "clinical effectiveness, cost-effectiveness, and health outcome;"

Page 14, delete lines 26 and 27

Page 14, line 30, after "existing" insert "high cost"

Page 15, lines 7 to 8, delete "An important factor contributing" and insert "One of the factors that is believed to contribute"

Page 17, line 19, before the period insert ", excluding wearable or implantable medical devices"

Page 17, after line 23, insert:

"(g) [NATIONAL REFERRAL CENTERS.] A major spending commitment may be made by a provider if the provider projects that at least 40 percent of the patients who will benefit from and pay for the

capital expenditure, equipment purchase, or new specialized service are residents of another state based on historical patient service data."

Page 18, line 12, after "cost-effective" insert ", clinically effective, and do not improve health outcomes,"

Page 18, line 13, delete "recommend" and insert "require those health care providers to follow the procedures for prospective review and approval established in subdivision 6.

Subd. 6. [PROSPECTIVE REVIEW AND APPROVAL.] (a) The commissioner shall prohibit those health care providers subject to prospective review and approval under subdivision 5 from making future major spending commitments or capital expenditures that are required to be reported under subdivision 4 for a period of up to five years, unless: (1) the provider has filed an application to proceed with the major spending commitment or capital expenditure with the commissioner and provided supporting documentation and evidence requested by the commissioner; and (2) the commissioner determines, based upon this documentation and evidence, that the spending commitment or capital expenditure is appropriate. The commissioner shall make a decision on a completed application within 60 days after an application is submitted. The Minnesota health care commission shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, and health care expenditures to review applications and make recommendations to the commissioner and the commission.

(b) A provider may make a major spending commitment to replace existing equipment with comparable equipment, if the old equipment will no longer be used in the state. A provider may make a major spending commitment to repair, remodel, or replace existing buildings or fixtures if, in the judgment of the commissioner, the project does not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

(c) This subdivision does not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity in the state or a substantial change in the nature of health care services provided."

Page 18, delete lines 14 to 27

Page 71, line 26, before the period, insert "or a similar tax on premiums imposed upon entities operating under chapter 62C or 62D"

Page 71, line 28, delete "the tax imposed by those sections" and insert "a tax described in this paragraph"

Page 72, line 29, before the period, insert ", except that the program is and must remain a contributing member of the comprehensive health association established in section 62E.10"

Page 77, line 26, delete "65" and insert "75"

Page 78, line 6, delete "a 70" and insert "an 80"

Page 86, line 17, after the comma, insert "the pooled employers insurance program established in section 43A.317,"

Page 86, line 30, after the comma, insert "the pooled employers insurance program established in section 43A.317,"

Page 98, line 33, delete everything after "whose"

Page 98, line 34, delete everything before "income"; delete "less" and insert "greater"

Page 98, line 35, delete "percentage limit" and insert "limits"

Page 99, line 14, delete everything after "whose"

Page 99, line 15, delete everything before "income"; delete "less" and insert "greater"; delete "percentage determined" and insert "limits established"

The motion prevailed and the first portion of the Ogren et al amendment, as amended, was adopted.

Sviggum requested a division of the remaining portion of the Ogren et al amendment, as amended, to H. F. No. 2800, the third engrossment, as amended.

Janezich requested to vote on the second portion of the Sviggum division first. The request was granted.

The second portion of the remaining portion of the Ogren et al amendment, as amended, to H. F. No. 2800, the third engrossment, as amended, reads as follows:

Pages 199 to 202, delete sections 3 to 9 and insert:

"HOSPITALS AND HEALTH CARE PROVIDERS

Sec. 3. [295.50] [DEFINITIONS.]

Subdivision 1. [DEFINITIONS.] For purposes of sections 295.50 to 295.58, the following terms have the meanings given.

Subd. 2. [COMMISSIONER.] "Commissioner" is the commissioner of revenue.

Subd. 3. [GROSS REVENUES.] "Gross revenues" are total amounts received in money or otherwise by:

(1) a resident hospital for inpatient or outpatient services as defined in Minnesota Rules, part 4650.0102, subparts 21 and 29;

(2) a nonresident hospital for inpatient or outpatient services as defined in Minnesota Rules, part 4650.0102, subparts 21 and 29, provided to patients domiciled in Minnesota;

(3) a resident health care provider, other than a health maintenance organization, for covered services listed in section 256B.0625;

(4) a nonresident health care provider for covered services listed in section 256B.0625 provided to an individual domiciled in Minnesota;

(5) a wholesale drug distributor for sale or distribution of prescription drugs that are delivered in Minnesota by the distributor or a common carrier, unless the prescription drugs are delivered to another wholesale drug distributor; and

(6) a health maintenance organization as gross premiums for enrollees, carrier copayments, and other fees for services provided.

Subd. 4. [HEALTH CARE PROVIDER.] "Health care provider" is a vendor of medical care qualifying for reimbursement under the medical assistance program provided under chapter 256B, and includes health maintenance organizations but excludes hospitals and pharmacies.

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, as defined in section 62A.46, subdivision 3, or intermediate care facility for persons with mental retardation as defined in section 256B.055, subdivision 12, paragraph (d).

Subd. 7. [HOSPITAL.] "Hospital" is a hospital licensed under chapter 144, a hospital providing inpatient or outpatient services licensed by any other state or province or territory of Canada or a surgical center.

Subd. 8. [NONRESIDENT HEALTH CARE PROVIDER.] "Nonresident health care provider" means a health care provider that is not a resident health care provider.

Subd. 9. [NONRESIDENT HOSPITAL.] "Nonresident hospital" means a hospital physically located outside Minnesota.

Subd. 10. [PHARMACY.] "Pharmacy" means a pharmacy, as defined in section 151.01, if the only goods or services the pharmacy sells that qualify for reimbursement under the medical assistance program under chapter 256B are drugs and prosthetics.

Subd. 11. [RESIDENT HEALTH CARE PROVIDER.] "Resident health care provider" means a health care provider whose principal place of dispensing health care is in Minnesota.

Subd. 12. [RESIDENT HOSPITAL.] "Resident hospital" means a hospital physically located inside Minnesota.

Subd. 13. [SURGICAL CENTER.] "Surgical center" is an outpatient surgical center as defined in Minnesota Rules, chapter 4675 or a similar facility located in any other state or province or territory of Canada.

Subd. 14. [WHOLESALE DRUG DISTRIBUTOR.] "Wholesale drug distributor" means a wholesale drug distributor required to be licensed under sections 151.42 to 151.51.

Sec. 4. [295.51] [MINIMUM CONTACTS REQUIRED FOR JURISDICTION TO TAX GROSS REVENUE.]

Subdivision 1. [BUSINESS TRANSACTIONS IN MINNESOTA.] A hospital or health care provider is subject to tax under sections 295.50 to 295.58 if it is "transacting business in Minnesota." A hospital or health care provider is transacting business in Minnesota only if it:

(1) maintains an office in Minnesota;

(2) has employees, representatives, or independent contractors conducting business in Minnesota;

(3) regularly sells covered services to customers that receive the covered services in Minnesota;

(4) regularly solicits business from potential customers in Minnesota;

(5) regularly performs services outside Minnesota the benefits of which are consumed in Minnesota;

(6) owns or leases tangible personal or real property physically located in Minnesota; or

(7) receives medical assistance payments from the state of Minnesota.

Subd. 2. [PRESUMPTION.] A hospital or health care provider is presumed to regularly solicit business within Minnesota if it receives gross receipts for covered services from 20 or more patients domiciled in Minnesota in a calendar year.

Sec. 5. [295.52] [TAXES IMPOSED.]

Subdivision 1. [HOSPITAL TAX.] A tax is imposed on each hospital equal to two percent of its gross revenues.

Subd. 2. [PROVIDER TAX.] A tax is imposed on each health care provider equal to two percent of its gross revenues.

Subd. 3. [WHOLESALE DRUG DISTRIBUTOR TAX.] A tax is imposed on each wholesale drug distributor equal to two percent of its gross revenues.

Subd. 4. [USE TAX; PRESCRIPTION DRUGS.] A person that receives prescription drugs for resale or use in Minnesota, other than from a wholesale drug distributor that paid the tax under subdivision 3, is subject to a tax equal to two percent of the price paid. Liability for the tax is incurred when prescription drugs are received in Minnesota by the person.

Sec. 6. [295.53] [EXEMPTIONS; SPECIAL RULES.]

Subdivision 1. [EXEMPTIONS.] The following payments are excluded from the gross revenues subject to the hospital or health care provider taxes under sections 295.50 to 295.57:

(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 services performed by a nursing home licensed under chapter 144A, services provided in an intermediate care facility for persons with mental retardation, and home health care services;

(4) payments received from hospitals for services that are subject to tax under section 295.52;

(5) payments received from health care providers for services that are subject to tax under section 295.52;

(6) amounts paid for prescription drugs to a wholesale drug distributor reduced by reimbursements received for prescription drugs under clauses (1), (2), (7), and (8);

(7) payments received under the general assistance medical care program; and

(8) payments received for providing services under the health right program under article 4.

Subd. 2. [DEDUCTIONS FOR HMOS.] (a) In addition to the exemptions allowed under subdivision 1, a health maintenance organization may deduct from its gross revenues for the year:

(1) amounts added to reserves, if total reserves do not exceed 25 percent of gross revenues for the prior year;

(2) assessments for the comprehensive health insurance plan under section 62E.11 paid during the year; and

(3) an allowance for administration and underwriting.

(b) The commissioner of commerce, in consultation with the commissioners of health and revenue, shall establish by rule under chapter 14 the percentage of health maintenance revenue that will be allowed as a deduction for administrative and underwriting expenses. The commissioner of commerce shall determine the percentage allowance based on the average expenses of health maintenance organizations 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, and

do not include costs deductible under paragraph (a), clauses (1) and (2). The commissioner of commerce may adopt emergency rules.

Subd. 3. [RESTRICTION ON ITEMIZATION.] A hospital or health care provider must not separately state the tax obligation under section 295.52 on bills provided to individual patients.

Sec. 7. [295.54] [CREDIT FOR TAXES PAID TO ANOTHER STATE.]

A resident hospital or resident health care provider who is liable for taxes payable to another state or province or territory of Canada measured by gross receipts and is subject to tax under section 295.52 is entitled to a credit for the tax paid to another state or province or territory of Canada to the extent of the lesser of (1) the tax actually paid to the other state or province or territory of Canada, or (2) the amount of tax imposed by Minnesota on the gross receipts subject to tax in the other taxing jurisdictions.

Sec. 8. [295.55] [PAYMENT OF TAX.]

Subdivision 1. [SCOPE.] The provisions of this section apply to the taxes imposed under sections 295.50 to 295.58.

Subd. 2. [ESTIMATED TAX; HOSPITALS.] (a) Each hospital must make estimated payments of the taxes for the calendar year in monthly installments to the commissioner within ten days after the end of the month.

(b) Estimated tax payments are not required if the tax for the calendar year is less than $500 or if the hospital has been allowed a grant under section 144.1484, subdivision 2 for the year.

(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 the difference between the amount paid and the lesser of (1) 90 percent of one-twelfth of the tax for the calendar year or (2) the tax for the actual gross revenues received during the month.

Subd. 3. [ESTIMATED TAX; OTHER TAXPAYERS.] (a) Each taxpayer, other than a hospital, 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 the difference between the amount paid and the lesser of (1) 90 percent of one-quarter of the tax for the calendar year or (2) the tax for the actual gross revenues received during the quarter.

Subd. 4. [ELECTRONIC FUNDS TRANSFER PAYMENTS.] A taxpayer with an aggregate tax liability of $60,000 or more during a calendar quarter ending the last day of March, June, September, or December must thereafter remit all liabilities by means of a funds transfer as defined in section 336.4A-104, paragraph (a). The funds transfer payment date, as defined in section 336.4A-401, is on or before the date the tax is due. If the date the tax is due is not a funds-transfer business day, as defined in section 336.4A-105, paragraph (a), clause (4), the payment date is on or before the first funds-transfer business day after the date the tax is due.

Subd. 5. [ANNUAL RETURN.] The taxpayer must file an annual return reconciling the quarterly estimated payments by March 15 of the following calendar year.

Subd. 6. [FORM OF RETURNS.] The estimated payments and annual return must contain the information and be in the form prescribed by the commissioner.

Sec. 9. [295.57] [COLLECTION AND ENFORCEMENT; RULEMAKING; APPLICATION OF OTHER CHAPTERS.]

Unless specifically provided by sections 295.50 to 295.58, the enforcement, interest, and penalty provisions under chapter 294, appeal and criminal penalty provisions under chapter 289A, and collection and rulemaking provisions under chapter 270, apply to a liability for the taxes imposed under sections 295.50 to 295.58.

Sec. 10. [295.58] [DEPOSIT OF REVENUES.]

The commissioner shall deposit all revenues, including penalties and interest, derived from the taxes imposed by sections 295.50 to 295.57 in the health care access account in the general fund.

Sec. 11. [295.59] [SEVERABILITY.]

If any section, subdivision, clause, or phrase of sections 295.50 to 295.58 is for any reason held to be unconstitutional or in violation of federal law, the decision shall not affect the validity of the remaining portions of sections 295.50 to 295.58. The legislature declares that it would have passed sections 295.50 to 295.58 and each section, subdivision, sentence, clause, and phrase thereof, irrespective of the

fact that any one or more sections, subdivisions, sentences, clauses, or phrases is declared unconstitutional.

Sec. 12. 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. 13. Minnesota Statutes 1991 Supplement, section 297.03, subdivision 5, is amended to read:

Subd. 5. [SALE OF STAMPS.] The commissioner shall sell stamps to any person licensed as a distributor at a discount of ~~1.1~~ 1.0 percent from the face amount of the stamps for the first $1,500,000 of such stamps purchased in any fiscal year; and at a discount of ~~.65~~ .60 percent on the remainder of such stamps purchased in any fiscal year. The commissioner shall not sell stamps to any other person. The commissioner may prescribe the method of shipment of the stamps to the distributor as well as the quantities of stamps purchased.

Sec. 14. [FLOOR STOCKS TAX.]

Subdivision 1. [CIGARETTES.] A floor stocks tax is imposed on every person engaged in business in this state as a distributor, retailer, subjobber, vendor, manufacturer, or manufacturer's representative of cigarettes, on the stamped cigarettes in the person's possession or under the person's control at 12:01 a.m. on July 1, 1992. The tax is imposed at the following rates, subject to the discounts in section 297.03:

(1) on cigarettes weighing not more than three pounds a thousand, 2.5 mills on each cigarette; and

(2) on cigarettes weighing more than three pounds a thousand, five mills on each cigarette.

Each distributor, by July 8, 1992, shall file a report with the commissioner, in the form the commissioner prescribes, showing the cigarettes on hand at 12:01 a.m. on July 1, 1992, and the amount of

tax due on the cigarettes. The tax imposed by this section is due and payable by August 1, 1992, and after that date bears interest at the rate of one percent a month.

Each retailer, subjobber, vendor, manufacturer, or manufacturer's representative shall file a return with the commissioner, in the form the commissioner prescribes, showing the cigarettes on hand at 12:01 a.m. on July 1, 1992, and pay the tax due thereon by August 1, 1992. Tax not paid by the due date bears interest at the rate of one percent a month.

Subd. 2. [AUDIT AND ENFORCEMENT.] The tax imposed by this section is subject to the audit, assessment, and collection provisions applicable to the taxes imposed under chapter 297C. The commissioner may require a distributor to receive and maintain copies of floor stock tax returns filed by all persons requesting a credit for returned cigarettes.

Subd. 3. [DEPOSIT OF PROCEEDS.] The revenue from the tax imposed under this section shall be deposited by the commissioner in the state treasury and credited to the health care access account in the general fund.

Sec. 15. [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, sections 297.01 to 297.13.

This section expires June 30, 1994.

Sec. 16. [TRANSITION PROVISION; HOSPITAL TAX.]

For gross revenues taxable under section 5, subdivision 1, for calendar year 1993, the exclusions under section 6, subdivision 1, clauses (5) and (6) do not apply.

Sec. 17. [EFFECTIVE DATE.]

Section 2 is effective for taxable years beginning after December 31, 1992. Section 5, subdivision 1, is effective for gross revenues generated by services performed and goods sold after December 31, 1992. Section 5, subdivisions 2 to 4, are effective for gross revenues

generated by services performed and goods sold after December 31, 1993. Sections 12 and 13 are effective July 1, 1992. Section 14 is effective the day following final enactment."

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the second portion of the remaining portion of the Ogren et al amendment, as amended, and the roll was called. There were 42 yeas and 91 nays as follows:

Those who voted in the affirmative were:

Anderson, R. H.	Gruenes	Lynch	Onnen	Vanasek
Begich	Hanson	Macklin	Ozment	Vellenga
Bishop	Heir	McGuire	Pauly	Wagenius
Blatz	Henry	McPherson	Runbeck	Weaver
Carruthers	Hufnagle	Nelson, K.	Schreiber	Welle
Dempsey	Jacobs	Newinski	Seaberg	Spk. Long
Dille	Kelso	Ogren	Skoglund	
Garcia	Krambeer	Olsen, S.	Stanius	
Greenfield	Lourey	Olson, E.	Valento	

Those who voted in the negative were:

Anderson, I.	Frederick	Kinkel	Omann	Solberg
Anderson, R.	Frerichs	Knickerbocker	Orenstein	Sparby
Battaglia	Girard	Koppendrayer	Orfield	Steensma
Bauerly	Goodno	Krinkie	Osthoff	Sviggum
Beard	Gutknecht	Krueger	Ostrom	Swenson
Bertram	Hartle	Lasley	Pellow	Thompson
Bettermann	Hasskamp	Leppik	Pelowski	Tompkins
Bodahl	Haukoos	Lieder	Peterson	Trimble
Boo	Hausman	Limmer	Pugh	Tunheim
Brown	Hugoson	Mariani	Reding	Uphus
Carlson	Janezich	Marsh	Rest	Waltman
Clark	Jaros	McEachern	Rice	Wejcman
Cooper	Jefferson	Milbert	Rodosovich	Welker
Dauner	Jennings	Morrison	Rukavina	Wenzel
Davids	Johnson, A.	Munger	Sarna	Winter
Dawkins	Johnson, R.	Murphy	Schafer	
Dorn	Johnson, V.	Nelson, S.	Segal	
Erhardt	Kahn	O'Connor	Simoneau	
Farrell	Kalis	Olson, K.	Smith	

The motion did not prevail and the second portion of the remaining portion of the Ogren et al amendment, as amended, was not adopted.

Ogren withdrew the remaining portion of the Ogren et al amendment, as amended, to H. F. No. 2800, the third engrossment, as amended.

Krueger moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 7, line 27, delete "26" and insert "27"

Page 8, after line 25, insert:

"(g) [MEDICAL TECHNOLOGY INDUSTRY.] The commission includes one member appointed by the Medical Alley Association."

Page 8, line 26, delete "(g)" and insert "(h)"

Page 8, line 29, delete "(h)" and insert "(i)"

The motion prevailed and the amendment was adopted.

Anderson, I., moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 95, line 14, delete "90" and insert "45"

The motion prevailed and the amendment was adopted.

The Speaker called Krueger to the Chair.

Anderson, R.; Sparby; Goodno and Dauner moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 102, line 12, delete everything after the period and insert "For purposes of this section, a "permanent Minnesota resident" is a person living in the state with the intention of making his or her home here and not for any temporary purpose. All applicants for subsidized premiums will be required to demonstrate the requisite intent and can do so in any of the following ways:

(1) by showing that the applicant maintains a residence at a verified address, other than a place of public accommodation. An applicant may verify a residence address by presenting a valid state driver's license, a state identification card, a voter registration card, a rent receipt, a statement by the landlord, apartment manager, or homeowner verifying that the individual is residing at the address, or other form of verification approved by the commissioner;

(2) by providing written documentation that the applicant came to the state in response to an offer of employment;

(3) by providing verification that the applicant has been a long-time resident of the state or was formerly a resident of the state for

at least 365 days and is returning to the state from a temporary absence; or

(4) by providing other persuasive evidence to show that the applicant is a resident of the state."

Page 102, delete lines 13 to 20

The motion prevailed and the amendment was adopted.

Jefferson; Johnson, A.; Winter; Bertram; Welker; Carruthers; Lourey; Sparby and Anderson, I., moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 7, line 27, delete "26" and insert "27"

Page 7, line 36, delete "seven" and insert "eight"

Page 8, line 7, after the comma insert "one member appointed by the Minnesota Chiropractic Association,"

Page 8, line 10, after "physicians," insert "chiropractors,"

Page 126, line 7, delete "physicians" and insert "health care providers"

Page 129, line 4, after "association" insert ", Minnesota Chiropractic Association or appropriate health licensing board" and after "specific" delete "medical" and insert "health care"

Page 129, lines 5 and 8, delete "medical"

Page 129, line 7, after "association" insert ", Minnesota Chiropractic Association or appropriate health licensing board"

Page 129, line 11, delete "medical" in both places

Page 129, lines 13, 18, and 25, delete "medical"

Page 129, lines 14 and 19, delete "medically"

Page 129, line 24, delete "physicians, other"

The motion prevailed and the amendment was adopted.

Cooper, Dorn, Jennings, Pelowski and Anderson, R., moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 104, line 23, before "A" insert "Subdivision 1. [PARTICIPATION REQUIREMENT.]"

Page 105, after line 10, insert:

"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 significantly 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."

A roll call was requested and properly seconded.

The question was taken on the Cooper et al amendment and the roll was called. There were 46 yeas and 84 nays as follows:

Those who voted in the affirmative were:

Abrams	Dorn	Henry	Ostrom	Sviggum
Anderson, R.	Erhardt	Hugoson	Pauly	Swenson
Bertram	Frederick	Jennings	Pelowski	Thompson
Bettermann	Frerichs	Kinkel	Peterson	Uphus
Boo	Girard	Knickerbocker	Pugh	Waltman
Brown	Goodno	Krinkie	Rodosovich	Welker
Cooper	Gutknecht	McPherson	Schafer	
Dauner	Hartle	Morrison	Segal	
Davids	Hasskamp	Onnen	Smith	
Dille	Heir	Orenstein	Sparby	

Those who voted in the negative were:

Anderson, I.	Gruenes	Leppik	Ogren	Skoglund
Anderson, R. H.	Hanson	Lieder	Olsen, S.	Solberg
Battaglia	Haukoos	Limmer	Olson, E.	Stanius
Bauerly	Hausman	Lourey	Olson, K.	Tompkins
Beard	Hufnagle	Lynch	Omann	Trimble
Begich	Jacobs	Macklin	Orfield	Tunheim
Bishop	Janezich	Mariani	Osthoff	Valento
Blatz	Jefferson	Marsh	Ozment	Vanasek
Bodahl	Johnson, A.	McEachern	Pellow	Vellenga
Carlson	Johnson, R.	McGuire	Reding	Wagenius
Carruthers	Johnson, V.	Milbert	Rest	Weaver
Clark	Kahn	Munger	Rice	Wejcman
Dawkins	Kelso	Murphy	Runbeck	Welle
Dempsey	Koppendrayer	Nelson, K.	Sarna	Wenzel
Farrell	Krambeer	Nelson, S.	Schreiber	Winter
Garcia	Krueger	Newinski	Seaberg	Spk. Long
Greenfield	Lasley	O'Connor	Simoneau	

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

Clark; Murphy; Hausman; Brown; Orenstein; Vellenga; Pauly; Kalis; Morrison; Rodosovich; Trimble; Mariani; Winter; Gruenes; Blatz; Munger; Wejcman; Olson, K.; Cooper; Peterson; Nelson, K.; Sarna; Sparby; Jaros; Orfield; Garcia; Farrell; Lourey; Wagenius; Steensma; Olsen, S.; Solberg; Anderson, R.; Henry; Jefferson; Ogren; Bettermann; Osthoff and Greenfield moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 7, line 27, delete "26" and insert "29"

Page 7, line 36, delete "seven" and insert "eight"

Page 8, line 7, delete "one member" and insert "two members"

Page 8, line 8, after the comma insert "one of whom practices in a rural area of the state and one of whom practices in an urban area,"

Page 8, delete lines 16 to 21 and insert:

"(e) [CONSUMERS.] The commission includes six consumer members with no financial interest in the health care system, including representatives of low-income persons, communities of color, and seniors. Three of the consumer members must be appointed by the governor. Three members must be appointed jointly under the rules of the house and the rules of the senate."

Correct internal references

The motion prevailed and the amendment was adopted.

Lourey and Ostrom moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 107, after line 2, insert:

"Sec. 3. [62A.65] [PARTICIPATING PROVIDERS.]

Subdivision 1. [HEALTH PLAN COMPANY.] For purposes of this section, "health plan company" means any entity governed by chapter 62A, 62C, 62D, 62E, 62H, or 64B, or section 471.617, subdivision 2, that offers, sells, issues, or renews health coverage in this state. Health plan company does not include an entity that sells only policies designed primarily to provide coverage on a per diem, fixed indemnity, or nonexpense-incurred basis, or policies that provide only accident coverage.

Subd. 2. [ACCEPTANCE AS PARTICIPATING PROVIDER.] A health plan company shall not exclude, as a participating provider, a physician who is licensed under chapter 147 and meets the requirements of section 147.02, subdivision 1, paragraph (b), solely because the physician has not completed a full residency or is not board certified, if:

(1) the physician meets all other requirements for serving as a participating provider;

(2) the physician has completed a minimum of two years residency in any specialty;

(3) the physician has not been disciplined by the board of medical practice under section 147.091;

(4) the physician is credentialed by and has staff privileges at a hospital, or is employed by a medical clinic, located in an area designated by the federal government as either a health personnel shortage area or a medically underserved area;

(5) the medical clinic at which the physician practices was part of the provider network of a health plan company, and that health plan company provides health care services to a significant number of persons residing in the community in which the medical clinic is located, many of whom had formerly received services at the medical clinic; and

(6) the medical clinic and the hospital at which the physician has staff privileges are the only providers of 24-hour emergency services in the county."

Page 115, after line 11, insert:

"Sec. 14. [REPEALER.]

Section 3 expires July 1, 1995, or one year after the date upon which a Minnesota program, established to conduct quality assurance and certification activities related to the participation of rural family practice physicians in health plan company provider networks, becomes operational, whichever occurs first."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Swenson, Greenfield and Gruenes moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 31, line 23, after the period insert "Where an association, described in section 62A.10, subdivision 1, comprised of employers contracts with a health carrier to provide coverage to its members who are small employers, the association may elect to be considered to be a small employer, even though the association provides coverage to more than 29 employees of its members, so long as each employer that is provided coverage through the association qualifies as a small employer. An association's election to be considered a small employer under this section is not effective unless filed with the commissioner of commerce. The association may revoke its election at any time by filing notice of revocation with the commissioner."

The motion prevailed and the amendment was adopted.

Sviggum moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

STATE AGENCY INITIATIVES

Section 1. [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 arrangements 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. 2. [62J.27] [MALPRACTICE PROTECTION FOR PROVIDERS.]

(a) The commissioner of health, after receiving the advice 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. 3. [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.

Sec. 4. [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.

Sec. 5. [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.

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 require-

ments 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. [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. 2. 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. 3. 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. 4. 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. 5. 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. 6. 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. 7. 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. 8. [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. 9. [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. 10. [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. 11. [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. 12. 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 healthy lifestyle behaviors, including but not limited to, refraining from the use of tobacco. Premium reductions must be actuarially valid and must relate only to those healthy lifestyle behaviors that have a proven positive impact on health. Factors used by the health carrier making this premium reduction must be filed with and approved by the commissioner of commerce.

Sec. 13. [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. 14. 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. 15. 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. 16. 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. 17. 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. 18. [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. 19. 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. 20. [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. 21. [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. 22. [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. 23. [REPEALER.]

Minnesota Statutes 1990, sections 62A.02, subdivisions 4 and 5; 62E.51; 62E.52; 62E.53; 62E.54; and 62E.55, are repealed.

Sec. 24. [EFFECTIVE DATE.]

Section 12 is effective July 30, 1992. Sections 1 to 8, 10, 11, 13, 18 and 23 are effective July 1, 1993. Sections 20, 21, and 22 are effective the day following final enactment.

ARTICLE 4

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.]

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.

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 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. 11. 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. 12. [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 coun-

cil, 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. 13. [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. 14. [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 5

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 appli-

cants 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 forgive-

ness 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 appropri-

ate 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 residency 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 6

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 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 param-

eters, 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. Upon the request of the commissioner or the data analysis unit, 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 failure to provide the health care analysis unit with data as required under this article.

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 7

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 8

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 9

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(l) of the Internal Revenue Code or excluded from income or (B) the total amount deductible for medical care under section 213(a).

Sec. 3. 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. 4. Minnesota Statutes 1990, section 297.13, is amended by adding a subdivision to read:

Subd. 8. [HEALTH CARE ACCESS.] Notwithstanding the provisions of subdivision 1, 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. Revenue includes revenue from the tax, interest, and penalties.

Sec. 5. [EFFECTIVE DATE.]

Section 2 is effective for taxable years beginning after December 31, 1991. Section 3 is effective for cigarettes sold or possessed after June 30, 1992.

ARTICLE 10

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. Higher Education Coordinating Board	166,000
Subd. 5. Board of Regents of the University of Minnesota	2,200,000
Subd. 6. Commissioner of Revenue	350,000
Subd. 7. Administration	514,000"

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Sviggum amendment and the roll was called. There were 52 yeas and 82 nays as follows:

Those who voted in the affirmative were:

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

Those who voted in the negative were:

Anderson, I.	Beard	Boo	Clark	Dempsey
Anderson, R.	Begich	Brown	Cooper	Dorn
Battaglia	Bishop	Carlson	Dauner	Farrell
Bauerly	Bodahl	Carruthers	Dawkins	Garcia

Greenfield	Kelso	Nelson, S.	Rest	Trimble
Gruenes	Kinkel	O'Connor	Rice	Tunheim
Hanson	Krueger	Ogren	Rodosovich	Vanasek
Hasskamp	Lasley	Olson, E.	Rukavina	Vellenga
Hausman	Lieder	Olson, K.	Sarna	Wagenius
Jacobs	Lourey	Orenstein	Segal	Wejcman
Janezich	Mariani	Orfield	Simoneau	Welle
Jaros	McEachern	Osthoff	Skoglund	Wenzel
Jefferson	McGuire	Ostrom	Solberg	Winter
Johnson, A.	Milbert	Ozment	Sparby	Spk. Long
Johnson, R.	Munger	Peterson	Stanius	
Kahn	Murphy	Pugh	Steensma	
Kalis	Nelson, K.	Reding	Thompson	

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

The Speaker resumed the Chair.

Skoglund; Winter; Nelson, S.; Knickerbocker; Bishop; Jennings; Uphus; Dawkins; Greenfield; Gruenes; Abrams; Hasskamp; Carruthers; Orenstein; Hausman; Ogren; Swenson; Clark; Lynch; Segal; Rodosovich; Bertram; Hanson; Munger; Mariani; Hartle; Anderson, R.; Macklin; Cooper; Wagenius; Dille; Ozment; Sparby; Wejcman; Kinkel; Reding; Thompson; Dauner; McGuire; Steensma and Farrell moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 78, line 9, after the period insert "The loss ratios required by this section for coverage sold in the small employer market also apply to all individual and group policies described in section 62A.135."

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 Skoglund et al amendment and the roll was called. There were 95 yeas and 37 nays as follows:

Those who voted in the affirmative were:

Abrams	Begich	Carlson	Dille	Greenfield
Anderson, I.	Bertram	Carruthers	Dorn	Gruenes
Anderson, R.	Bishop	Clark	Farrell	Hanson
Battaglia	Blatz	Cooper	Garcia	Hartle
Bauerly	Bodahl	Dauner	Girard	Hausman
Beard	Brown	Dawkins	Goodno	Hugoson

Jacobs	Krueger	Murphy	Peterson	Sparby
Janezich	Lasley	Nelson, K.	Pugh	Steensma
Jaros	Leppik	Nelson, S.	Reding	Swenson
Jefferson	Lieder	Ogren	Rest	Thompson
Johnson, A.	Limmer	Olsen, S.	Rice	Trimble
Johnson, R.	Lourey	Olson, E.	Rodosovich	Tunheim
Kahn	Lynch	Olson, K.	Rukavina	Vellenga
Kalis	Macklin	Omann	Sarna	Wagenius
Kelso	Mariani	Orenstein	Segal	Wejcman
Kinkel	McEachern	Orfield	Simoneau	Welle
Knickerbocker	McGuire	Ostrom	Skoglund	Wenzel
Koppendrayer	Milbert	Pauly	Smith	Winter
Krambeer	Munger	Pelowski	Solberg	Spk. Long

Those who voted in the negative were:

Anderson, R. H.	Gutknecht	Marsh	Pellow	Uphus
Bettermann	Haukoos	McPherson	Runbeck	Valento
Boo	Heir	Morrison	Schafer	Waltman
Davids	Henry	Newinski	Schreiber	Weaver
Dempsey	Hufnagle	O'Connor	Seaberg	Welker
Erhardt	Jennings	Onnen	Stanius	
Frederick	Johnson, V.	Osthoff	Sviggum	
Frerichs	Krinkie	Ozment	Tompkins	

The motion prevailed and the amendment was adopted.

Olsen, S., moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 102, line 25, delete "four" and insert "12"

A roll call was requested and properly seconded.

The question was taken on the Olsen, S., amendment and the roll was called. There were 14 yeas and 118 nays as follows:

Those who voted in the affirmative were:

Anderson, R. H.	Erhardt	Limmer	Onnen	Uphus
Boo	Knickerbocker	McPherson	Schreiber	Welker
Dempsey	Krinkie	Olsen, S.	Smith	

Those who voted in the negative were:

Abrams	Brown	Frerichs	Heir	Kahn
Anderson, I.	Carlson	Garcia	Henry	Kalis
Anderson, R.	Carruthers	Girard	Hufnagle	Kelso
Battaglia	Clark	Goodno	Hugoson	Kinkel
Bauerly	Cooper	Greenfield	Jacobs	Koppendrayer
Beard	Dauner	Gruenes	Janezich	Krambeer
Begich	Davids	Gutknecht	Jaros	Krueger
Bertram	Dawkins	Hanson	Jefferson	Lasley
Bettermann	Dille	Hartle	Jennings	Leppik
Bishop	Dorn	Hasskamp	Johnson, A.	Lieder
Blatz	Farrell	Haukoos	Johnson, R.	Lourey
Bodahl	Frederick	Hausman	Johnson, V.	Lynch

Macklin	Ogren	Peterson	Simoneau	Valento
Mariani	Olson, E.	Pugh	Skoglund	Vellenga
Marsh	Olson, K.	Reding	Solberg	Wagenius
McEachern	Omann	Rest	Sparby	Waltman
McGuire	Orenstein	Rice	Stanius	Weaver
Milbert	Orfield	Rodosovich	Steensma	Wejcman
Morrison	Osthoff	Rukavina	Sviggum	Welle
Munger	Ostrom	Runbeck	Swenson	Wenzel
Murphy	Ozment	Sarna	Thompson	Winter
Nelson, K.	Pauly	Schafer	Tompkins	Spk. Long
Nelson, S.	Pellow	Seaberg	Trimble	
Newinski	Pelowski	Segal	Tunheim	

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

Onnen moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 21, delete lines 21 to 31

Renumber the sections in sequence

A roll call was requested and properly seconded.

The question was taken on the Onnen amendment and the roll was called. There were 50 yeas and 82 nays as follows:

Those who voted in the affirmative were:

Abrams	Davids	Heir	Marsh	Seaberg
Anderson, R.	Dille	Henry	McPherson	Smith
Anderson, R. H.	Erhardt	Hufnagle	Morrison	Sviggum
Bertram	Frederick	Hugoson	Onnen	Swenson
Bettermann	Frerichs	Johnson, R.	Ozment	Tompkins
Blatz	Girard	Kalis	Pauly	Uphus
Boo	Goodno	Knickerbocker	Pellow	Valento
Brown	Gutknecht	Krinkie	Peterson	Waltman
Cooper	Hartle	Limmer	Runbeck	Weaver
Dauner	Haukoos	Lynch	Schafer	Welker

Those who voted in the negative were:

Anderson, I.	Gruenes	Krambeer	Newinski	Rice
Battaglia	Hanson	Krueger	O'Connor	Rodosovich
Bauerly	Hasskamp	Lasley	Ogren	Rukavina
Beard	Hausman	Leppik	Olsen, S.	Sarna
Begich	Jacobs	Lieder	Olson, E.	Segal
Bishop	Janezich	Lourey	Olson, K.	Simoneau
Bodahl	Jaros	Macklin	Omann	Skoglund
Carlson	Jefferson	Mariani	Orenstein	Solberg
Carruthers	Jennings	McEachern	Orfield	Sparby
Clark	Johnson, A.	McGuire	Osthoff	Stanius
Dawkins	Johnson, V.	Milbert	Ostrom	Steensma
Dorn	Kahn	Munger	Pelowski	Thompson
Farrell	Kelso	Murphy	Pugh	Trimble
Garcia	Kinkel	Nelson, K.	Reding	Tunheim
Greenfield	Koppendrayer	Nelson, S.	Rest	Vanasek

Vellenga	Wejcman	Wenzel	Spk. Long
Wagenius	Welle	Winter	

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

Davids and Swenson moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Pages 65 to 72, delete sections 1 to 4

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 Davids and Swenson amendment and the roll was called. There were 34 yeas and 95 nays as follows:

Those who voted in the affirmative were:

Abrams	Dempsey	Hufnagle	Olsen, S.	Swenson
Anderson, R. H.	Erhardt	Johnson, V.	Pellow	Tompkins
Bauerly	Frerichs	Krambeer	Runbeck	Valento
Bettermann	Girard	Krinkie	Schafer	Waltman
Blatz	Goodno	Lynch	Seaberg	Weaver
Boo	Gutknecht	McPherson	Smith	Welker
Davids	Haukoos	Newinski	Sviggum	

Those who voted in the negative were:

Anderson, I.	Greenfield	Koppendrayer	Ogren	Segal
Anderson, R.	Gruenes	Krueger	Olson, E.	Simoneau
Battaglia	Hanson	Lasley	Olson, K.	Skoglund
Beard	Hartle	Leppik	Omann	Solberg
Begich	Hasskamp	Lieder	Onnen	Sparby
Bertram	Hausman	Limmer	Orenstein	Stanius
Bishop	Henry	Lourey	Orfield	Steensma
Bodahl	Hugoson	Macklin	Ostrom	Thompson
Brown	Jacobs	Mariani	Ozment	Trimble
Carlson	Janezich	Marsh	Pauly	Tunheim
Carruthers	Jaros	McEachern	Pelowski	Uphus
Clark	Jefferson	McGuire	Peterson	Vanasek
Cooper	Jennings	Milbert	Pugh	Vellenga
Dauner	Johnson, A.	Morrison	Reding	Wagenius
Dawkins	Johnson, R.	Munger	Rest	Wejcman
Dorn	Kahn	Murphy	Rice	Welle
Farrell	Kalis	Nelson, K.	Rodosovich	Wenzel
Frederick	Kelso	Nelson, S.	Rukavina	Winter
Garcia	Kinkel	O'Connor	Sarna	Spk. Long

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

Leppik moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 21, delete lines 33 to 36

Page 22, delete lines 1 to 9 and insert:

"Subdivision 1. [ESTABLISHMENT OF PRACTICE PARAMETERS.] The commissioner of health, after receiving the advice and recommendations of the Minnesota health care commission, may through rulemaking under chapter 14 establish medical practice parameters to minimize unnecessary, unproven, or ineffective care. Such rules must be supported by medical literature and appropriate control studies and be recommended by the health care commission.

Subd. 2. [MEDICAL NEGLIGENCE CASES.] (a) In a negligence action against a health care professional, as defined in section 145.61 for malpractice, error, mistake or failure to cure, whether based on contract or tort, adherence to a practice parameter established by the commissioner of health is an absolute defense against an allegation that the health care professional did not comply with the standard of care of practice in the community, except that a failure on the part of a health care professional to properly provide the services established by the practice parameter is not entitled to such defense.

(b) Evidence of a departure from a practice parameter is admissible only on the issue of whether the provider is entitled to an absolute defense under paragraph (a).

(c) Paragraphs (a) and (b) apply to claims arising on or after August 1, 1993, or 90 days after the effective date of rules adopted by the commissioner establishing the applicable practice parameter, whichever is later."

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

Leppik and Hasskamp moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 1, line 14 of the Clark et al amendment, before the period insert ", including one biomedical moral ethicist"

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

Sviggum moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 43, delete lines 6 to 21 and insert:

"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 any two regions by more than twenty 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) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;

(3) if one geographic region is rural, the index rate for the rural region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area;

(4) 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."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Kahn; Vellenga; Osthoff; Hausman; Jaros; Bishop; Segal; Munger; Clark; Wagenius; Orenstein; Johnson, A.; Simoneau; Wejcman; Trimble; Leppik and Skoglund moved to amend H. F. No. 2800, the third engrossment, as amended, as follows:

Page 15, after line 3, insert:

"Sec. 7. [RU-486 STUDY.]

The commissioner of health, in consultation with the Minnesota health care commission, shall work to encourage the appropriate federal agencies to study the effectiveness and cost containment

implications of RU-486 as a family planning and birth control alternative and its possible use in treating breast, prostate, and ovarian cancer, brain tumors, endometriosis, and other hormonal diseases. The commissioner shall also encourage the federal Food and Drug Administration to rescind the ban on the importation of RU-486."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

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

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; transferring authority for regulation of health maintenance organizations from the commissioner of health to the commissioner of commerce; giving the commissioner of health certain duties; 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; 60B.03, subdivision 2; 60B.15; 60B.20; 62A.02, subdivisions 1, 2, 3, and by adding subdivisions; 62D.01, subdivision 2; 62D.02, subdivision 3, and by adding a subdivision; 62D.03; 62D.04; 62D.05, subdivision 6; 62D.06, subdivision 2; 62D.07, subdivisions 2, 3, and 10; 62D.08; 62D.09, subdivisions 1 and 8; 62D.10, subdivision 4; 62D.11; 62D.12, subdivisions 1, 2, and 9; 62D.121, subdivisions 2, 3a, 4, 5, and 7; 62D.14; 62D.15; 62D.16; 62D.17; 62D.18; 62D.19; 62D.20, subdivision 1; 62D.21; 62D.211; 62D.22, subdivision 10; 62D.24; and 62D.30, subdivisions 1 and 3; 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; 144.699, subdivision 2; 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; 290.06, by adding a subdivision; 290.62; and 447.31, subdivisions 1 and 3; Minnesota Statutes 1991 Supplement, sections 62A.31, subdivision 1; 62D.122; 145.61, subdivision 5; 145.64, subdivision 2; 256.936, subdivision 5; and 297.02, subdivision 1; 297.03, subdivision 5; proposing coding for new law in Minnesota Statutes, chapters 16A; 43A; 62A; 62E; 62J; 136A; 137; 144; 214; 256; 256B; 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; 62D.041, subdivision 4; 62D.042, subdivision 3; 62E.51; 62E.52; 62E.53; 62E.54; and 62E.55; Minnesota Statutes 1991 Supplement, section 43A.316, subdivisions 8 and 9.

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 76 yeas and 58 nays as follows:

Those who voted in the affirmative were:

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

Those who voted in the negative were:

Abrams	Goodno	Knickerbocker	Olsen, S.	Smith
Anderson, R. H.	Gutknecht	Koppendrayer	Omann	Sviggum
Bertram	Hartle	Krambeer	Onnen	Swenson
Bettermann	Haukoos	Krinkie	Ozment	Tompkins
Blatz	Heir	Leppik	Pauly	Uphus
Brown	Henry	Limmer	Pellow	Valento
Dauner	Hufnagle	Lynch	Pelowski	Vanasek
Davids	Hugoson	Macklin	Rodosovich	Waltman
Dille	Johnson, V.	Marsh	Runbeck	Weaver
Erhardt	Kalis	McPherson	Schafer	Welker
Frerichs	Kelso	Morrison	Schreiber	
Girard	Kinkel	Newinski	Seaberg	

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. 804, A bill for an act relating to transportation; making

technical and clarifying changes; defining terms; providing for maximum weight per inch of tire width; modifying axle weight limitations; providing for a comprehensive, coordinated public transit system; allowing commissioner of transportation to adopt rules assessing administrative penalties for violations of special transportation service standards; providing for regulation of motor vehicles having a gross vehicle weight of 10,000 pounds or more and operated by motor carriers; requiring certain carriers to comply with rules on driver qualifications and maximum hours of service after August 1, 1994; applying federal regulations on drug testing to intrastate motor carriers; regulating transportation of hazardous materials, substances, and waste; specifying identification information required on power units; authorizing small fee for motor carrier identification stamps; regulating building movers; authorizing release of criminal history data for purposes of special transportation license endorsements; amending Minnesota Statutes 1990, sections 169.825, subdivision 14; 174.23, by adding a subdivision; 174.30, subdivision 2; 221.011, subdivisions 20, 21, 25, and by adding a subdivision; 221.021; 221.031, as amended; 221.033, subdivisions 1, 2, and by adding a subdivision; 221.034, subdivisions 1 and 3; 221.035, subdivisions 1, 2, and by adding a subdivision; 221.121, subdivisions 1 and 7; 221.131, subdivisions 1, 2, and 6; 221.161, subdivision 1; 221.60, subdivision 2; 221.605, subdivision 1; and 221.81, subdivisions 2, 4, and by adding subdivisions; Minnesota Statutes 1991 Supplement, sections 169.781, subdivisions 1 and 5; 169.825, subdivisions 8 and 10; 169.86, subdivision 5; 221.025; and 364.09; proposing coding for new law in Minnesota Statutes, chapter 221.

Reported the same back with the following amendments:

Page 1, after line 38, insert:

"ARTICLE 1

MOTOR CARRIERS"

Page 13, delete section 7

Page 20, line 9, after "sod," insert "construction debris, and solid waste when transported by a transfer driver,"

Page 38, after line 15, insert:

"Sec. 39. [APPROPRIATION.]

$24,000 is appropriated to the commissioner of transportation from the trunk highway fund for fiscal year 1993. This appropriation is for the cost of rules authorized by this act."

Page 38, line 16, delete "39" and insert "40"

Page 38, line 17, before "Sections" insert "Sections 1 and 2 are effective the day following final enactment."

Page 38, after line 18, insert:

"ARTICLE 2

PERSONAL TRANSPORTATION SERVICES

Section 1. Minnesota Statutes 1990, section 168.011, is amended by adding a subdivision to read:

Subd. 36. [PERSONAL TRANSPORTATION SERVICE VEHICLE.] "Personal transportation service vehicle" is a passenger vehicle that has a seating capacity of up to six persons excluding the driver, or a van or station wagon with a seating capacity of up to 12 persons excluding the driver, that provides personal transportation service as defined in section 221.011, subdivision 33.

Sec. 2. [168.1281] [PERSONAL TRANSPORTATION SERVICE PLATES.]

Subdivision 1. [LICENSE PLATES.] A person who operates a personal transportation service vehicle shall apply to register the vehicle as provided in this section. The registrar shall issue personal transportation service plates on the applicant's compliance with laws relating to registration and licensing of motor vehicles and drivers, and certification by the owner that an insurance policy meeting the requirements of subdivision 2 is in effect for the entire period of registration. The applicant must provide the registrar with proof that the passenger automobile license tax and a $10 fee have been paid for each vehicle receiving personal transportation service license plates. The registrar shall design personal transportation service license plates so that the plates identify the vehicle as a personal transportation service vehicle, and clearly display the letters "LS." Personal transportation service license plates issued to a vehicle may not be transferred to another vehicle, except that they may be transferred to another personal transportation service vehicle owned by the same owner on notification to the registrar and payment of a $5 transfer fee.

Subd. 2. [INSURANCE.] An application under subdivision 1 must include a certificate of insurance that (1) verifies that a valid commercial insurance policy is in effect; and (2) gives the name of the insurance company and the number of the policy. The policy must provide stated limits of liability, exclusive of interest and costs, with respect to each vehicle for which coverage is granted, of (1) not less than $100,000 because of bodily injury to one person in any one

accident; (2) subject to the limit for one person, not less than $300,000 because of injury to two or more persons in any one accident; and (3) not less than $100,000 because of injury to or destruction of property. The insurance company must notify the commissioner if the policy is canceled or if the policy no longer provides the coverage required by this subdivision.

Subd. 3. [NOTIFICATION OF CANCELLATION.] The commissioner shall immediately notify the commissioner of transportation if the policy of a person required to have a permit under section 4 is canceled or no longer provides the coverage required by subdivision 2.

Sec. 3. Minnesota Statutes 1990, section 221.011, is amended by adding a subdivision to read:

Subd. 33. [PERSONAL TRANSPORTATION SERVICE.] "Personal transportation service" means service that:

(1) is not provided on a regular route;

(2) is provided in a personal transportation service vehicle as defined in section 168.011, subdivision 36;

(3) is not metered for the purpose of determining fares;

(4) provides prearranged pickup of passengers;

(5) charges more than a taxicab fare for a comparable trip.

Sec. 4. Minnesota Statutes 1991 Supplement, section 221.091, is amended to read:

221.091 [LIMITATIONS.]

No provision in sections 221.011 to 221.291 and 221.84 to 221.85 shall authorize the use by any carrier of any public highway in any city of the first class in violation of any charter provision or ordinance of such city in effect January 1, 1925, unless and except as such charter provisions or ordinance may be repealed after that date; nor shall sections 221.011 to 221.291 and 221.84 to 221.85 be construed as in any manner taking from or curtailing the right of any city to reasonably regulate or control the routing, parking, speed or the safety of operation of a motor vehicle operated by any carrier under the terms of those sections ~~221.011 to 221.291 and 221.84~~, or the general police power of any such city over its highways; nor shall sections 221.011 to 221.291 and 221.84 to 221.85 be construed as abrogating any provision of the charter of any such city requiring certain conditions to be complied with before such carrier can use the highways of such city and such rights and powers

herein stated are hereby expressly reserved and granted to such city; but no such city shall prohibit or deny the use of the public highways within its territorial boundaries by any such carrier for transportation of passengers or property received within its boundaries to destinations beyond such boundaries, or for transportation of passengers or property from points beyond such boundaries to destinations within the same, or for transportation of passengers or property from points beyond such boundaries through such municipality to points beyond the boundaries of such municipality, where such operation is pursuant to a certificate of convenience and necessity issued by the commission or to a permit issued by the commissioner under section 221.84 or 221.85.

Sec. 5. Minnesota Statutes 1991 Supplement, section 221.84, subdivision 2, is amended to read:

Subd. 2. [PERMIT REQUIRED; RULES.] No person may operate a for-hire limousine service without a permit from the commissioner. The commissioner shall adopt rules governing the issuance of permits for for-hire operation of limousines that include:

(1) annual inspections of limousines;

(2) driver qualifications, including requiring a criminal history check of drivers;

(3) insurance requirements ~~in accordance with section 168.128~~;

(4) advertising regulation, including requiring a copy of the permit to be carried in the limousine and use of the words "licensed and insured";

(5) provisions for agreements with political subdivisions for sharing enforcement costs;

(6) issuance of temporary permits and temporary permit fees; and

(7) other requirements deemed necessary by the commissioner.

This section does not apply to limousines operated by persons meeting the definition of private carrier in section 221.011, subdivision 26.

Sec. 6. [221.85] [PERSONAL TRANSPORTATION SERVICE.]

Subdivision 1. [PERMIT REQUIRED; RULES.] No person may provide personal transportation service for hire without having obtained a personal transportation service permit from the commissioner. The commissioner shall adopt rules governing the issuance of

permits and furnishing of personal transportation service. The rules must provide for:

(1) annual inspections of vehicles;

(2) driver qualifications including requiring a criminal history check of drivers;

(3) insurance requirements;

(4) advertising regulations, including requiring a copy of the permit to be carried in the personal transportation service vehicle and the use of the words "licensed and insured";

(5) agreements with political subdivisions for sharing enforcement costs with the state;

(6) issuance of temporary permits and fees therefor; and

(7) other requirements the commissioner deems necessary to carry out the purposes of this section.

Subd. 2. [PENALTIES.] The commissioner may issue an order requiring violations of law, rules, and local ordinances that govern the operation of personal transportation service vehicles to be corrected and assessing monetary penalties of up to $1,000. The commissioner may suspend or revoke a permit for violation of applicable law and rules and, on request of a political subdivision, may immediately suspend a permit for multiple violations of local ordinances. The commissioner shall immediately suspend a permit for failure to maintain required insurance and shall not restore the permit until proof of insurance is provided. A person whose permit is revoked or suspended or who is assessed an administrative penalty may appeal the commissioner's action in a contested case proceeding under chapter 14.

Subd. 3. [PERMITS; DECALS.] (a) The commissioner shall design a distinctive decal to be issued to permit holders under this section. A decal is valid for one year from the date of issuance. No person may provide personal transportation service in a personal transportation service vehicle that does not conspicuously display a decal issued under this subdivision.

(b) From August 1, 1992 to June 30, 1993, the fee for each decal issued under this section is $150. On and after July 1, 1993, the fee for each decal issued under this section is $80. The fee for each permit issued under this section is $150. The commissioner shall deposit all fees under this subdivision in the trunk highway fund.

Sec. 7. [TRANSITION.]

A person providing personal transportation service as defined in section 3, in a personal transportation service vehicle as defined in section 1, on August 1, 1992, may continue to provide personal transportation service in the vehicle without a permit under section 4, subdivision 1, until the effective date of the final rules adopted by the commissioner under that subdivision."

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 1313, A bill for an act relating to traffic regulations; authorizing the operation of recreational vehicle combinations with certain restrictions; amending Minnesota Statutes 1990, sections 169.01, by adding a subdivision; and 169.81, by adding a subdivision.

Reported the same back with the following amendments:

Pages 1 and 2, delete sections 2 and 3, and insert:

"Sec. 2. Minnesota Statutes 1990, section 169.86, is amended by adding a subdivision to read:

Subd. 1b. [RECREATIONAL COMBINATION.] The commissioner may issue a single trip permit or annual permit to permit the operation of a recreational vehicle combination on any highway in the state, except a highway where operation is prohibited by the permit. The permit must among other things require that:

(1) the combination not consist of more than three vehicles;

(2) the towing rating of the pickup truck is at least equal to the combined gross weight of all vehicles being towed;

(3) the total length of the combination not exceed 59 feet, and the length of the camper-trailer in the combination does not exceed 26 feet;

(4) the operator of the combination is at least 18 years of age;

(5) the trailers in the combination are connected to the pickup truck and to each other in conformity with section 169.82; and

(6) the trailer carrying a watercraft meets all requirements of law.

The permit may not authorize the combination to be operated within Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, or Washington county on Mondays through Fridays between the hours of 6:30 a.m. to 9:30 a.m. and 3:30 p.m. to 6:30 p.m.

Sec. 3. Minnesota Statutes 1991 Supplement, section 169.86, subdivision 5, is amended to read:

Subd. 5. [FEES.] The commissioner, with respect to highways under the commissioner's jurisdiction, may charge a fee for each permit issued. All such fees for permits issued by the commissioner of transportation shall be deposited in the state treasury and credited to the trunk highway fund. Except for those annual permits for which the permit fees are specified elsewhere in this chapter, the fees shall be:

(a) $15 for each single trip permit.

(b) $3 for each single trip permit for a recreational vehicle combination.

(c) $36 for each job permit. A job permit may be issued for like loads carried on a specific route for a period not to exceed two months. "Like loads" means loads of the same product, weight, and dimension.

~~(c)~~ (d) $60 for an annual permit to be issued for a period not to exceed 12 consecutive months. Annual permits may be issued for:

(1) refuse compactor vehicles that carry a gross weight up to but not in excess of 22,000 pounds on a single rear axle and not in excess of 38,000 pounds on a tandem rear axle;

(2) motor vehicles used to alleviate a temporary crisis adversely affecting the safety or well-being of the public;

(3) motor vehicles which travel on interstate highways and carry loads authorized under subdivision 1a;

(4) motor vehicles operating with gross weights authorized under section 169.825, subdivision 11, paragraph (a), clause (3); and

(5) special pulpwood vehicles described in section 169.863.

(e) $15 for an annual permit for a recreational vehicle combination.

~~(d)~~ (f) $120 for an oversize annual permit to be issued for a period not to exceed 12 consecutive months. Annual permits may be issued for:

(1) mobile cranes;

(2) construction equipment, machinery, and supplies;

(3) manufactured homes;

(4) farm equipment when the movement is not made according to the provisions of section 169.80, subdivision 1, paragraphs (a) to (f);

(5) double-deck buses;

(6) commercial boat hauling.

~~(e)~~ (g) For vehicles which have axle weights exceeding the weight limitations of section 169.825, an additional cost added to the fees listed above. The additional cost is equal to the product of the distance traveled times the sum of the overweight axle group cost factors shown in the following chart:

Overweight Axle Group Cost Factors

Weight (pounds) exceeding weight limitations on axles	Cost Per Mile For Each Group Of: Two consecutive axles spaced within 8 feet or less	Three consecutive axles spaced within 9 feet or less	Four consecutive axles spaced within 14 feet or less
0-2,000	.100	.040	.036
2,001-4,000	.124	.050	.044
4,001-6,000	.150	.062	.050
6,001-8,000	Not permitted	.078	.056
8,001-10,000	Not permitted	.094	.070
10,001-12,000	Not permitted	.116	.078
12,001-14,000	Not permitted	.140	.094
14,001-16,000	Not permitted	.168	.106
16,001-18,000	Not permitted	.200	.128
18,001-20,000	Not permitted	Not permitted	.140
20,001-22,000	Not permitted	Not permitted	.168

The amounts added are rounded to the nearest cent for each axle

or axle group. The additional cost does not apply to paragraph (c), clauses (1) and (3).

For a vehicle found to exceed the appropriate maximum permitted weight, a cost-per-mile fee of 22 cents per ton, or fraction of a ton, over the permitted maximum weight is imposed in addition to the normal permit fee. Miles must be calculated based on the distance already traveled in the state plus the distance from the point of detection to a transportation loading site or unloading site within the state or to the point of exit from the state.

~~(f)~~ (h) As an alternative to paragraph (e), an annual permit may be issued for overweight, or oversize and overweight, construction equipment, machinery, and supplies. The fees for the permit are as follows:

Gross Weight (pounds) of vehicle	Annual Permit Fee
90,000 or less	$200
90,001 – 100,000	$300
100,001 – 110,000	$400
110,001 – 120,000	$500
120,001 – 130,000	$600
130,001 – 140,000	$700
140,001 – 145,000	$800

If the gross weight of the vehicle is more than 145,000 pounds the permit fee is determined under paragraph (e).

~~(g)~~ (i) For vehicles which exceed the width limitations set forth in section 169.80 by more than 72 inches, an additional cost equal to $120 added to the amount in paragraph (a) when the permit is issued while seasonal load restrictions pursuant to section 169.87 are in effect."

Amend the title as follows:

Page 1, line 3, delete "with"

Page 1, line 4, delete "certain restrictions" and insert "by permit"

Page 1, delete line 6 and insert "169.86, by adding a subdivision; Minnesota Statutes 1991 Supplement, section 169.86, subdivision 5."

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 1985, A bill for an act relating to the environment; providing protection from liability for releases of hazardous substances to persons not otherwise liable who undertake and complete cleanup actions under an approved cleanup plan; providing for submission and approval of cleanup plans and supervision of cleanup by the commissioner of the pollution control agency; authorizing the commissioner of the pollution control agency to issue determinations or enter into agreements with property owners near the source of releases of hazardous substances regarding future cleanup liability; appropriating money; amending Minnesota Statutes 1990, section 115B.17, subdivision 14; proposing coding for new law in Minnesota Statutes, chapter 115B.

Reported the same back with the following amendments:

Page 7, line 18, delete ".." and insert "7"

Page 7, line 22, delete "$....." and insert "$545,000"

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2032, A bill for an act relating to highways; providing for resolution of local disapproval of certain county state-aid highway actions; expanding natural preservation routes category and specifying standards and procedures for their construction and reconstruction; providing that part of county state-aid highway fund be apportioned on basis of lane-miles; changing composition of county and municipal state-aid screening boards; increasing the mileage of the municipal state-aid street system; providing for determination of population for eligibility for inclusion in the municipal state-aid street system; making technical changes; amending Minnesota Statutes 1990, sections 160.02, by adding a subdivision; 162.02, subdivisions 8, 10, and by adding a subdivision; 162.07, subdivisions 1, 5, and 6; 162.09, subdivisions 1 and 4; 162.13, subdivision 3; and 162.155; Minnesota Statutes 1991 Supplement, section 162.021, subdivisions 1, 5, and by adding a subdivision.

Reported the same back with the following amendments:

Pages 3 to 5, delete sections 5 to 7

Page 10, line 10, delete "14" and insert "11"

Renumber the sections in sequence

Amend the title as follows:

Page 1, line 4, delete everything after the semicolon

Page 1, delete line 5

Page 1, line 6, delete everything before "providing"

Page 1, line 18, delete everything after "162.155" and insert a period

Page 1, delete lines 19 and 20

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2134, A bill for an act relating to energy; prescribing the method of payment of petroleum tank release cleanup fees; requiring persons who remove basement heating oil storage tanks to remove fill and vent pipes to the outside; changing the inspection fee for petroleum products; imposing a fee on sales of propane; appropriating money to energy and conservation account for programs to improve energy efficiency of residential oil-fired heating plants in low-income households; amending Minnesota Statutes 1990, section 115C.08, subdivision 3; Minnesota Statutes 1991 Supplement, section 239.78; proposing coding for new law in Minnesota Statutes, chapters 116; and 239.

Reported the same back with the following amendments:

Page 2, line 26, delete "PROPANE" and insert "LIQUEFIED PETROLEUM GAS"

Page 2, lines 27 and 29, delete "propane" and insert "liquefied petroleum gas"

Page 2, delete lines 33 and 34

Page 2, line 35, delete everything before "is" and insert "$296,000"

Page 3, line 8, delete "$350,000" and insert "$331,000"

Page 3, line 12, delete everything after "for" and insert "programs administered by the commissioner of public service or the commissioner of jobs and training to improve the energy efficiency of residential liquefied petroleum gas heating equipment in low-income households, and, when necessary, provide weatherization services to the homes."

Page 3, delete lines 13 and 14

Amend the title as follows:

Page 1, line 7, delete "propane" and insert "liquefied petroleum gas"

Page 1, line 9, before "heating" insert "and liquefied petroleum gas"

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2349, A bill for an act relating to motor vehicles; allowing registrar to recover the cost of manufacturing and issuing motor vehicle license plates and stickers; crediting fees from the sale of license plates to the highway user tax distribution fund; amending Minnesota Statutes 1990, sections 168.012, by adding a subdivision; 168.042, by adding a subdivision; 168.12, subdivisions 2 and 5; 168.128, by adding a subdivision; and 168.29; Minnesota Statutes 1991 Supplement, section 168.041, by adding a subdivision.

Reported the same back with the following amendments:

Page 1, after line 18, insert:

"Sec. 2. Minnesota Statutes 1991 Supplement, section 168.021, subdivision 1, is amended to read:

Subdivision 1. [SPECIAL PLATES; APPLICATION.] (a) When a motor vehicle registered under section 168.017, a motorcycle, or a self-propelled recreational vehicle is owned or primarily operated by a permanently physically disabled person or a custodial parent or guardian of a permanently physically disabled minor, the owner may apply for and secure from the registrar of motor vehicles (1) in the case of a motorcycle, one license plate with attached emblems, to be attached to the rear of the vehicle, or (2) in the case of any other vehicle, two license plates with attached emblems, one plate to be attached to the front, and one to the rear of the vehicle. Application for the plates must be made at the time of renewal or first application for registration. When the owner first applies for the plates, the owner must submit a physician's statement on a form developed by the commissioner under section 169.345, or proof of physical disability provided for in that section.

(b) The owner of a motor vehicle may apply for and secure a set of special plates for a motor vehicle if:

(1) the owner employs a permanently physically disabled person who would qualify for special plates under this section; and

(2) the owner furnishes the motor vehicle to the physically disabled person for the exclusive use of that person in the course of employment.

(c) The registrar may not refuse to issue a license plate under this section for a motorcycle to a person who qualifies for the license plate, solely on the grounds that the registrar has issued license plates under this section to the person for another motor vehicle.

Sec. 3. Minnesota Statutes 1990, section 168.021, subdivision 2a, is amended to read:

Subd. 2a. [PLATE RETURNS, TRANSFERS.] (a) When vehicle ownership is transferred, the owner of the vehicle shall remove the special plates from the vehicle and return them to the registrar. The buyer of the vehicle shall repay the $1 credit for each month remaining in the registration period for which the special plates were issued. On returning the plates and repaying the remaining credit, the buyer is entitled to receive regular plates for the vehicle without further cost for the rest of the registration period.

(b) Notwithstanding section 168.12, subdivision 1, the special plates may be transferred to a replacement motor vehicle on notification to the registrar. However, the special plates may not be transferred unless the replacement motor vehicle (1) is registered under section 168.017, is a motorcycle, or is a self-propelled recreational vehicle, and (2) is owned or primarily operated by the permanently physically disabled person.

(c) The transferor shall not receive the $1 credit for each month the replacement vehicle is registered until the time of renewal or first application for registration on the replacement vehicle."

Page 2, after line 2, insert:

"Sec. 6. Minnesota Statutes 1991 Supplement, section 168.10, subdivision 1b, is amended to read:

Subd. 1b. [COLLECTOR'S VEHICLE, CLASSIC CAR LICENSE.] Any motor vehicle manufactured between and including the years 1925 and 1948, and designated by the registrar of motor vehicles as a classic car because of its fine design, high engineering standards, and superior workmanship, and owned and operated solely as a collector's item shall be listed for taxation and registration as follows: An affidavit shall be executed stating the name and address of the owner, the name and address of the person from whom purchased, the make of the motor vehicle, year and number of the model, the manufacturer's identification number and that the vehicle is owned and operated solely as a collector's item and not for general transportation purposes. If the registrar is satisfied that the affidavit is true and correct and that the motor vehicle qualifies to be classified as a classic car, and the owner pays a $25 tax, the registrar shall list such vehicle for taxation and registration and shall issue number plates.

The number plates so issued shall bear the inscription "Classic Car," "Minnesota," and the registration number or other combination of characters authorized under section 168.12, subdivision 2a, but no date. The number plates are valid without renewal as long as the vehicle is in existence and shall be issued for the applicant's use only for such vehicle. The registrar has the power to revoke said plates for failure to comply with this subdivision.

The following cars built between and including 1925 and 1948 are classic:

A.C.	
Adler	
Alfa Romeo	
Alvis	Speed 20, 25, and 4.3 litre.
Amilcar	
Aston Martin	
Auburn	All 8-cylinder and 12-cylinder models.
Audi Austro-Daimler	
Avions Voisin 12	
Bentley	
Blackhawk	
B.M.W.	Models 327, 328, and 335 only.
Brewster	
(Heart-front Ford)	

Bugatti	
Buick	1931 through 1942: series 90 only.
Cadillac	All 1925 through 1935. All 12's and 16's. 1936-1948: Series 63, 64, 67, 70, 72, 75, 80, 85 and 90 only. ~~1938-1941~~ 1938-1947: 60 special only. 1940-1947: All 62 Series.
Chrysler	1926 through 1930: Imperial 80. 1929: Imperial L. ~~1931: Imperial 8 Series CG.~~ ~~1932: Series CG, CH and CL.~~ ~~1933: Series CL.~~ ~~1934: Series CW.~~ ~~1935: Series CW.~~ 1931 through 1937: Imperial Series CG, CH, CL, and CW. All Newports and Thunderbolts. 1934 CX. 1935 C-3. 1936 C-11. 1937 through 1948: Custom Imperial, Crown Imperial Series C-15, C-20, C-24, C-27, C-33, C-37, and C-40.
Cord	
Cunningham	
Dagmar	Model 25-70 only.
Daimler	
Delage	
Delahaye	
Doble	
Dorris	
Duesenberg	
du Pont	
Franklin	All models except 1933-34 Olympic Sixes.
Frazer Nash	
Graham	1930-1931: Series 137.
Graham-Paige	1929-1930: Series 837.
Hispano Suiza	
Horch	
Hotchkiss	
Invicta	
Isotta Fraschini	
Jaguar	
Jordan	Speedway Series 'Z' only.
Kissel	1925, 1926 and 1927: Model 8-75. 1928: Model 8-90, and 8-90 White Eagle. 1929: Model 8-126, and 8-90 White Eagle.

	1930: Model 8-126.
	1931: Model 8-126.
Lagonda	
Lancia	
La Salle	1927 through 1933 only.
Lincoln	All models K, L, KA, and KB.
	1941: Model 168H.
	1942: Model 268H.
Lincoln Continental	1939 through 1948.
Locomobile	All models 48 and 90.
	1927: Model 8-80.
	1928: Model 8-80.
	1929: Models 8-80 and 8-88.
Marmon	All 16-cylinder models.
	1925: Model 74.
	1926: Model 74.
	1927: Model 75.
	1928: Model E75.
	1930: Big 8 model.
	1931: Model 88, and Big 8.
Maybach	
McFarlan	
Mercedes Benz	All models 2.2 litres and up.
Mercer	
M.G.	6-cylinder models only.
Minerva	
Nash	1931: Series 8-90.
	1932: Series 9-90, Advanced 8, and Ambassador 8.
	1933-1934: Ambassador 8.
Packard	1925 through 1934: All models.
	1935 through 1942: Models 1200, 1201, 1202, 1203, 1204, 1205, 1207, 1208, 1400, 1401, 1402, 1403, 1404, 1405, 1407, 1408, 1500, 1501, 1502, 1506, 1507, 1508, 1603, 1604, 1605, 1607, 1608, 1705, 1707, 1708, 1806, 1807, 1808, 1906, 1907, 1908, 2006, 2007, and 2008 only.
	1946 and 1947: Models 2106 and 2126 only.
Peerless	1926 through 1928: Series 69.
	1930-1931: Custom 8.
	1932: Deluxe Custom 8.
Pierce Arrow	
Railton	
Renault	Grand Sport model only.
Reo	1930-1931: Royale Custom 8, and Series 8-35 and 8-52 Elite 8.
	1933: Royale Custom 8.
Revere	

Roamer	1925: Series 8-88, 6-54e, and 4-75. 1926: Series 4-75e, and 8-88. 1927-1928: Series 8-88. 1929: Series 8-88, and 8-125. 1930: Series 8-125.
Rohr	
Rolls Royce	
Ruxton	
Salmson	
Squire	
Stearns Knight	
Stevens Duryea	
Steyr	
Studebaker	1929-1933: President, except model 82.
Stutz	
Sunbeam	
Talbot	
Triumph	Dolomite 8 and Gloria 6.
Vauxhall	Series 25-70 and 30-98 only.
Voisin	
Wills Saint Claire	

No commercial vehicles such as hearses, ambulances, or trucks are considered to be classic cars."

Page 4, after line 3, insert:

"Sec. 10. Minnesota Statutes 1990, section 168.187, subdivision 17, is amended to read:

Subd. 17. [TRIP PERMITS.] ~~The commission may,~~ Subject to agreements or arrangements made or entered into pursuant to subdivision 7, the commissioner may issue trip permits for use of Minnesota highways by individual vehicles, on an occasional basis, for periods not to exceed 120 hours in compliance with rules promulgated pursuant to subdivision 23 and upon payment of a fee of $15.

Sec. 11. Minnesota Statutes 1990, section 168.187, subdivision 26, is amended to read:

Subd. 26. [DELINQUENT FILING OR PAYMENT.] If a fleet owner licensed under this section and section ~~296.17, subdivision 9a~~ 3, is delinquent in either ~~the~~ filing or ~~payment of~~ paying the international fuel tax agreement reports for more than 30 days, or ~~the payment of~~ paying the international registration plan billing for more than 30 days, the fleet owner, after ten days' written notice, is subject to suspension of the apportioned license plates and the international fuel tax agreement license.

Sec. 12. [296.171] [FUEL TAX COMPACTS.]

Subdivision 1. [AUTHORITY.] The commissioner of public safety has the powers granted to the commissioner of revenue under section 296.17. The commissioner of public safety may enter into an agreement or arrangement with the duly authorized representative of another state or make an independent declaration, granting to owners of vehicles properly registered or licensed in another state, benefits, privileges, and exemptions from paying, wholly or partially, fuel taxes, fees, or other charges imposed for operating the vehicles under the laws of Minnesota. The agreement, arrangement, or declaration may impose terms and conditions not inconsistent with Minnesota laws.

Subd. 2. [RECIPROCAL PRIVILEGES AND TREATMENT.] An agreement or arrangement must be in writing and provide that when a vehicle properly licensed for fuel in Minnesota is operated on highways of the other state, it must receive exemptions, benefits, and privileges of a similar kind or to a similar degree as are extended to a vehicle properly licensed for fuel in that state, when operated in Minnesota. A declaration must be in writing and must contemplate and provide for mutual benefits, reciprocal privileges, or equitable treatment of the owner of a vehicle registered for fuel in Minnesota and the other state. In the judgment of the commissioner of public safety, an agreement, arrangement, or declaration must be in the best interest of Minnesota and its citizens and must be fair and equitable regarding the benefits that the agreement brings to the economy of Minnesota.

Subd. 3. [COMPLIANCE WITH MINNESOTA LAWS.] Agreements, arrangements, and declarations made under authority of this section must contain a provision specifying that no fuel license, or exemption issued or accruing under the license, excuses the operator or owner of a vehicle from compliance with Minnesota laws.

Subd. 4. [EXCHANGES OF INFORMATION.] The commissioner of public safety may make arrangements or agreements with other states to exchange information for audit and enforcement activities in connection with fuel tax licensing. The filing of fuel tax returns under this section is subject to the rights, terms, and conditions granted or contained in the applicable agreement or arrangement made by the commissioner under the authority of this section.

Subd. 5. [BASE STATE FUEL COMPACT.] The commissioner of public safety may ratify and effectuate the international fuel tax agreement or other fuel tax agreement. The commissioner's authority includes, but is not limited to, collecting fuel taxes due, issuing fuel licenses, issuing refunds, conducting audits, assessing penalties and interest, issuing fuel trip permits, issuing decals, and suspending or denying licensing.

Subd. 6. [MINNESOTA-BASED INTERSTATE CARRIERS.] Notwithstanding the exemption contained in section 296.17, subdivision 9, as the commissioner of public safety enters into interstate fuel tax compacts requiring base state licensing and filing and eliminating filing in the nonresident compact states, the Minnesota-based motor vehicles registered under section 168.187 will be required to license under the fuel tax compact in Minnesota.

Subd. 7. [DELINQUENT FILING OR PAYMENT.] If a fleet owner licensed under this section is delinquent in either filing or paying the international fuel tax agreement reports for more than 30 days, or paying the international registration plan billing under section 168.187 for more than 30 days, the fleet owner, after ten days written notice, is subject to suspension of the apportioned license plates and the international fuel tax agreement license.

Subd. 8. [TRANSFERRING FUNDS TO PAY DELINQUENT FEES.] If a fleet owner licensed under this section is delinquent in either filing or paying the international fuel tax agreement reports for more than 30 days, or paying the international registration plan billing under section 168.187 for more than 30 days, the commissioner may authorize any credit in either the international fuel tax agreement account or the international registration plan account to be used to offset the liability in either the international registration plan account or the international fuel tax agreement account.

Subd. 9. [FUEL COMPACT FEES.] License fees paid to the commissioner of public safety under the international fuel tax agreement must be deposited in the highway user tax distribution fund. The commissioner shall charge the fuel license fee of $30 established under section 296.17, subdivision 10, in annual installments of $15 and an annual application filing fee of $13 for quarterly reporting of fuel tax.

Subd. 10. [FUEL DECAL FEES.] The commissioner of public safety may issue and require the display of a decal or other identification to show compliance with subdivision 5. The commissioner may charge a fee to cover the cost of issuing the decal or other identification. Decal fees paid to the commissioner under this subdivision must be deposited in the highway user tax distribution fund."

Page 4, after line 29, insert:

"Sec. 14. [REPEALER.]

Minnesota Statutes 1990, section 296.17, subdivision 9a, is repealed."

Renumber the remaining sections

Amend the title as follows:

Page 1, line 4, after the semicolon insert "modifying provisions for motorcycle license plates;"

Page 1, line 6, after the semicolon insert "changing requirements for classic car licenses; authorizing fuel tax compacts;"

Page 1, line 7, after the semicolon insert "168.021, subdivision 2a;"

Page 1, line 9, after "subdivision;" insert "168.187, subdivisions 17 and 26;"

Page 1, line 10, delete "section" and insert "sections 168.021, subdivision 1;"

Page 1, line 11, after "subdivision" insert "; and 168.10, subdivision 1b; proposing coding in Minnesota Statutes, chapter 296; repealing Minnesota Statutes 1990, section 296.17, subdivision 9a"

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2368, A bill for an act relating to motor carriers; providing for the expiration of certificates and permits as regular and irregular route carriers of property, and for their conversion to class I certificates and class II permits; specifying operating authority granted by each class; restricting transfer of certain operating authority; prohibiting the lease of class I certificates and class II permits; specifying service that may be offered by courier service carriers; redefining the local cartage zone; increasing registration fees for vehicles of motor carriers; appropriating money; amending Minnesota Statutes 1990, sections 168.013, subdivision 1e; 221.011, subdivisions 7, 8, 9, 14, 25, 28, and by adding subdivisions; 221.036, subdivision 1; 221.041; 221.051; 221.061; 221.071, subdivision 1; 221.081; 221.111; 221.121, subdivisions 1, 6, 6a, and by adding subdivisions; 221.131, subdivisions 2 and 3; 221.141, subdivision 4; and 221.151, subdivision 1, and by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 221; repealing Minnesota Statutes 1990, section 221.011, subdivisions 11 and 17.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 1990, section 221.011, subdivision 7, is amended to read:

Subd. 7. "Certificate" means the certificate of public convenience and necessity ~~which may be~~ issued under ~~the provisions of sections 221.011 to 221.291~~ section 221.071 to a regular route common carrier of passengers, a class I motor carrier, or a petroleum carrier.

Sec. 2. Minnesota Statutes 1990, section 221.011, subdivision 8, is amended to read:

Subd. 8. "Permit" means the license, or franchise, which may be issued to motor carriers other than regular route common carriers of passengers, class I common carriers, and petroleum carriers, under the provisions of this chapter, authorizing the use of the highways of Minnesota for transportation for hire.

Sec. 3. Minnesota Statutes 1990, section 221.011, subdivision 9, is amended to read:

Subd. 9. "Regular route common carrier" means a person who holds out to the public as willing, for hire, to transport passengers ~~or property~~ by motor vehicle between fixed termini over a regular route upon the public highways.

Sec. 4. Minnesota Statutes 1990, section 221.011, subdivision 14, is amended to read:

Subd. 14. "Permit carrier" means a motor carrier embraced within this chapter other than regular route common carriers of passengers, class I carriers, and petroleum carriers.

Sec. 5. Minnesota Statutes 1990, section 221.011, is amended by adding a subdivision to read:

Subd. 33. [TRUCKLOAD FREIGHT.] "Truckload freight" means freight collected by a motor carrier (1) from one consignor at a single place and delivered directly to one or more consignees at a place or places under the consignees' control, or (2) from one or more consignors and delivered directly to one consignee at a place under the consignee's control.

Sec. 6. Minnesota Statutes 1990, section 221.011, is amended by adding a subdivision to read:

Subd. 34. [LESS-THAN-TRUCKLOAD FREIGHT.] "Less-than-truckload freight" means freight carried by a motor carrier that is not truckload freight.

Sec. 7. Minnesota Statutes 1990, section 221.011, is amended by adding a subdivision to read:

Subd. 35. [CERTIFICATED CARRIER.] "Certificated carrier" means a motor carrier holding a certificate issued under section 221.071.

Sec. 8. Minnesota Statutes 1990, section 221.011, is amended by adding a subdivision to read:

Subd. 36. [CLASS I CARRIER.] "Class I carrier" means a person who has been issued a certificate under section 221.071 to operate as a class I carrier.

Sec. 9. Minnesota Statutes 1990, section 221.011, is amended by adding a subdivision to read:

Subd. 37. [CLASS II CARRIER.] "Class II carrier" means a person who has been issued a permit under section 221.121, subdivisions 6c to 6e, to operate as a class II carrier. Class II carrier includes persons who have been issued either a class II-T or class II-L permit, or both.

Sec. 10. Minnesota Statutes 1990, section 221.011, is amended by adding a subdivision to read:

Subd. 38. [TERMINAL.] "Terminal" means (1) a facility that a motor carrier owns, leases, or otherwise controls, and uses to load, unload, dispense, receive, interchange, gather, or otherwise physically handle freight for shipment, or (2) any other location at which freight is exchanged by motor carriers between vehicles. Terminal does not mean a public warehouse with a storage capacity of at least 5,000 square feet that was licensed under chapter 231 on or before March 1, 1992.

Sec. 11. Minnesota Statutes 1990, section 221.011, is amended by adding a subdivision to read:

Subd. 39. [TEMPERATURE-CONTROLLED COMMODITY.] "Temperature-controlled commodity" means a commodity requiring protection from heat or cold that is transported with or without other commodities, provided that all such commodities move in mechanically temperature controlled vehicles.

Sec. 12. Minnesota Statutes 1990, section 221.036, subdivision 1, is amended to read:

Subdivision 1. [AUTHORITY TO ISSUE PENALTY ORDERS.] The commissioner may issue an order requiring violations to be corrected and administratively assessing monetary penalties for a violation of (1) section 221.021; (2) section 221.035; (3) section

221.041, subdivision 3; (4) section 221.081; (5) section 221.151; (6) section 221.171, ~~of~~ a material term or condition of a license issued under that section ~~221.035,~~ or ~~of~~ a rule or order of the commissioner relating to the transportation of hazardous waste. An order must be issued as provided in this section.

Sec. 13. Minnesota Statutes 1990, section 221.041, is amended to read:

221.041 [RATE-MAKING POWERS.]

Subdivision 1. [CONSIDERATIONS; PROCEDURES.] The board shall fix and establish just, reasonable, and nondiscriminatory rates, fares, charges, and the rules and classifications incident to tariffs for ~~regular route common carriers and petroleum~~ certificated carriers. In prescribing rates, fares, charges, classifications, and rules for the carrying of freight, persons, or property, the board shall take into consideration the effect of the proposed rates or fares upon the users of the service and upon competitive carriers by motor vehicle and rail and, insofar as possible, avoid rates and fares which will result in unreasonable and destructive competition. In making its determination, the board shall consider, among other things, the cost of the service rendered by the carrier, including an adequate sum for maintenance and depreciation, and an adequate operating ratio under honest, economical, and efficient management. No rate or fares may be put into effect or changed or altered except upon hearing duly had and an order therefor by the board, or except as herein otherwise provided. The board may authorize rate changes ex parte which, in its opinion, are not of sufficient import to require a hearing. In an emergency, the board may order a change in existing rates or fares without a hearing. In instances of ex parte or emergency orders, the board shall, within five days, serve a copy of its order granting the change in rates upon parties which the board deems interested in the matter, including competing carriers. An interested party shall have 30 days from the date of the issuance of the order to object to the order. If objection is made, the board shall determine whether a hearing is necessary for resolution of the material issues relating to the proposed change in rates. On finding that a hearing is unnecessary for this purpose, the board, no sooner than 30 days after issuing its initial order granting the change in rates, may enter an order finally disposing of the rate change application. On determining otherwise, the board may take final action on the rate change application and the objections to it only after a contested case hearing has been conducted under chapter 14.

Subd. 2. [FILING.] A ~~regular route common carrier and a petroleum~~ certificated carrier, upon approval by the board of its rates, fares, charges, and rules and classifications incident to tariffs shall file its rates, fares, charges, and tariffs with the commissioner. Filings must be prepared and filed in the manner prescribed by the commissioner. The commissioner may not accept for filing rates,

fares, charges, and tariffs which have not been approved by the board.

Subd. 3. [PROHIBITIONS; COMPENSATION AND TIME SCHEDULES.] No ~~regular route common carrier or petroleum~~ certificated carrier may charge or receive a greater or less or different compensation for the transportation of passengers or property or for service in connection therewith than the rates, fares, and charges and the rules and classifications governing the same which have been duly approved therefor by order of the board; ~~nor may~~. A ~~regular route common carrier or petroleum~~ certificated carrier may not refund or remit in any manner or by any device a portion of those rates, fares, and charges required to be collected under the board's order; nor extend to a shipper or person a privilege or facilities in connection with the transportation of passengers or property except as are authorized under the order of the board. No passenger-carrying regular route common carrier may alter or change its time schedules except upon order of the board. The order may be issued ex parte unless the board decides that the public interest requires that a hearing be ~~had thereon~~ held.

Subd. 4. [NONAPPLICABILITY.] This section does not apply to any regular-route passenger transportation being performed with operating assistance provided by the regional transit board.

Sec. 14. Minnesota Statutes 1990, section 221.051, is amended to read:

221.051 [ABANDONMENT OR DISCONTINUANCE OF SERVICE.]

No regular route common carrier ~~shall~~ of passengers or class I carrier may abandon or discontinue any service required under its certificate without an order of the board therefor, except in cases of emergency or conditions beyond its control.

A passenger regular route common carrier may depart from the route over which it is authorized to operate for the purpose of transporting chartered or excursion parties to any point in the state of Minnesota on such terms and conditions as the board may prescribe.

Sec. 15. Minnesota Statutes 1990, section 221.061, is amended to read:

221.061 [OPERATION CERTIFICATE FOR REGULAR ROUTE COMMON CARRIER OR PETROLEUM CARRIER.]

A person desiring a certificate authorizing operation as a regular route common carrier of passengers, a class I carrier, or petroleum

carrier, or an extension of or amendment to that certificate, shall file a petition with the commissioner which must contain information as the board and commissioner, by rule may prescribe.

Upon the filing of a petition for a certificate, the petitioner shall pay to the commissioner as a fee for issuing the certificate the sum of $300 and for a transfer or lease of the certificate the sum of $300.

The petition must be processed as any other petition. The board shall cause a copy and a notice of hearing thereon to be served upon a competing carrier operating into a city located on the proposed route of the petitioner and to other persons or bodies politic which the board deems interested in the petition. A competing carrier and other persons or bodies politic are hereby declared to be interested parties to the proceedings.

If, during the hearing, an amendment to the petition is proposed which appears to be in the public interest, the board may allow it when the issues and the territory are not unduly broadened by the amendment.

Sec. 16. Minnesota Statutes 1990, section 221.071, subdivision 1, is amended to read:

Subdivision 1. [CONSIDERATIONS; TEMPORARY CERTIFICATES; AMENDING.] If the board finds from the evidence that the petitioner is fit and able to properly perform the services proposed and that public convenience and necessity require the granting of the petition or a part of the petition, it shall issue a certificate of public convenience and necessity to the petitioner. In determining whether a certificate should be issued, the board shall give primary consideration to the interests of the public that might be affected, to the transportation service being furnished by a railroad which may be affected by the granting of the certificate, and to the effect which the granting of the certificate will have upon other transportation service essential to the communities which might be affected by the granting of the certificate. The board may issue a certificate as applied for or issue it for a part only of the authority sought and may attach to the authority granted terms and conditions as in its judgment public convenience and necessity may require. If the petitioner is seeking authority to operate regular-route transit service wholly within the seven-county metropolitan area with operating assistance provided by the regional transit board, the board shall consider only whether the petitioner is fit and able to perform the proposed service. The operating authority granted to such a petitioner must be the operating authority for which the petitioner is receiving operating assistance from the regional transit board. A carrier receiving operating assistance from the regional transit board may amend the certificate to provide for additional routes by filing a copy of the amendment with the board, and approval of the amendment by the board is not required if the

additional service is provided with operating assistance from the regional transit board.

The board may grant a temporary certificate, ex parte, valid for a period not exceeding 180 days, upon a showing that no regular route common carrier or petroleum carrier is then authorized to serve on the route sought, that no other petition is on file with the board covering the route, and that a need for the proposed service exists.

A certificate ~~issued to a regular route common carrier or petroleum carrier~~ may be amended by the board on ex parte petition and payment of a $25 fee to the commissioner, to grant an additional or alternate route if there is no other means of transportation over the proposed additional route or between its termini, and the proposed additional route does not exceed ten miles in length.

Sec. 17. [221.072] [CLASS I CARRIERS.]

Subdivision 1. [AUTHORITY.] The board may issue a class I certificate only to a motor carrier who owns, leases, or otherwise controls more than one terminal. Except as provided in subdivision 2, a motor carrier may not own, operate, or otherwise control more than one terminal without having obtained a class I certificate from the board. For purposes of this section, utilization of a local cartage carrier by a class I carrier constitutes ownership, lease, or control of a terminal.

Subd. 2. [EXCEPTIONS.] This section does not apply to any carrier listed in section 221.111, clauses (3) to (9).

Subd. 3. [OPERATION.] A class I certificate authorizes the certificate holder to transport both truckload and less-than-truckload freight to and from points named in the certificate, over routes described in the certificate. A holder of a class I certificate may transfer freight to and from another class I carrier.

Sec. 18. Minnesota Statutes 1990, section 221.111, is amended to read:

221.111 [PERMITS TO OTHER MOTOR CARRIERS.]

Motor carriers other than ~~regular route common carriers, petroleum~~ certificated carriers~~,~~ and local cartage carriers~~,~~ shall obtain a permit in accordance with section 221.121~~, including irregular route carriers, livestock carriers, contract carriers, charter carriers, and courier service carriers~~. The board shall issue only the following kinds of permits:

(1) class II-T permits;

(2) class II-L permits;

(3) livestock carrier permits;

(4) contract carrier permits;

(5) charter carrier permits;

(6) courier service carrier permits;

(7) local cartage carrier permits;

(8) household goods mover permits; and

(9) temperature-controlled commodities permits.

Sec. 19. Minnesota Statutes 1990, section 221.121, subdivision 1, is amended to read:

Subdivision 1. [PERMIT CARRIERS.] (a) A person desiring to operate as a permit carrier, except as ~~a livestock carrier, or a local cartage carrier~~ provided in subdivision 5 or section 221.296, shall file a petition with the commissioner specifying the kind of permit desired, the name and address of the petitioner and the names and addresses of the officers, if a corporation, and other information as the board and commissioner may require. The board, after notice to interested parties and a hearing, shall issue the permit upon compliance with the laws and rules relating to it, if it finds that petitioner is fit and able to conduct the proposed operations, that petitioner's vehicles meet the safety standards established by the department, that the area to be served has a need for the transportation services requested in the petition, and that existing permit and certificated carriers in the area to be served have failed to demonstrate that they offer sufficient transportation services to meet fully and adequately those needs, provided that no person who holds a permit at the time sections 221.011 to 221.291 take effect may be denied a renewal of the permit upon compliance with other provisions of sections 221.011 to 221.291. A permit once granted continues in full force and effect until abandoned or unless suspended or revoked, subject to compliance by the permit holder with the applicable provisions of law and the rules of the commissioner or board governing permit carriers. No permit may be issued to a common carrier by rail permitting the common carrier to operate trucks for hire within this state, nor may a common carrier by rail be permitted to own, lease, operate, control, or have an interest in a permit carrier by truck, either by stock ownership or otherwise, directly, indirectly, through a holding company, or by stockholders or directors in common, or in any other manner. Nothing in sections 221.011 to 221.291 prevents the board from issuing a permit to a common carrier by rail authorizing the carrier to operate trucks

wholly within the limits of a municipality or within adjacent or contiguous municipalities or a common rate point served by the railroad and only as a service supplementary to the rail service now established by the carriers.

Sec. 20. Minnesota Statutes 1990, section 221.121, subdivision 4, is amended to read:

Subd. 4. [EXTENSIONS OF AUTHORITY.] The board may grant extensions of authority ex parte after due notice of a petition has been published. A party desiring to protest the petition shall file its protest by mail or in person within 20 days of the date of notice, except that no protest may be filed against an application submitted under subdivision 6f. If a timely filed protest is received, the matter must be placed on the calendar for hearing. If a timely protest is not received, the board may issue its order ex parte.

Sec. 21. Minnesota Statutes 1990, section 221.121, subdivision 6a, is amended to read:

Subd. 6a. [HOUSEHOLD GOODS CARRIER.] A person who desires to hold out or to operate as a carrier of household goods shall follow the procedure established in subdivision 1, and shall specifically request ~~an irregular route common carrier~~ a household goods mover permit ~~with authority to transport household goods~~. The permit granted by the board to a person who meets the criteria established in this subdivision and subdivision 1 shall authorize the person to hold out and to operate as ~~an irregular route common carrier of~~ a household goods mover. A person who provides or offers to provide household goods packing services and who makes any arrangement directly or indirectly by lease, rental, referral, or by other means to provide or to obtain drivers, vehicles, or transportation service for moving household goods, must have ~~an irregular route common carrier permit with authority to transport~~ a household goods mover permit.

Sec. 22. Minnesota Statutes 1990, section 221.121, is amended by adding a subdivision to read:

Subd. 6c. [CLASS II CARRIERS.] A person desiring to operate as a permit carrier, other than as a carrier listed in section 221.111, clauses (3) to (9), shall follow the procedure established in subdivision 1 and shall specify in the petition whether the person is seeking a class II-T or class II-L permit. If the person meets the criteria established in subdivision 1, the board shall grant the class II-T or class II-L permit or both. A class II permit holder may not own, lease, or otherwise control more than one terminal. The board may not issue a class II permit to a motor carrier who owns, leases, or otherwise controls more than one terminal. For purposes of this section: (1) utilization of a local cartage carrier by a class II carrier constitutes ownership, lease, or control of a terminal; and (2)

terminal does not include a terminal used by a permit holder who also holds a class I certificate, household goods permit, or temperature-controlled commodities permit for the unloading, docking, handling, and storage of freight transported under the certificate, household goods permit, or temperature-controlled commodities permit.

Sec. 23. Minnesota Statutes 1990, section 221.121, is amended by adding a subdivision to read:

Subd. 6d. [TEMPERATURE-CONTROLLED COMMODITIES CARRIERS.] A person who desires to hold out or to operate as a carrier of temperature-controlled commodities shall follow the procedure established in subdivision 1 and shall specifically request a temperature-controlled commodities permit. The permit granted by the board to a person who meets the criteria established in subdivision 1 shall authorize the person to hold out and to operate as a carrier of temperature-controlled commodities.

Sec. 24. Minnesota Statutes 1990, section 221.121, is amended by adding a subdivision to read:

Subd. 6e. [CLASS II-T PERMITS.] A holder of a class II-T permit may transport truckload freight to and from any point named in the permit without restriction as to routes, schedules, or frequency of service.

Sec. 25. Minnesota Statutes 1990, section 221.121, is amended by adding a subdivision to read:

Subd. 6f. [CLASS II-L PERMITS.] (a) A motor carrier with a class II-L permit may transport less-than-truckload freight as provided in this subdivision.

(b) A motor carrier with a class II-L permit may transport less-than-truckload freight to and from any point named in the permit, without restriction as to routes, schedules, or frequency of service.

(c) A motor carrier with a class II-L permit may transport less-than-truckload freight to and from points within the geographic area the carrier was authorized to serve on December 31, 1992, that were not listed in the carrier's permit. Service by a carrier under this paragraph may be provided no more often than on 24 days in a 12-month period.

(d) A motor carrier described in paragraph (c) may amend the carrier's permit to add points within the geographic area the carrier was authorized to serve on December 31, 1992. The carrier must submit to the commissioner an application on a form provided by the

commissioner. The application must name the points proposed to be served and include evidence of need for the proposed service. The commissioner shall transmit the application to the board. The board shall publish notice of the application in the board's next weekly calendar. Failure by the board to deny the application within ten days after the date of publication in the calendar constitutes approval of the application.

Sec. 26. Minnesota Statutes 1990, section 221.131, subdivision 2, is amended to read:

Subd. 2. [PERMIT CARRIERS; ANNUAL VEHICLE REGISTRATION.] The permit holder shall pay an annual registration fee of ~~$20~~ $40 on each vehicle, including pickup and delivery vehicles, operated by the holder under authority of the permit during the 12-month period or fraction of the 12-month period. Trailers and semitrailers used by a permit holder in combination with power units may not be counted as vehicles in the computation of fees under this section if the permit holder pays the fees for power units. The commissioner shall furnish a distinguishing annual identification card for each vehicle or power unit for which a fee has been paid. The identification card must at all times be carried in the vehicle or power unit to which it has been assigned. An identification card may be reassigned to another vehicle or power unit upon application of the permit holder and a transfer fee of $10. An identification card issued under the provisions of this section is valid only for the period for which the permit is effective. The name and residence of the permit holder must be stenciled or otherwise shown on the outside of both doors of each registered vehicle operated under the permit. A fee of $10 is charged for the replacement of an unexpired identification card that has been lost or damaged. The total annual registration fee per vehicle for class II-T, class II-L, household goods mover and temperature-controlled commodities, or any combination thereof, may not exceed $40.

Sec. 27. Minnesota Statutes 1990, section 221.131, subdivision 3, is amended to read:

Subd. 3. [CERTIFICATE CARRIERS; ANNUAL VEHICLE REGISTRATION.] ~~Regular route common carriers and petroleum~~ Certificated carriers~~, operating under sections 221.011 to 221.291,~~ shall ~~annually~~ pay ~~into the treasury of the state of Minnesota~~ an annual registration fee of ~~$20~~ $40 for each vehicle, including pickup and delivery vehicles, operated during a calendar year. The commissioner shall issue distinguishing identification cards as provided in subdivision 2.

Sec. 28. Minnesota Statutes 1990, section 221.141, subdivision 4, is amended to read:

Subd. 4. [~~IRREGULAR ROUTE CARRIERS OF~~ HOUSEHOLD

GOODS MOVERS.] ~~An irregular route common carrier of~~ A household goods mover shall maintain in effect cargo insurance or cargo bond in the amount of $50,000 and shall file with the commissioner a cargo certificate of insurance or cargo bond. A cargo certificate of insurance must conform to Form H, Uniform Motor Cargo Certificate of Insurance, described in Code of Federal Regulations, title 49, part 1023. A cargo bond must conform to Form J, described in Code of Federal Regulations, title 49, part 1023. Both Form H and Form J are incorporated by reference. The cargo certificate of insurance or cargo bond must be issued in the full and correct name of the person, corporation, or partnership to whom the ~~irregular route common carrier of~~ household goods mover permit was issued and whose operations are being insured. ~~A carrier that was issued a permit as an irregular route common carrier of household goods before August 1, 1989, shall obtain and file a cargo certificate of insurance or bond within 90 days of August 1, 1989.~~

Sec. 29. Minnesota Statutes 1990, section 221.151, is amended by adding a subdivision to read:

Subd. 3. [TRANSFER OF CERTAIN AUTHORITY.] Operating authority described in section 25, paragraph (c), that has not been added to the motor carrier's permit under section 25, paragraph (d), may not be transferred to any person except a member of the transferor's immediate family as defined in subdivision 2.

Sec. 30. [221.152] [CONVERSION OF PERMITS.]

Subdivision 1. [EXPIRATION OF OPERATING AUTHORITY.] Except as provided in subdivision 3, paragraph (c), the following certificates and permits in effect on January 1, 1993, and all operating authority granted by those certificates and permits, expire on January 1, 1993:

(1) all certificates authorizing operation as a regular route common carrier of property, other than petroleum carrier certificates; and

(2) all permits authorizing operation as an irregular route common carrier, except those carriers listed in section 221.111, clauses (3) to (9).

Subd. 2. [CONVERSION.] All holders of certificates and permits that expire on January 1, 1993, under subdivision 1, who wish to continue providing the service authorized by those certificates and permits, must convert the certificates and permits into class I or class II certificates or permits by that date.

Subd. 3. [ISSUANCE OF NEW CERTIFICATES AND PERMITS.] (a) By September 1, 1992, a motor carrier described in subdivision 2

must submit to the commissioner an application for conversion. The application must be on a form prescribed by the commissioner and must be accompanied by an application fee of $50. The application must state: (1) the name and address of the applicant; (2) the identifying number of the expiring certificates or permits the applicant wishes to convert; and (3) other information the commissioner deems necessary. An applicant for a class II-L permit must also submit a statement of the extent of operating authority that the applicant holds under the applicant's existing permit or permits and wishes to include in the new permit or permits, and evidence of the operating authority actually exercised as described in section 221.151, subdivision 1.

(b) The commissioner shall transmit to the board all applications that meet the requirements of paragraph (a). The board shall develop an expedited process for hearing and ruling on applications submitted under this subdivision. Within 60 days after receiving an application under this subdivision, the board shall issue an order approving or denying the issuance of a new certificate or permit. The board shall issue the certificate or permit requested in the application if it finds that the issuance is authorized under this section. An application submitted to the commissioner under this subdivision by September 1, 1992, is deemed approved by the board unless by November 1, 1992, or a later date determined under paragraph (c), the board has issued an order denying the application.

(c) If the board determines that a conversion of a certificate or permit under this subdivision requires a longer period of deliberation than that provided in paragraph (b), the board may prescribe a date: (1) on which a class I certificate or class II permit becomes effective; (2) on which the application for conversion becomes effective unless denied by the board; and (3) on which the certificate or permit being converted expires. The board may not prescribe a date under clauses (1) to (3) that is later than June 30, 1993.

Subd. 4. [AUTHORITY CONVERTED.] (a) The board shall not issue any certificate or permit under this subdivision that authorizes the carrier to serve any geographic area or transport any commodities that the carrier was not authorized to serve or transport under the expiring certificate or permit.

(b) Notwithstanding paragraph (a), the board shall not grant a class II-L permit to an applicant under this section that names points that the permit holder did not serve at any time in the two years before the effective date of this section.

(c) When a person who had been issued before January 1, 1993, an irregular route common carrier permit with authority to transport household goods applies for conversion of that permit to a class II permit under subdivision 3, the board shall issue the applicant, along with a class II permit, a household goods mover permit with

the same operating authority to transport household goods as was granted under the person's irregular route common carrier permit.

(d) When a person who, before January 1, 1993, held an irregular route common carrier permit under which the person transported temperature-controlled commodities applies for conversion of that permit to a class II permit under subdivision 3, the board shall issue the applicant a temperature-controlled commodities permit with authority to operate in the same geographic area authorized under the person's irregular route common carrier permit and a class II permit.

Sec. 31. [TRANSITION.]

By August 1, 1992, the commissioner shall send a notice by certified mail, return receipt requested, to all holders of certificates and permits that expire January 1, 1993, under this act. The notice must summarize the requirements for conversion of the certificates and permits and include an application form for conversion. By August 18, 1992, the commissioner shall send a second notice by certified mail, return receipt requested, to all certificate and permit holders who have not submitted an application for conversion.

Sec. 32. [APPROPRIATION.]

$491,000 is appropriated from the trunk highway fund for the fiscal year ending June 30, 1993, for the purpose of implementing sections 1 to 31. This appropriation is available during the fiscal year ending June 30, 1992. Of this amount, $466,000 is appropriated to the commissioner of transportation and $25,000 is appropriated to the transportation regulation board. The complement of the department of transportation is increased by seven positions.

Sec. 33. [REPEALER.]

Minnesota Statutes 1990, section 221.011, subdivision 11, is repealed.

Sec. 34. [EFFECTIVE DATE.]

Sections 1 to 29 and 33 are effective January 1, 1993. Sections 30 and 31 are effective the day following final enactment. Section 32 is effective July 1, 1992."

Delete the title and insert:

"A bill for an act relating to motor carriers; providing for the expiration of certificates and permits as regular and irregular route carriers of property, and for their conversion to class I certificates

and class II permits; specifying operating authority granted by each class; restricting transfer of certain operating authority; prohibiting the lease of class I certificates and class II permits; increasing registration fees for vehicles of motor carriers; appropriating money; amending Minnesota Statutes 1990, sections 221.011, subdivisions 7, 8, 9, 14, and by adding subdivisions; 221.036, subdivision 1; 221.041; 221.051; 221.061; 221.071, subdivision 1; 221.111; 221.121, subdivisions 1, 4, 6a, and by adding subdivisions; 221.131, subdivisions 2 and 3; 221.141, subdivision 4; and 221.151, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 221; repealing Minnesota Statutes 1990, section 221.011, subdivision 11."

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2688, A bill for an act relating to insurance; solvency; making various technical corrections; amending Minnesota Statutes 1990, sections 60A.03, subdivision 6; and 60A.10, subdivision 4; 61B.03, subdivision 5; Minnesota Statutes 1991 Supplement, sections 60A.092, subdivision 3; 60A.11, subdivisions 13 and 20; 60A.112; 60A.12, subdivision 10; 60A.124; and 60D.17, subdivision 1; Laws 1991, chapter 325, article 5, section 6; proposing coding for new law in Minnesota Statutes, chapter 60C; repealing Minnesota Statutes 1991 Supplement, section 72A.206.

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. 2855, A bill for an act relating to agriculture; regulating aquatic farming; protecting certain wildlife populations; amending Minnesota Statutes 1990, sections 97C.203; 97C.301, by adding a subdivision; 97C.345, subdivision 4; 97C.391; and 97C.505, subdivision 6; proposing coding for new law in Minnesota Statutes, chapter 17; repealing Minnesota Statutes 1990, sections 97A.475, subdivision 29a; and 97C.209.

Reported the same back with the following amendments:

Delete page 10, line 33 to page 11, line 2, and insert:

"(d) For transportation and stocking of waters that are not public waters:

(1) a bill of lading must be submitted to the regional fisheries manager 72 hours before transporting fish for stocking;

(2) a bill of lading must be submitted to the regional fisheries manager within five days after stocking if the waters to be stocked are confirmed by telecopy or telephone prior to stocking by the regional fisheries office not to be public waters; or

(3) a completed bill of lading may be submitted to the regional fisheries office by telecopy prior to transporting fish for stocking. Confirmation that the waters to be stocked are not public waters may be made by returning the bill of lading by telecopy or in writing, in which cases additional copies need not be submitted to the department of natural resources."

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

H. F. No. 2867, A bill for an act relating to drivers' licenses; increasing fees; appropriating money; amending Minnesota Statutes 1990, section 171.06, subdivision 2.

Reported the same back with the following amendments:

Page 1, delete lines 19 to 22, and insert:

"Sec. 2. Minnesota Statutes 1990, section 177.42, subdivision 6, is amended to read:

Subd. 6. "Prevailing wage rate" means the hourly basic rate of pay plus the contribution for health and welfare benefits, vacation benefits, pension benefits, and any other economic benefit paid to the mode, which is the largest number of workers engaged in the same class of labor within the area and includes, for the purposes of section 177.44, rental rates for truck hire paid to those who own and operate the truck. The prevailing wage rate may not be less than a reasonable and living wage.

Sec. 3. [DRIVERS' LICENSE STANDARDS.]

The commissioner of public safety shall develop new standards for manufacturing Minnesota drivers' licenses and identification cards that provide increased resistance to alteration. On July 1, 1993, the commissioner shall begin issuing driver's licenses and identification cards manufactured according to the new standards."

Page 1, line 23, delete "3." and insert "4."

Page 1, line 24, after the period insert "Section 2 is effective the day following final enactment."

Amend the title as follows:

Page 1, line 2, delete "appropriating money" and insert "providing for new standards for drivers' licenses and identification cards that increase resistance to alteration; defining a term for purposes of determining prevailing wage rates"

Page 1, line 4, after "2" insert "; and 177.42, subdivision 6"

With the recommendation that when so amended the bill pass.

The report was adopted.

Simoneau from the Committee on Appropriations to which was referred:

S. F. No. 1854, A bill for an act relating to appropriations; clarifying the purposes for which a certain appropriation may be spent at Worthington community college.

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

The report was adopted.

SECOND READING OF HOUSE BILLS

H. F. Nos. 804, 1313, 1985, 2032, 2134, 2349, 2368, 2688, 2855 and 2867 were read for the second time.

SECOND READING OF SENATE BILLS

S. F. No. 1854 was 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 Senate File, herewith transmitted:

S. F. No. 2199.

PATRICK E. FLAHAVEN, Secretary of the Senate

FIRST READING OF SENATE BILLS

S. F. No. 2199, A bill for an act relating to waste management; defining postconsumer material; emphasizing and clarifying waste reduction; moving from the office of waste management to the environmental quality board the responsibility for supplementary review of waste facility siting; setting requirements for use of labels on products and packages indicating recycled content; amending provisions related to designation of waste; expanding fee exemptions for waste residue from certain construction debris processing facilities; strengthening the requirement for pricing of waste collection based on volume or weight of waste collected; requiring recycled content in and recyclability of telephone directories and requiring recycling of waste directories; changing provisions relating to financial responsibility requirements and low-level radioactive waste; requiring labeling of rechargeable batteries; prohibiting the imposition of fees on the generation of certain hazardous wastes that are reused or recycled; requiring studies on automobile waste, construction debris, and used motor oil; requiring an assessment of regional waste management needs; and making various other amendments and additions related to solid waste management; authorizing rulemaking; providing penalties; amending Minnesota Statutes 1990, sections 16B.121; 115A.03, subdivision 36a, and by adding subdivisions; 115A.07, by adding a subdivision; 115A.32; 115A.557, subdivision 3; 115A.63, subdivision 3; 115A.81, subdivision 2; 115A.87; 115A.93, by adding a subdivision; 115A.981; 116.12, subdivision 2; 325E.12; 325E.125, subdivision 1; 400.08, subdivisions 4 and 5; 400.161; 473.811, subdivision 5b; and 473.844, subdivision 4; Minnesota Statutes 1991 Supplement, sections

16B.122, subdivision 2; 115A.02; 115A.15, subdivision 9; 115A.411, subdivision 1; 115A.83; 115A.9157, subdivisions 4 and 5; 115A.919, subdivision 3; 115A.93, subdivision 3; 115A.931; 116.07, subdivision 4h; 116.90; 116C.852; and 473.849; Laws 1990, chapter 600, section 7; Laws 1991, chapter 337, section 90; proposing coding for new law in Minnesota Statutes, chapters 16B; 115A; and 325E.

The bill was read for the first time.

Wagenius moved that S. F. No. 2199 and H. F. No. 2150, now on General Orders, be referred to the Chief Clerk for comparison. The motion prevailed.

CONSIDERATION UNDER RULE 1.10

Pursuant to rule 1.10, Simoneau requested immediate consideration of H. F. No. 2848.

H. F. No. 2848, A bill for an act relating to state government; ratifying labor agreements; providing for classification changes for certain employees; amending Minnesota Statutes 1990, section 21.85, subdivision 2; Minnesota Statutes 1991 Supplement, section 349A.02, subdivision 4.

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

The question was taken on the passage of the bill and the roll was called. There were 90 yeas and 43 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Farrell	Kelso	Ogren	Sarna
Anderson, R.	Garcia	Kinkel	Olson, E.	Schreiber
Battaglia	Goodno	Knickerbocker	Olson, K.	Segal
Bauerly	Greenfield	Krambeer	Omann	Simoneau
Beard	Gruenes	Krueger	Orenstein	Skoglund
Begich	Hanson	Lasley	Orfield	Solberg
Bertram	Hasskamp	Lieder	Osthoff	Sparby
Bishop	Haukoos	Lourey	Ostrom	Steensma
Bodahl	Hausman	Mariani	Ozment	Thompson
Boo	Jacobs	Marsh	Pauly	Trimble
Brown	Janezich	McEachern	Pelowski	Tunheim
Carlson	Jaros	McGuire	Peterson	Vellenga
Carruthers	Jefferson	Milbert	Pugh	Wagenius
Clark	Jennings	Munger	Reding	Wejcman
Cooper	Johnson, A.	Murphy	Rest	Welle
Dauner	Johnson, R.	Nelson, K.	Rice	Wenzel
Dawkins	Kahn	Nelson, S.	Rodosovich	Winter
Dorn	Kalis	O'Connor	Rukavina	Spk. Long

Those who voted in the negative were:

Abrams	Frerichs	Koppendrayer	Olsen, S.	Swenson
Anderson, R. H.	Girard	Krinkie	Onnen	Tompkins
Bettermann	Gutknecht	Leppik	Pellow	Uphus
Blatz	Hartle	Limmer	Runbeck	Valento
Davids	Heir	Lynch	Schafer	Waltman
Dempsey	Henry	Macklin	Seaberg	Weaver
Dille	Hufnagle	McPherson	Smith	Welker
Erhardt	Hugoson	Morrison	Stanius	
Frederick	Johnson, V.	Newinski	Sviggum	

The bill was passed and its title agreed to.

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

Boo moved that the name of Dorn be added as an author on H. F. No. 2286. The motion prevailed.

Hasskamp moved that the following statement be printed in the Permanent Journal of the House:

"It was my intention to vote in the negative on Monday, April 6, 1992, on the first Dempsey amendment to H. F. No. 2694, as amended." The motion prevailed.

Hasskamp moved that the following statement be printed in the Permanent Journal of the House:

"It was my intention to vote in the negative on Monday, April 6, 1992, on the Stanius amendment to H. F. No. 2694, as amended." 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 negative on Tuesday, April 7,

1992, on the Bertram amendment to H. F. No. 1849, as amended." The motion prevailed.

Henry moved that the following statement be printed in the Permanent Journal of the House:

"It was my intention to vote in the affirmative on Wednesday, April 8, 1992, on final passage of S. F. No. 1558." The motion prevailed.

Kalis moved that the following statement be printed in the Permanent Journal of the House:

"It was my intention to vote in the affirmative on Wednesday, April 8, 1992, on H. F. No. 1114, as amended by the Senate." The motion prevailed.

Osthoff moved that House Concurrent Resolution No. 14 be recalled from the Committee on General Legislation, Veterans Affairs and Gaming and be re-referred to the Committee on Judiciary. The motion prevailed.

Tunheim moved that H. F. No. 2285 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. 2113:

Orenstein; Johnson, A., and Seaberg.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 1722:

Jefferson, Sarna and Boo.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 2136:

Farrell, Beard and Dille.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 2257:

Winter, Steensma and Dille.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 2430:

Krueger, Kinkel and Pellow.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 2728:

Wenzel, Bauerly and Omann.

ADJOURNMENT

Welle moved that when the House adjourns today it adjourn until 1:00 p.m., Monday, April 13, 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., Monday, April 13, 1992.

EDWARD A. BURDICK, Chief Clerk, House of Representatives