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S.F. No. 1427 - Electric Sign Installer Licenses

Author: Senator David Gaither

Prepared by: Matthew S. Grosser, Senate Research (651/296-1890) MG

Date: March 31, 2005

Section 1 increases the membership of the Board of Electricity by one to include a licensed electric sign installer.

Section 2 creates a licensing requirement for electric sign installers with education and experience prerequisites, as well as examination and licensing fees. Licensed electricians and journeymen electricians are exempt from the electric sign installers license requirement.

MG:dv

Senators Gaither and Kiscaden introduced--

S.F. No. 1427: Referred to the Committee on State and Local Government Operations.

A bill for an act

relating to occupations; creating sign specialist licenses to be issued by the Board of Electricity; authorizing rulemaking; amending Minnesota Statutes 2004, sections 326.241, subdivision 1; 326.242, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 326.241, subdivision 1, is amended to read:

Subdivision 1. [COMPOSITION.] The Board of Electricity shall consist of ~~11~~ 12 members, residents of the state, appointed by the governor of whom two shall be representatives of the electrical suppliers in the rural areas of the state, two shall be master electricians, who shall be contractors, two journeyman electricians, one registered consulting electrical engineer, two power limited technicians, who shall be technology system contractors primarily engaged in the business of installing technology circuits or systems, one licensed sign installer, and two public members as defined by section 214.02. Membership terms, compensation of members, removal of members, the filling of membership vacancies, and fiscal year and reporting requirements shall be as provided in sections 214.07 to 214.09. The provision of staff, administrative services and office space; the review and processing of complaints; the setting of board fees; and other provisions relating to board operations shall be as provided in chapter 214.

Sec. 2. Minnesota Statutes 2004, section 326.242, is amended by adding a subdivision to read:

Subd. 3e. [LICENSED SIGN INSTALLER.] (a) Except as otherwise provided by law, no person shall install, alter, repair, plan, lay out, or supervise the installing, altering, or repairing of electrical wiring, apparatus, or equipment for electric signs unless the person is licensed by the board as a sign installer.

(b) The board shall issue a sign installer's license to a person not less than 18 years of age who:

(1) files a completed application form provided by the board;

(2) pays the examination fee prescribed by law and passes an examination provided for by the board;

(3) pays the license fee prescribed by law;

(4) has not less than 4,000 hours of experience, obtained over a period of not less than two years, related to the manufacture, installation, maintenance, connection, or repair of electric signs and related wiring. The hours of experience may be obtained from multiple employers, and equivalent education as determined by the board may be substituted for work experience; and

(5) demonstrates the successful completion of a course concerning the installation, maintenance, connection, or repair of electric signs and related wiring as contained in the sign electrician's workbook published by the American Technical Publishers, Inc. or any other course designed to address the installation, maintenance, connection, or repair of electric signs and related wiring, as approved by the board.

(c) Upon failure to pass the sign installer examination two times within a period of two years, an applicant is ineligible to sit for another examination until the applicant presents to the board proof of the successful completion of a course on code and electrical fundamentals approved by the board, in order to become eligible again to sit for an examination.

(d) As a condition of renewal of a sign installer's

license, the installer shall demonstrate the successful completion of a course, approved by the board, concerning any update or change in applicable sections of the code within 12 months after the update or change in that code. This requirement applies only during or after those years that the code is updated or changed.

(e) A licensed master electrician or journeyman electrician is not required to have a sign installer's license to perform sign installations.

Sec. 3. [EFFECTIVE DATE.]

Sections 1 and 2 are effective July 1, 2006.

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S.F. No. 65 - Health Care (First Engrossment)

Author: Senator Linda Berglin

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC VS

Date: March 25, 2005

S.F. No. 65 makes a number of modifications to the public health care programs.

Section 1 (62A.65) requires the Commissioners of Commerce and Health to apply the premium growth limits established under Minnesota Statutes, section 62J.04, subdivision 1b, when approving the individual market rates.

Section 2 (62D.12, subdivision 19) permits a health maintenance organization to deny or limit coverage for services requiring prior authorization under public health care programs.

Section 3 (62J.04, subdivision 1b) requires the Commissioner of Health to establish premium growth limits for health plan companies.

Paragraph (a) states that for calendar years 2005 to 2010 the premium limits shall be set at Consumer Price Index (CPI) for urban consumers for the preceding calendar year plus two percent. An additional one percentage point shall be added to be used to finance the implementation of the electronic medical record system. The commissioner is required to ensure that the additional percentage point is being used to provide financial assistance to health care providers for that purpose.

Paragraph (b) states that for calendar years beyond 2010, the premium growth limits shall be set at CPI for urban consumers plus two percent. The Commissioners of Health and Commerce shall make a recommendation to the Legislature on whether to continue the additional percentage point described in **paragraph (a)**.

Paragraph (c) authorizes the commissioner to add additional percentage points if a major disaster, bioterrorism, or a public health emergency event occurs that effects heath care costs.

Paragraph (d) requires the commissioner to publish the annual premium growth limits in the *State Register* by January 31 of the year that the limits are to be in effect.

Paragraph (e) states that premium growth is measured as the percentage change in per member, per month premium revenue from the current year to the previous year. Requires premium growth rates to be calculated for the individual, small group, and large group lines of business.

Paragraph (f) clarifies that this section applies to employee health plans offered by self-insured employers.

Paragraph (g) requires the Commissioner of Employee Relations to direct contracting health plan companies to reduce reimbursement to providers in order to meet the premium growth limitations.

Section 4 (62J.04, subdivision 3) authorizes the commissioner to use the data collected to be used to monitor the achievement of premium growth limits.

Section 5 (62J.041) requires the Commissioner of Health to establish annual health care expenditure limits not to exceed the premium limits. Defines "health care expenditures" as incurred claims or expenditures on health care services. Requires the commissioner to publish in the *State Register* and make available to the public by July 1, 2007, and each year thereafter a list of all health plan companies that exceeded their health care expenditure limit for the previous calendar year.

Section 6 (62J.255) requires health plan companies to provide educational information to enrollees on the increased personal health risks and the additional cost to the health care system due to obesity and due to smoking. It also requires the Commissioner of Health, in consultation with the Minnesota Medical Association (MMA), to develop an information sheet on the personal health risks and on the additional costs to the health care system associated with obesity and on smoking.

Section 7 (62J.301, subdivision 3) requires the commissioner to collect and maintain data for the purposes of setting premium growth limits and measuring compliance.

Section 8 (62J.38) requires the cost containment data to be broken down to distinguish between the individual market, the small group market, and the large group market.

Section 9 (62J.692, subdivision 3) states that a clinical medical education program that trains pediatricians is requested to include in their program curriculum training in case management and medication management for children suffering from mental illness in order to eligible for MERC funds.

Section 10 (62L.08, subdivision 8) requires the Commissioners of Health and Commerce to apply the premium growth limits established under section 62J.04, subdivision 1b, when approving the small employer market rates.

Section 11 (62Q.175) states that no health plan company is required to cover any health care service included in the list established under section 256B.0625, subdivision 46.

Sections 12 and 13 (144.1501) extends the loan forgiveness program to medical residents who are specializing in the area of pediatric psychiatry.

Section 14 (256.045, subdivision 3a) states that on appeal, the referee may not overturn a decision on prior authorization for services requiring prior authorization if the prepaid health plan has appropriately used evidence-based criteria or guidelines in making its determination.

Section 15 (256.9545) reinstates the Prescription Drug Discount Program (which expired upon the effective date of an expanded prescription drug benefit under Medicare) and makes changes to the program by eliminating the income limit on eligibility, making individuals who are enrolled in Medicare ineligible, and changing the administration fee to an enrollment fee of $100.

Section 16 (256.9693) extends the continuing care program for persons with mental illness to persons with mental illness who are eligible for general assistance medical care.

Section 17 (256B.0625, subdivision 3b) extends coverage of telemedicine consultations to include telephone conversations between a pediatrician and a psychiatrist when the consultation is for the purpose of managing the medications of a child with mental health needs.

Section 18 (256B.0625, subdivision 46) requires the commissioner, in consultation with the Commissioner of Health, to biennially develop a list of services that are not eligible for reimbursement under chapters 256B, 256D, and 256L effective for services provided on or after July 1, 2007. The commissioner must review the list in effect for the prior biennium and make any additions or deletions from the list as appropriate. The commissioner may convene an ad hoc panel to assist the commissioner in reviewing and establishing the list. The commissioner must solicit comments and recommendations from the public through public hearings. The initial list must be established by January 15, 2007, for the list effective July 1, 2007, and by October 1 of the even-numbered years beginning October 1, 2008, and must be published in the *State Register* by November 1 of the even-numbered years beginning November 1, 2008. The commissioner must submit the list to the Legislature by January 15 of the odd-numbered years beginning January 15, 2007.

Section 19 (256B.0627, subdivision 1) modifies several definitions in the statute outlining home care covered services. It prohibits assessments of client needs from being conducted by the entity providing the services. It places restrictions on the delegation of authority by a responsible party to another person.

Section 20 (256B.0627, subdivision 4) prohibits certain relatives from providing personal care assistant (PCA) services to recipients unless hardship criteria are satisfied and DHS approves the arrangement. This section also requires DHS to establish an ongoing effort to uncover potential fraud and abuse int eh PCA program.

Section 21 (256B. 0627, subdivision 9) authorizes the flexible use of PCA house only if allowed by DHS. It establishes requirements for determining whether flexible use of hours is an appropriate

option for a recipient. Its authorizes DHS to deny, revoke, or suspend the authorization for flexible use of hours if program requirements are not met.

Section 22 (256B.0631, subdivision 5), states that the medical assistance co-payments shall be waived by the provider if the recipient is practicing a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program.

Section 23 (256B.072), paragraph (a), requires the commissioner to establish a performance reporting and payment system for providers who provide services to public program recipients.

Paragraph (b) establishes the measures that are to be used for the reporting and payment system.

Paragraph (c) requires the commissioner to provide a performance bonus payment to providers who have met certain levels of performance established by the commissioner.

Paragraph (d) states the performance bonus payments shall be funded with the projected savings in the program costs due to improved results of these measures with the eligible providers.

Paragraph (e) requires the commissioner to publish a description of the proposed performance reporting and payment system for the calendar year beginning January 1, 2007, and each subsequent calendar year at least three months before the beginning of that calendar year.

Paragraph (f) requires the commissioner to report annually through a public Web site the results by medical group, single-physician practice, and hospital of the measures and performance payments under this section and shall compare the results for patients enrolled in public programs with those enrolled in private health plans.

Section 24 (256B.0918) provides a rate increase of two-tenths of one percent to specified providers for employee scholarships and job-related training in English as a second language. Eligible provider groups are listed and include all waivered services providers, personal care service providers, home health service providers, day training and habilitation services, etc.

Section 25 (256D.03, subdivision 4) states that the GAMC co-payments shall be waived by the provider if the recipient is practicing a healthy lifestyle by reforming from tobacco use or if participating in a smoking cessation program.

Section 26 (256L.07, subdivision 1) reinstates the ability of individuals and families to remain on MinnesotaCare if their income increases over the maximum income eligibility level but is less than ten percent of the annual premium for a policy with a $500 deductible available through MCHA.

Section 27 (256L.20) establishes the MinnesotaCare option for small employers.

Subdivision 1 defines the following terms: "dependent," "eligible employer," "eligible employee," "maximum premium," "participating employer," and "program."

Subdivision 2 authorizes enrollment in MinnesotaCare coverage for all eligible employees and their dependents, if the eligible employer meets the requirements of subdivision 3.

Subdivision 3 states that to participate an eligible employer must: (1) agree to contribute toward the cost of the premium for the employee and the employee's dependents; (2) certify that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program; (3) offer coverage to all eligible employees and the dependents of those employees; and (4) not have provided employer-subsidized health coverage as an employee benefit during the previous 12 months.

Subdivision 4 requires the employer to pay 50 percent of the maximum premium for eligible employees without dependents with income equal to or less than 175 percent of the federal poverty guidelines (FPG) and for eligible employees with dependents with income equal to or less than 275 percent of FPG. States that for eligible employees without dependents with income over 175 percent of FPG and eligible employees with dependents with income over 275 percent of FPG, the employer must pay the full cost of the maximum premium. Permits employer to require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent of the total cost. If the employee is required to pay a portion of the premium, the payment shall be made to the employer. Requires the commissioner to collect the premiums from the participating employers.

Subdivision 5 states that the coverage provided shall be the MinnesotaCare covered services with all applicable co-pays and coinsurance.

Subdivision 6 states that upon the payment of the premium eligible employees and their dependents shall be enrolled in the MinnesotaCare program. States that the insurance barrier of section 256L.07, subdivisions 2 and 3, do not apply. Authorizes the commissioner to require eligible employees to provide income verification to determine premiums.

Section 28 lists a number of services that will require prior authorization for reimbursement in the public program effective July 1, 2005. This section also requires that a technology assessment be conducted by an independent organization before any new medical device, brand drug, or medical procedure is included in the covered services for public programs.

Section 29 requires the Commissioner of Health, in consultation with the Commissioners of Human Services and Education, to convene a task force to study and make recommendations on reducing the rate of obesity among children in Minnesota. Requires the task force to set a goal in terms of reducing the rate of childhood obesity and make recommendations as to how to achieve the goal, including increasing the physical education activities, improving the nutritional offerings, exploring opportunities to promote physical education and healthy eating programs, and evaluating the availability and choice

of nutritional products offered within the schools. States the make up of the task force. Requires that these recommendations be submitted to the Legislature by January 15, 2007.

Section 30 requires the Commissioner of Health, in consultation with the electronic health records planning work group, to develop a statewide plan for all hospitals ands physician group practices to have in place an interoperable electronic health records system by January 1, 2015.

Section 31 appropriates money: a blank amount to the Board of Trustees of the Minnesota State Colleges and Universities for the nursing and health care education plan; and a blank amount to the Commissioner of Health for the loan forgiveness program.

KC:vs

A bill for an act

relating to health care; modifying premium rate restrictions; establishing expenditure limits; modifying cost containment provisions; modifying certain loan forgiveness programs; modifying medical assistance, general assistance medical care, and MinnesotaCare programs; requiring reports; appropriating money; amending Minnesota Statutes 2004, sections 62A.65, subdivision 3; 62D.12, subdivision 19; 62J.04, subdivision 3, by adding a subdivision; 62J.041; 62J.301, subdivision 3; 62J.38; 62J.692, subdivision 3; 62L.08, subdivision 8; 144.1501, subdivisions 2, 4; 256.045, subdivision 3a; 256.9693; 256B.0625, subdivision 3b, by adding a subdivision; 256B.0627, subdivisions 1, 4, 9; 256B.0631, by adding a subdivision; 256D.03, subdivision 4; 256L.07, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 256; 256B; 256L.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 62A.65, subdivision 3, is amended to read:

Subd. 3. [PREMIUM RATE RESTRICTIONS.] No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, 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 by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(c) 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 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. 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) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area; and

(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.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) Notwithstanding paragraphs (a) to (g), the rates must not be approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risks associated with the enrollee populations~~,~~ and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

Sec. 2. Minnesota Statutes 2004, section 62D.12, subdivision 19, is amended to read:

Subd. 19. [COVERAGE OF SERVICE.] A health maintenance organization may not deny or limit coverage of a service which the enrollee has already received solely on the basis of lack of

prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained. This subdivision does not apply to prior authorization under chapter 256B, 256D, or 256L.

Sec. 3. Minnesota Statutes 2004, section 62J.04, is amended by adding a subdivision to read:

Subd. 1b. [PREMIUM GROWTH LIMITS.] (a) For calendar year 2005 and each year thereafter, the commissioner shall set annual premium growth limits for health plan companies. The premium limits set by the commissioner for calendar years 2005 to 2010 shall not exceed the regional Consumer Price Index for urban consumers for the preceding calendar year plus two percentage points and an additional one percentage point to be used to finance the implementation of the electronic medical record system described under section 62J.565. The commissioner shall ensure that the additional percentage point is being used to provide financial assistance to health care providers to implement electronic medical record systems either directly or through an increase in reimbursement.

(b) For the calendar years beyond 2010, the rate of premium growth shall be limited to the change in the Consumer Price Index for urban consumers for the previous calendar year plus two percentage points. The commissioners of health and commerce shall make a recommendation to the legislature by January 15, 2009, regarding the continuation of the additional percentage point to the growth limit described in paragraph (a). The recommendation shall be based on the progress made by health care providers in instituting an electronic medical record system and in creating a statewide interactive electronic health record system.

(c) The commissioner may add additional percentage points as needed to the premium limit for a calendar year if a major disaster, bioterrorism, or a public health emergency occurs that results in higher health care costs. Any additional percentage

points must reflect the additional cost to the health care system directly attributed to the disaster or emergency.

(d) The commissioner shall publish the annual premium growth limits in the State Register by January 31 of the year that the limits are to be in effect.

(e) For the purpose of this subdivision, premium growth is measured as the percentage change in per member, per month premium revenue from the current year to the previous year. Premium growth rates shall be calculated for the following lines of business: individual, small group, and large group. Data used for premium growth rate calculations shall be submitted as part of the cost containment filing under section 62J.38.

(f) For purposes of this subdivision, "health plan company" has the meaning given in section 62J.041.

(g) For coverage that is provided by a health plan company under the terms of a contract with the Department of Employee Relations, the commissioner of employee relations shall direct the contracting health plan companies to reduce reimbursement to providers in order to meet the premium growth limitations required by this section.

Sec. 4. Minnesota Statutes 2004, section 62J.04, subdivision 3, is amended to read:

Subd. 3. [COST CONTAINMENT DUTIES.] The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section and collect data as described in sections 62J.38 to 62J.41 to monitor statewide achievement of the cost containment goals and premium growth limits;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne Counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve the cost containment goals;

(3) monitor the quality of health care throughout the state

and take action as necessary to ensure an appropriate level of quality;

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

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

(7) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

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

(9) make the cost containment goal and premium growth limit data available to the public in a consumer-oriented manner.

Sec. 5. Minnesota Statutes 2004, section 62J.041, is amended to read:

62J.041 [~~INTERIM~~ HEALTH PLAN COMPANY ~~COST-CONTAINMENT GOALS~~ HEALTH CARE EXPENDITURE LIMITS.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the following definitions apply.

(b) "Health plan company" has the definition provided in section 62Q.01 and also includes employee health plans offered by self-insured employers.

(c) "~~Total~~ Health care expenditures" means incurred claims or expenditures on health care services~~, administrative expenses, charitable contributions, and all other payments~~ made by health plan companies ~~out of premium revenues~~.

~~(d) "Net expenditures" means total expenditures minus exempted taxes and assessments and payments or allocations made to establish or maintain reserves.~~

~~(e) "Exempted taxes and assessments" means direct payments for taxes to government agencies, contributions to the Minnesota Comprehensive Health Association, the medical assistance provider's surcharge under section 256.9657, the MinnesotaCare provider tax under section 295.52, assessments by the Health Coverage Reinsurance Association, assessments by the Minnesota Life and Health Insurance Guaranty Association, assessments by the Minnesota Risk Adjustment Association, and any new assessments imposed by federal or state law.~~

~~(f)~~ "Consumer cost-sharing or subscriber liability" means enrollee coinsurance, co-payment, deductible payments, and amounts in excess of benefit plan maximums.

Subd. 2. [ESTABLISHMENT.] The commissioner of health shall establish ~~cost containment goals~~ health care expenditure limits for ~~the increase in net~~ calendar year 2006, and each year thereafter, for health care expenditures by each health plan company ~~for calendar years 1994, 1995, 1996, and 1997. The cost containment goals must be the same as the annual cost containment goals for health care spending established under section 62J.04, subdivision 1, paragraph (b)~~. Health plan companies that are affiliates may elect to meet one combined ~~cost containment goal~~ health care expenditure limit. The limits set by the commissioner shall not exceed the premium limits established in section 62J.04, subdivision 1b.

Subd. 3. [DETERMINATION OF EXPENDITURES.] Health plan companies shall submit to the commissioner of health, by April ~~1, 1994, for calendar year 1993, April 1, 1995, for calendar year 1994, April 1, 1996, for calendar year 1995, April 1, 1997, for calendar year 1996, and April 1, 1998, for calendar year 1997~~ of each year beginning 2006, all information the commissioner determines to be necessary to implement this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, health care expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health plan company to the commissioner, and approved by the commissioner as actuarially justified. ~~The methodology to be used for adjustments and the election to meet one cost containment goal for affiliated health plan companies must be submitted to the commissioner by September 1, 1994. Community integrated service networks may submit the information with their application for licensure. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner.~~

Subd. 4. [MONITORING OF RESERVES.] (a) The commissioners

of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates to assess the degree to which savings resulting from the establishment of cost containment goals are passed on to consumers in the form of lower premium rates.

(b) Health plan companies shall fully reflect in the premium rates the savings generated by the cost containment goals. No premium rate, currently reviewed by the Department of Health or Commerce, may be approved for those health plan companies unless the health plan company establishes to the satisfaction of the commissioner of commerce or the commissioner of health, as appropriate, that the proposed new rate would comply with this paragraph.

(c) Health plan companies, except those licensed under chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company expects to attain during each quarter of the following fiscal year. These health plan companies shall submit with required quarterly financial statements a calculation of the actual reserve level attained by the company at the end of each quarter including identification of the sources of any significant changes in the reserve level and an updated projection of the level of reserves the health plan company expects to attain by the end of the fiscal year. In cases where the health plan company has been given a certificate to operate a new health maintenance organization under chapter 62D, or been licensed as a community integrated service network under chapter 62N, or formed an affiliation with one of these organizations, the health plan company shall also submit with its quarterly financial statement, total enrollment at the beginning and end of the quarter and enrollment changes within each service area of the new organization. The reserve calculations shall be

maintained by the commissioners as trade secret information, except to the extent that such information is also required to be filed by another provision of state law and is not treated as trade secret information under such other provisions.

(d) Health plan companies in paragraph (c) whose reserves are less than the required minimum or more than the required maximum at the end of the fiscal year shall submit a plan of corrective action to the commissioner of health or commerce under subdivision 7.

(e) The commissioner of commerce, in consultation with the commissioner of health, shall report to the legislature no later than January 15, 1995, as to whether the concept of a reserve corridor or other mechanism for purposes of monitoring reserves is adaptable for use with indemnity health insurers that do business in multiple states and that must comply with their domiciliary state's reserves requirements.

Subd. 5. [NOTICE.] The commissioner of health shall publish in the State Register and make available to the public by July 1, ~~1995~~ 2007, and each year thereafter, a list of all health plan companies that exceeded their ~~cost-containment-goal~~ health care expenditure limit for the ~~1994~~ previous calendar year. ~~The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health plan companies that exceeded their combined cost containment goal for calendar years 1994 and 1995.~~ The commissioner shall notify each health plan company that the commissioner has determined that the health plan company exceeded its ~~cost-containment-goal,~~ health care expenditure limit at least 30 days before publishing the list, and shall provide each health plan company ~~with~~ ten days to provide an explanation for exceeding the ~~cost-containment-goal~~ health care expenditure limit. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

Subd. 6. [ASSISTANCE BY THE COMMISSIONER OF COMMERCE.] The commissioner of commerce shall provide assistance to the

commissioner of health in monitoring health plan companies regulated by the commissioner of commerce.

Sec. 6. [62J.255] [HEALTH RISK INFORMATION SHEET.]

(a) A health plan company shall provide to each enrollee on an annual basis information on the increased personal health risks and the additional costs to the health care system due to obesity and to the use of tobacco.

(b) The commissioner, in consultation with the Minnesota Medical Association, shall develop an information sheet on the personal health risks of obesity and smoking and on the additional costs to the health care system due to obesity and due to smoking. The information sheet shall be posted on the Minnesota Department of Health's Web site.

(c) When providing the information required in paragraph (a), the health plan company must also provide each enrollee with information on the best practices care guidelines and quality of care measurement criteria identified in section 62J.43 as well as the availability of this information on the department's Web site.

Sec. 7. Minnesota Statutes 2004, section 62J.301, subdivision 3, is amended to read:

Subd. 3. [GENERAL DUTIES.] The commissioner shall:

(1) collect and maintain data which enable population-based monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota;

(2) collect and maintain data for the purpose of estimating total Minnesota health care expenditures and trends;

(3) collect and maintain data for the purposes of setting cost containment goals and premium growth limits under section 62J.04, and measuring cost containment goal and premium growth limit compliance;

(4) conduct applied research using existing and new data and promote applications based on existing research;

(5) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health plan companies, as defined in section 62Q.01,

subdivision 4;

(6) work closely with health plan companies and health care providers to promote improvements in health care efficiency and effectiveness; and

(7) 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.

Sec. 8. Minnesota Statutes 2004, section 62J.38, is amended to read:

62J.38 [COST CONTAINMENT DATA FROM GROUP PURCHASERS.]

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for each calendar year. Group purchasers shall submit data for the 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Premium revenue data, information on aggregate enrollment, and data on member months must be broken down to distinguish between individual market, small group market, and large group market. Filings under this section for calendar year 2005 must also include information broken down by individual market, small group market, and large group market for calendar year 2004. Expenditure data must distinguish between costs incurred for patient care and administrative costs. Patient care and administrative costs must include only expenses incurred on behalf of health plan members and must not include the cost of providing health care services for nonmembers at facilities owned by the group purchaser or affiliate. Expenditure data must be provided separately for the following categories and for other categories required by the commissioner: physician services, dental services, other

professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. Administrative costs must include costs for marketing; advertising; overhead; salaries and benefits of central office staff who do not provide direct patient care; underwriting; lobbying; claims processing; provider contracting and credentialing; detection and prevention of payment for fraudulent or unjustified requests for reimbursement or services; clinical quality assurance and other types of medical care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider. Capital costs and costs incurred must be recorded according to standard accounting principles. The reports of this data must also separately identify expenses for local, state, and federal taxes, fees, and assessments. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs. In addition to reporting administrative costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider; reports submitted under this section also must include the payments made during the calendar year for these purposes. The commissioner shall make public, by group purchaser data collected under this paragraph in accordance with section 62J.321, subdivision 5. Workers' compensation insurance plans and automobile insurance

plans are exempt from complying with this paragraph as it relates to the submission of administrative costs.

(c) The commissioner may collect information on:

(1) premiums, benefit levels, managed care procedures, and other features of health plan companies;

(2) prices, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses; and

(3) information on health care services not provided through health plan companies, including information on prices, costs, expenditures, and utilization.

(d) All group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

Sec. 9. Minnesota Statutes 2004, section 62J.692, subdivision 3, is amended to read:

Subd. 3. [APPLICATION PROCESS.] (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, or physician assistants is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

A clinical medical education program that trains pediatricians is requested to include in its program curriculum training in case management and medication management for children suffering from mental illness to be eligible for funds under subdivision 4.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of

Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number of each training site used in the program; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site. Only those training sites that host 0.5 FTE or more eligible trainees for a program may be included in the program's application; and

(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) in the first year of each biennium:

(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;

(2) a description of current sources of funding for

clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and

(3) other revenue received for the purposes of clinical training.

(e) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Sec. 10. Minnesota Statutes 2004, section 62L.08, subdivision 8, is amended to read:

Subd. 8. [FILING REQUIREMENT.] (a) 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 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.

(b) Notwithstanding paragraph (a), the rates shall not be approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549. ~~For premium rates proposed to go into effect between July 1, 1993 and December 31, 1993, the pertinent growth rate is the growth rate applied under section 62J.04, subdivision 1, paragraph (b), to calendar year 1994.~~

Sec. 11. [62Q.175] [COVERAGE EXEMPTIONS.]

Notwithstanding any law to the contrary, no health plan

company is required to provide coverage for any health care service included on the list established under section 256B.0625, subdivision 46.

Sec. 12. Minnesota Statutes 2004, section 144.1501, subdivision 2, is amended to read:

Subd. 2. [CREATION OF ACCOUNT.] (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents agreeing to practice in designated rural areas or underserved urban communities, or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas; and

(3) for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 13. Minnesota Statutes 2004, section 144.1501, subdivision 4, is amended to read:

Subd. 4. [LOAN FORGIVENESS.] The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area ~~or~~, facility type, or specialty area specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that ~~75~~ 50 percent of the funds available are used for rural physician loan forgiveness ~~and~~, 25 percent of the funds available are used for underserved urban communities loan forgiveness, and 25 percent

of the funds available are used for pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for urban underserved communities, the remaining funds may be allocated for rural physician loan forgiveness. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area ~~or~~, facility type, or specialty area specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Sec. 14. Minnesota Statutes 2004, section 256.045, subdivision 3a, is amended to read:

Subd. 3a. [PREPAID HEALTH PLAN APPEALS.] (a) All prepaid health plans under contract to the commissioner under chapter

256B or 256D must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request a hearing under paragraph (b). When a complaint is filed, the prepaid health plan must notify the ombudsman within three working days. Recipients may request the assistance of the ombudsman in the complaint system process. The prepaid health plan must issue a written resolution of the complaint to the recipient within 30 days after the complaint is filed with the prepaid health plan. A recipient is not required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

(b) Recipients enrolled in a prepaid health plan under chapter 256B or 256D may contest a prepaid health plan's denial, reduction, or termination of health services, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. <u>The referee may not overturn a decision on prior authorization for services covered under section 28, if the prepaid health plan has appropriately used evidence-based criteria or guidelines in making the determination.</u> The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services referee may order a second medical opinion from the prepaid health plan or may order a second medical opinion from a nonprepaid health plan provider at the expense of the prepaid

health plan. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to authorize a previously authorized service, or the prepaid health plan's written resolution to a complaint, a recipient may request an expedited hearing. If an expedited appeal is warranted, the state human services referee shall hear the appeal and render a decision within a time commensurate with the level of urgency involved, based on the individual circumstances of the case.

Sec. 15. [256.9545] [PRESCRIPTION DRUG DISCOUNT PROGRAM.]

Subdivision 1. [ESTABLISHMENT; ADMINISTRATION.] The commissioner shall establish and administer the prescription drug discount program, effective July 1, 2005.

Subd. 2. [COMMISSIONER'S AUTHORITY.] The commissioner shall administer a drug rebate program for drugs purchased according to the prescription drug discount program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The rebate program shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title XIX of the federal Social Security Act.

Subd. 3. [DEFINITIONS.] For the purpose of this section, the following terms have the meanings given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Manufacturer" means a manufacturer as defined in section 151.44, paragraph (c).

(c) "Covered prescription drug" means a prescription drug as defined in section 151.44, paragraph (d), that is covered under medical assistance as described in section 256B.0625,

subdivision 13, and that is provided by a manufacturer that has a fully executed rebate agreement with the commissioner under this section and complies with that agreement.

(d) "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue an individual or group 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 joint self-insurance employee health plan operating under chapter 62H; a community integrated systems network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a city, county, school district, or other political subdivision providing self-insured health coverage under section 471.617 or sections 471.98 to 471.982; and a self-funded health plan under the Employee Retirement Income Security Act of 1974, as amended.

(e) "Participating pharmacy" means a pharmacy as defined in section 151.01, subdivision 2, that agrees to participate in the prescription drug discount program.

(f) "Enrolled individual" means a person who is eligible for the program under subdivision 4 and has enrolled in the program according to subdivision 5.

Subd. 4. [ELIGIBLE PERSONS.] To be eligible for the program, an applicant must:

(1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision 4;

(2) not be enrolled in Medicare, medical assistance, general assistance medical care, or MinnesotaCare;

(3) not be enrolled in and have currently available prescription drug coverage under a health plan offered by a health carrier or employer or under a pharmacy benefit program offered by a pharmaceutical manufacturer; and

(4) not be enrolled in and have currently available prescription drug coverage under a Medicare supplement plan, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health

maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

Subd. 5. [APPLICATION PROCEDURE.] (a) Applications and information on the program must be made available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Individuals shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the commissioner. The commissioner shall determine an applicant's eligibility for the program within 30 days from the date the application is received. Upon notice of approval, the applicant must submit to the commissioner the enrollment fee specified in subdivision 10. Eligibility begins the month after the enrollment fee is received by the commissioner.

(b) An enrollee's eligibility must be renewed every 12 months with the 12-month period beginning in the month after the application is approved.

(c) The commissioner shall develop an application form that does not exceed one page in length and requires information necessary to determine eligibility for the program.

Subd. 6. [PARTICIPATING PHARMACY.] According to a valid prescription, a participating pharmacy must sell a covered prescription drug to an enrolled individual at the pharmacy's usual and customary retail price, minus an amount that is equal to the rebate amount described in subdivision 8, plus the amount of any switch fee established by the commissioner under subdivision 10. Each participating pharmacy shall provide the commissioner with all information necessary to administer the program, including, but not limited to, information on prescription drug sales to enrolled individuals and usual and customary retail prices.

Subd. 7. [NOTIFICATION OF REBATE AMOUNT.] The commissioner shall notify each drug manufacturer, each calendar quarter or according to a schedule to be established by the commissioner,

of the amount of the rebate owed on the prescription drugs sold by participating pharmacies to enrolled individuals.

Subd. 8. [PROVISION OF REBATE.] To the extent that a manufacturer's prescription drugs are prescribed to a resident of this state, the manufacturer must provide a rebate equal to the rebate provided under the medical assistance program for any prescription drug distributed by the manufacturer that is purchased by an enrolled individual at a participating pharmacy. The manufacturer must provide full payment within 30 days of receipt of the state invoice for the rebate, or according to a schedule to be established by the commissioner. The commissioner shall deposit all rebates received into the Minnesota prescription drug dedicated fund established under subdivision 11. The manufacturer must provide the commissioner with any information necessary to verify the rebate determined per drug.

Subd. 9. [PAYMENT TO PHARMACIES.] The commissioner shall distribute on a biweekly basis an amount that is equal to an amount collected under subdivision 8 to each participating pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals.

Subd. 10. [ENROLLMENT FEE; SWITCH FEE.] (a) The commissioner shall establish an annual enrollment fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates under this program.

(b) The commissioner shall establish a reasonable switch fee that covers expenses incurred by pharmacies in formatting for electronic submission claims for prescription drugs sold to enrolled individuals.

Subd. 11. [DEDICATED FUND; CREATION; USE OF FUND.] (a) The Minnesota prescription drug dedicated fund is established as an account in the state treasury. The commissioner of finance shall credit to the dedicated fund all rebates paid under subdivision 8, any federal funds received for the program, all enrollment fees paid by the enrollees, and any appropriations or allocations designated for the fund. The commissioner of

finance shall ensure that fund money is invested under section 11A.25. All money earned by the fund must be credited to the fund. The fund shall earn a proportionate share of the total state annual investment income.

(b) Money in the fund is appropriated to the commissioner to reimburse participating pharmacies for prescription drug discounts provided to enrolled individuals under this section; to reimburse the commissioner for costs related to enrollment, processing claims, and distributing rebates and for other reasonable administrative costs related to administration of the prescription drug discount program; and to repay the appropriation provided for this section. The commissioner must administer the program so that the costs total no more than funds appropriated plus the drug rebate proceeds.

Sec. 16. Minnesota Statutes 2004, section 256.9693, is amended to read:

256.9693 [CONTINUING CARE PROGRAM FOR PERSONS WITH MENTAL ILLNESS.]

The commissioner shall establish a continuing care benefit program for persons with mental illness in which persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for up to 45 days beyond that allowed by section 256.969. Persons with mental illness who are eligible for medical assistance or general assistance medical care may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be assured. Payments under this section shall not affect payments under section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner, as part of the contracts with hospitals, shall establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a

court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric benefit under Medicare. If a recipient is enrolled in a prepaid plan, this program is included in the plan's coverage.

Sec. 17. Minnesota Statutes 2004, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. [TELEMEDICINE CONSULTATIONS.] Medical assistance covers telemedicine consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation, unless the communication is between a pediatrician and psychiatrist for the purpose of managing the medications of a child with mental health needs. Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate.

Sec. 18. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 46. [LIST OF HEALTH CARE SERVICES NOT ELIGIBLE FOR COVERAGE.] (a) The commissioner of human services, in consultation with the commissioner of health, shall biennially establish a list of diagnosis/treatment pairings that are not eligible for reimbursement under this chapter and chapters 256D

and 256L, effective for services provided on or after July 1, 2007. The commissioner shall review the list in effect for the prior biennium and shall make any additions or deletions from the list as appropriate, taking into consideration the following:

(1) scientific and medical information;

(2) clinical assessment;

(3) cost-effectiveness of treatment;

(4) prevention of future costs; and

(5) medical ineffectiveness.

(b) The commissioner may appoint an ad hoc advisory panel made up of physicians, consumers, nurses, dentists, chiropractors, and other experts to assist the commissioner in reviewing and establishing the list. The commissioner shall solicit comments and recommendations from any interested persons and organizations and shall schedule at least one public hearing.

(c) The list must be established by January 15, 2007, for the list effective July 1, 2007, and by October 1 of the even-numbered years beginning October 1, 2008, for the lists effective the following July 1. The commissioner shall publish the list in the State Register by November 1 of the even-numbered years beginning November 1, 2008. The list shall be submitted to the legislature by January 15 of the odd-numbered years beginning January 15, 2007.

Sec. 19. Minnesota Statutes 2004, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A

face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care assistant services is conducted on those recipients who have never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party. Assessments shall not be conducted by the same agency, individual, or organization providing the care services.

(c) "Care plan" means a written description of personal

care assistant services developed by the qualified professional or the recipient's physician with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(d) "Complex and regular private duty nursing care" means:

(1) complex care is private duty nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for private duty nursing the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care; and

(2) regular care is private duty nursing provided to all other recipients.

(e) "Health-related functions" means functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care attendant.

(f) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

(g) "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

(h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(i) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D;

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services; and

(6) is subject to criminal background checks and procedures specified in chapter 245C.

(j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in chapter 245C. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in chapter 245C, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in chapter 245C; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the Department of Human Services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

(k) "Responsible party" means an individual who is capable

of providing the support necessary to assist the recipient to live in the community, is at least 18 years old, actively participates in planning and directing of personal care assistant services, and is not the personal care assistant. The responsible party must be accessible to the recipient and the personal care assistant when personal care services are being provided and monitor the services at least weekly according to the plan of care. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and care plan. Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult ~~who is not the personal care assistant~~ during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. The responsible party must assure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the service agreement and the care plan. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

(l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must

be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

(m) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

(n) "Telehomecare" means the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located.

Sec. 20. Minnesota Statutes 2004, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. [PERSONAL CARE ASSISTANT SERVICES.] (a) The personal care assistant services that are eligible for payment are services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivision 5.

(c) The amount and type of services authorized shall be

based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning

can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18). For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

(d) The personal care assistant services that are not eligible for payment are the following:

(1) services not ordered by the physician;

(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) <u>services provided by parents of adult recipients, adult children, or siblings of the recipient, unless these</u>

relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

(ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;

(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;

(iv) the relative incurs substantial expenses by providing personal care for the recipient; or

(v) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

(11) homemaker services that are not an integral part of a personal care assistant services;

~~(11)~~ (12) home maintenance or chore services;

~~(12)~~ (13) services not specified under paragraph (a); and

~~(13)~~ (14) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

(f) The commissioner shall establish an ongoing audit process for potential fraud and abuse for personal care

assistant services.

Sec. 21. Minnesota Statutes 2004, section 256B.0627, subdivision 9, is amended to read:

Subd. 9. [FLEXIBLE USE OF PERSONAL CARE ASSISTANT HOURS.] (a) The commissioner may allow for the flexible use of personal care assistant hours. "Flexible use" means the scheduled use of authorized hours of personal care assistant services, which vary within the length of the service authorization in order to more effectively meet the needs and schedule of the recipient. Recipients may use their approved hours flexibly within the service authorization period for medically necessary covered services specified in the assessment required in subdivision 1. The flexible use of authorized hours does not increase the total amount of authorized hours available to a recipient as determined under subdivision 5. The commissioner shall not authorize additional personal care assistant services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the county public health nurse determines a change in condition and a need for increased services is established.

(b) The recipient or responsible party, together with the county public health nurse, shall determine whether flexible use is an appropriate option based on the needs and preferences of the recipient or responsible party, and, if appropriate, must ensure that the allocation of hours covers the ongoing needs of the recipient over the entire service authorization period. As part of the assessment and service planning process, the recipient or responsible party must work with the county public health nurse to develop a written month-to-month plan of the projected use of personal care assistant services that is part of the service plan and ensures:

(1) that the health and safety needs of the recipient will be met;

(2) that the total annual authorization will not exceed before the end date; and

(3) how actual use of hours will be monitored.

(c) If the actual use of personal care assistant service varies significantly from the use projected in the plan, the written plan must be promptly updated by the recipient or responsible party and the county public health nurse.

(d) The recipient or responsible party, together with the provider, must work to monitor and document the use of authorized hours and ensure that a recipient is able to manage services effectively throughout the authorized period. The provider must ensure that the month-to-month plan is incorporated into the care plan. Upon request of the recipient or responsible party, the provider must furnish regular updates to the recipient or responsible party on the amount of personal care assistant services used.

(e) The recipient or responsible party may revoke the authorization for flexible use of hours by notifying the provider and county public health nurse in writing.

(f) If the requirements in paragraphs (a) to (e) have not substantially been met, the commissioner shall deny, revoke, or suspend the authorization to use authorized hours flexibly. The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the flexible hours option shall not affect the recipient's authorized level of personal care assistant services as determined under subdivision 5.

Sec. 22. Minnesota Statutes 2004, section 256B.0631, is amended by adding a subdivision to read:

Subd. 5. [HEALTHY LIFESTYLE WAIVER.] The co-payments described in subdivision 1 shall be waived by the provider if the recipient is practicing a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program. To obtain the waiver, the recipient must sign a statement stating that the recipient does not use tobacco products or is currently participating in a smoking cessation program. The provider shall keep the signed statement on file.

Sec. 23. [256B.072] [PERFORMANCE REPORTING AND QUALITY IMPROVEMENT PAYMENT SYSTEM.]

(a) The commissioner of human services shall establish a performance reporting and payment system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L.

(b) The measures used for the performance reporting and payment system for medical groups or single-physician practices shall include, but are not limited to, measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting and payment system for inpatient hospitals shall include, but are not limited to, measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the case of a medical group or single-physician practice, the measures used shall be consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines. In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to develop the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) For recipients seen on or after January 1, 2007, the commissioner shall provide a performance bonus payment to providers who have achieved certain levels of performance established by the commissioner with respect to the measures or who have achieved certain rates of improvement established by the commissioner with respect to the measures or whose rates of achievement have increased over a previous period, as established by the commissioner. The performance bonus payment

may be a fixed dollar amount per patient, paid quarterly or annually, or alternatively payment may be made as a percentage increase over payments allowed elsewhere in statute for the recipients identified in paragraph (a). In order for providers to be eligible for a performance bonus payment under this section, the commissioner may require the providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may contract with a reporting organization to assist with the collection of reporting information and to prevent duplication of reporting. The commissioner may limit application of the performance bonus payment system to providers that provide a sufficiently large volume of care to permit adequate statistical precision in the measurement of that care, as established by the commissioner, after consulting with other health care quality reporting organizations.

(d) The performance bonus payments shall be funded with the projected savings in the program costs due to improved results of these measures with the eligible providers.

(e) The commissioner shall publish a description of the proposed performance reporting and payment system for the calendar year beginning January 1, 2007, and each subsequent calendar year, at least three months prior to the beginning of that calendar year.

(f) By April 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical group, single-physician practice, and hospital of the measures and the performance payments under this section, and shall compare the results by medical group, single-physician practice, and hospital for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may contract with a health care reporting organization that operates a Web site suitable for this purpose.

Sec. 24. [256B.0918] [EMPLOYEE SCHOLARSHIP COSTS AND

TRAINING IN ENGLISH AS A SECOND LANGUAGE.]

(a) For the fiscal year beginning July 1, 2005, the commissioner shall provide to each provider listed in paragraph (c) a scholarship reimbursement increase of two-tenths percent of the reimbursement rate for that provider to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week for the provider, except administrators, department supervisors, and registered nurses; and

(ii) the course of study is expected to lead to career advancement with the provider or in long-term care, including home care or care of persons with disabilities, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) A provider receiving a rate adjustment under this subdivision with an annualized value of at least $1,000 shall maintain documentation to be submitted to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner of the scholarship rate increase received, including:

(1) the amount received from this reimbursement increase;

(2) the amount used for training in English as a second language;

(3) the number of persons receiving the training;

(4) the name of the person or entity providing the training; and

(5) for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the program completion date, and a determination of the amount spent as a percentage of the provider's reimbursement.

The commissioner shall report to the legislature annually, beginning January 15, 2006, with information on the use of these

funds.

(c) The rate increases described in this section shall be provided to home and community-based waivered services for persons with mental retardation or related conditions under section 256B.501; home and community-based waivered services for the elderly under section 256B.0915; waivered services under community alternatives for disabled individuals under section 256B.49; community alternative care waivered services under section 256B.49; traumatic brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under sections 252.40 to 252.46; alternative care services under section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; semi-independent living services (SILS) under section 252.275, including SILS funding under county social services grants formerly funded under chapter 256I; community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; the group residential housing supplementary service rate under section 256I.05, subdivision 1a; chemical dependency residential and nonresidential service providers under section 254B.03; and intermediate care facilities for persons with mental retardation under section 256B.5012.

(d) These increases shall be included in the provider's reimbursement rate for the purpose of determining future rates for the provider.

Sec. 25. Minnesota Statutes 2004, section 256D.03, subdivision 4, is amended to read:

Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.] (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical

care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services and dentures, subject to the limitations specified in section 256B.0625, subdivision 9;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need

for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a

prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Recipients eligible under subdivision 3, paragraph (a), clause (2), item (i), shall pay the following co-payments for services provided on or after October 1, 2003:

(1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $25 for eyeglasses;

(3) $25 for nonemergency visits to a hospital-based emergency room;

(4) $3 per brand-name drug prescription and $1 per generic

drug prescription, subject to a $20 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(5) 50 percent coinsurance on restorative dental services.

(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).

(f) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

(g) The co-payments described in paragraph (d) shall be waived by the provider if the recipient practices a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program. To obtain the waiver, the recipient must sign a statement stating that the recipient does not use tobacco products or is currently participating in a smoking cessation program. The provider shall keep the signed statement on file.

~~(g)~~ (h) Any county may, from its own resources, provide medical payments for which state payments are not made.

~~(h)~~ (i) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

~~(i)~~ (j) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

~~(j)~~ (k) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

~~(k)~~ (l) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

~~(l)~~ (m) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

~~(m)~~ (n) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

~~(n)~~ (o) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

Sec. 26. Minnesota Statutes 2004, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. [GENERAL REQUIREMENTS.] (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the

federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(c)~~(1)~~ Notwithstanding paragraph (b), individuals and families ~~enrolled in MinnesotaCare under section 256L.04, subdivision 1,~~ may remain enrolled in MinnesotaCare if ten percent of their annual income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Individuals and families who are no longer eligible for MinnesotaCare under this subdivision shall be given ~~an 18-month~~ a 12-month notice period from the date that ineligibility is determined before disenrollment. ~~This clause expires February 1, 2004.~~

~~(2) Effective February 1, 2004, notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their annual family income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment.~~ The premium for ~~children~~ individuals and families remaining eligible under this ~~clause~~ paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(d) Effective July 1, 2003, notwithstanding paragraphs (b)

and (c), parents are no longer eligible for MinnesotaCare if gross household income exceeds $50,000.

Sec. 27. [256L.20] [MINNESOTACARE OPTION FOR SMALL EMPLOYERS.]

Subdivision 1. [DEFINITIONS.] (a) For the purpose of this section, the terms used have the meanings given them.

(b) "Dependent" means an unmarried child under 21 years of age.

(c) "Eligible employer" means a business that employs at least two, but not more than 50, eligible employees, the majority of whom are employed in the state, and includes a municipality that has 50 or fewer employees.

(d) "Eligible employee" means an employee who works at least 20 hours per week for an eligible employer. Eligible employee does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.

(e) "Maximum premium" has the meaning given under section 256L.15, subdivision 2, paragraph (b), clause (3).

(f) "Participating employer" means an eligible employer who meets the requirements described in subdivision 3 and applies to the commissioner to enroll its eligible employees and their dependents in the MinnesotaCare program.

(g) "Program" means the MinnesotaCare program.

Subd. 2. [OPTION.] Eligible employees and their dependents may enroll in MinnesotaCare if the eligible employer meets the requirements of subdivision 3. The effective date of coverage is according to section 256L.05, subdivision 3.

Subd. 3. [EMPLOYER REQUIREMENTS.] The commissioner shall establish procedures for an eligible employer to apply for coverage through the program. In order to participate, an eligible employer must meet the following requirements:

(1) agrees to contribute toward the cost of the premium for the employee and the employee's dependents according to subdivision 4;

(2) certifies that at least 75 percent of its eligible

employees who do not have other creditable health coverage are enrolled in the program;

(3) offers coverage to all eligible employees and the dependents of eligible employees; and

(4) has not provided employer-subsidized health coverage as an employee benefit during the previous 12 months, as defined in section 256L.07, subdivision 2, paragraph (c).

Subd. 4. [PREMIUMS.] (a) The premium for MinnesotaCare coverage provided under this section is equal to the maximum premium regardless of the income of the eligible employee.

(b) For eligible employees without dependents with income equal to or less than 175 percent of the federal poverty guidelines and for eligible employees with dependents with income equal to or less than 275 percent of the federal poverty guidelines, the participating employer shall pay 50 percent of the maximum premium for the eligible employee and any dependents, if applicable.

(c) For eligible employees without dependents with income over 175 percent of the federal poverty guidelines and for eligible employees with dependents with income over 275 percent of the federal poverty guidelines, the participating employer shall pay the full cost of the maximum premium for the eligible employee and any dependents, if applicable. The participating employer may require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent of the cost. If the employer requires the employee to pay a portion of the premium, the employee shall pay the portion of the cost to the employer.

(d) The commissioner shall collect premium payments from participating employers for eligible employees and their dependents who are covered by the program as provided under this section. All premiums collected shall be deposited in the health care access fund.

Subd. 5. [COVERAGE.] The coverage offered to those enrolled in the program under this section must include all health services described under section 256L.03 and all

co-payments and coinsurance requirements described under section 256L.03, subdivision 5, apply.

Subd. 6. [ENROLLMENT.] Upon payment of the premium, in accordance with this section and section 256L.06, eligible employees and their dependents shall be enrolled in MinnesotaCare. For purposes of enrollment under this section, income eligibility limits established under sections 256L.04 and 256L.07, subdivision 1, and asset limits established under section 256L.17 do not apply. The barriers established under section 256L.07, subdivision 2 or 3, do not apply to enrollees eligible under this section. The commissioner may require eligible employees to provide income verification to determine premiums.

Sec. 28. [LIMITING COVERAGE OF HEALTH CARE SERVICES FOR MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND MINNESOTACARE PROGRAMS.]

Subdivision 1. [PRIOR AUTHORIZATION OF SERVICES.] (a) Effective July 1, 2005, prior authorization is required for the diagnosis/treatment pairings described in subdivision 2 for reimbursement under Minnesota Statutes, chapters 256B, 256D, and 256L.

(b) This subdivision expires July 1, 2007, or when a list is established according to Minnesota Statutes, section 256B.0625, subdivision 46, whichever is earlier.

Subd. 2. [SERVICES REQUIRING PRIOR AUTHORIZATION.] The following services require prior authorization:

(1) obstetrical ultrasound;

(2) positive emission tomography (PET) scans;

(3) electronic beam computed tomography (EBCT);

(4) virtual colonoscopy;

(5) spinal fusion, unless in an emergency situation related to trauma;

(6) bariatric surgery; and

(7) orthodontia.

Subd. 3. [SERVICES REQUIRING REVIEW BEFORE ADDITION TO PUBLIC PROGRAMS BENEFIT SETS.] No new medical device, brand

drug, or medical procedure shall be included in the public programs benefit sets under Minnesota Statutes, chapter 256B, 256D, or 256L, until a technology assessment has been completed and the potential benefits are proven to outweigh the additional costs of the new device, drug, or procedure. Technology assessments by independent organizations with no conflict of interest should be used in making these determinations.

Sec. 29. [TASK FORCE ON CHILDHOOD OBESITY.]

(a) The commissioner of health, in consultation with the commissioners of human services and education, shall convene a task force to study and make recommendations on reducing the rate of obesity among the children in Minnesota. The task force shall determine the number of children who are currently obese and set a goal, including measurable outcomes for the state in terms of reducing the rate of childhood obesity. The task force shall make recommendations on how to achieve this goal, including, but not limited to, increasing physical activities; exploring opportunities to promote physical education and healthy eating programs; improving the nutritional offerings through breakfast and lunch menus; and evaluating the availability and choice of nutritional products offered in public schools. The members of the task force shall include representatives of the Minnesota Medical Association; the Minnesota Nurses Association; the Local Public Health Association of Minnesota; the Minnesota Dietetic Association; the Minnesota School Food Service Association; the Minnesota Association of Health, Physical Education, Recreation, and Dance; the Minnesota School Boards Association; the Minnesota School Administrators Association; the Minnesota Secondary Principals Association; the vending industry; and consumers. The terms and compensation of the members of the task force shall be in accordance with Minnesota Statutes, section 15.059, subdivision 6.

(b) The commissioner must submit the recommendations of the task force to the legislature by January 15, 2007.

Sec. 30. [IMPLEMENTATION OF AN ELECTRONIC HEALTH RECORDS

SYSTEM.]

The commissioner of health, in consultation with the electronic health record planning work group established in Laws 2004, chapter 288, article 7, section 7, shall develop a statewide plan for all hospitals and physician group practices to have in place an interoperable electronic health records system by January 1, 2015. In developing the plan, the commissioner shall consider:

(1) creating financial assistance to hospitals and providers for implementing or updating an electronic health records system, including, but not limited to, the establishment of grants, financial incentives, or low-interest loans;

(2) addressing specific needs and concerns of safety-net hospitals, community health clinics, and other health care providers who serve low-income patients in implementing an electronic records system within the hospital or practice; and

(3) providing assistance in the development of possible alliances or collaborations among providers.

The commissioner shall provide preliminary reports to the chairs of the senate and house committees with jurisdiction over health care policy and finance biennially beginning January 15, 2007, on the status of reaching the goal for all hospitals and physician group practices to have an interoperable electronic health records system in place by January 1, 2005. The reports shall include recommendations on statutory language necessary to implement the plan, including possible financing options.

Sec. 31. [APPROPRIATION.]

(a) $..... is appropriated for the biennium beginning July 1, 2005, from the general fund to the Board of Trustees of the Minnesota State Colleges and Universities for the nursing and health care education plan designed to:

(1) expand the system's enrollment in registered nursing education programs;

(2) support practical nursing programs in regions of high need;

(3) address the shortage of nursing faculty; and

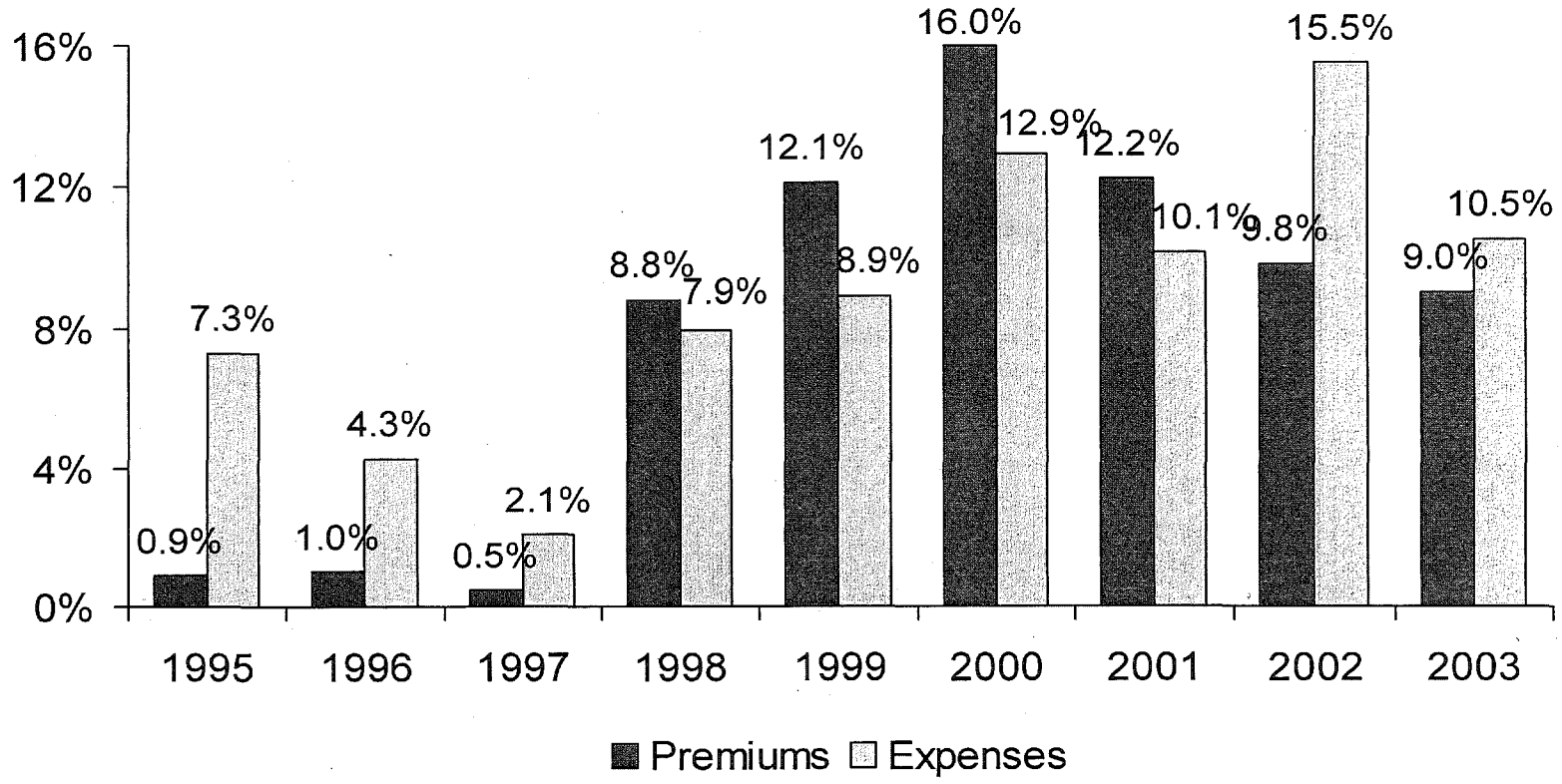
(4) provide accessible learning opportunities to students through distance education and simulation experiences.

(b) $..... is appropriated for the biennium beginning July 1, 2005, from the general fund to the commissioner of health for the loan forgiveness program in Minnesota Statutes, section 144.1501.

H.O. #1

Premium and Spending Trends for Minnesota Private Health Insurance, 1995-2003

(per member)



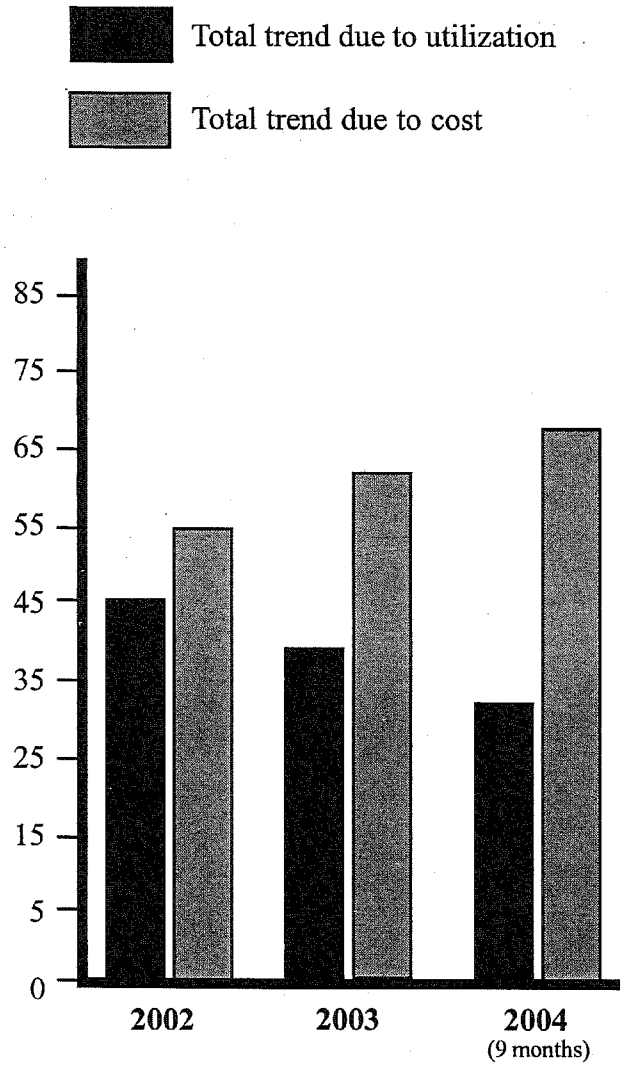
Source: MDH Health Economics Program. Fully-insured market only.

MINNESOTA MDH DEPARTMENT OF HEALTH

H.O.#2

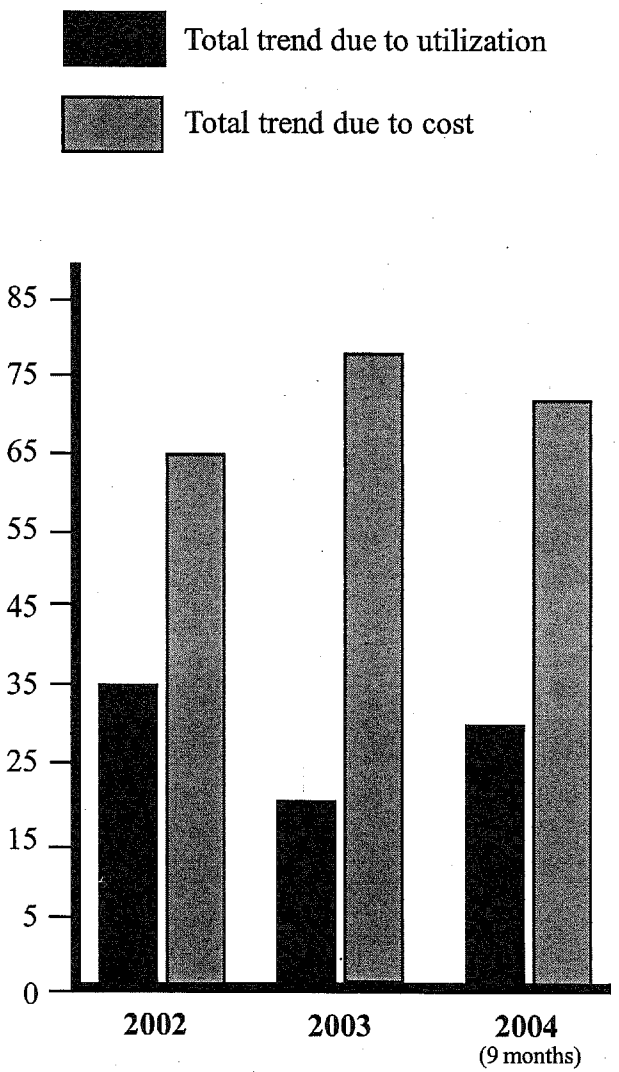
Changing Drivers of Health Care Costs

Utilization is measured by number of services per thousand; cost is measured by cost per service which includes the impact of changes in reimbursement for services as well as the change in the mix of services provided.

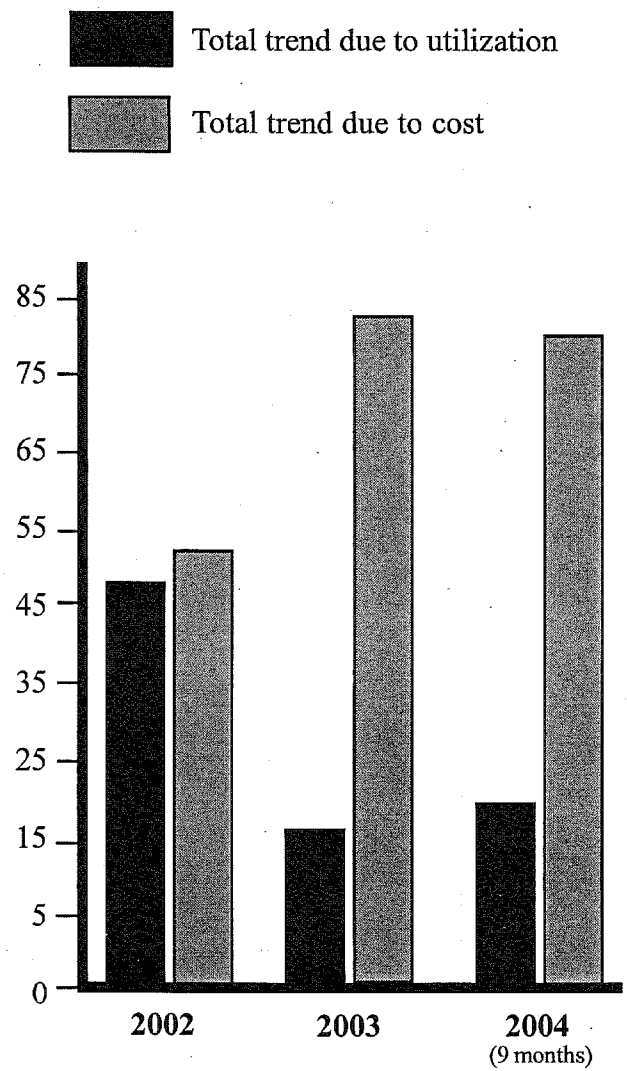


Inpatient hospital costs accounted for more than 32% of all claim costs in 2003.

This category includes surgeries and other hospital admissions. The trend has been driven by cost for past several years.



Outpatient hospital costs (ER, lab, X-ray, outpatient surgery, etc.), accounted for more than 17% of all claim costs in 2003. Once again, the trend has changed to being driven more by cost and case-mix changes beginning in 2002.



PRESCRIPTION DRUG PROGRAMS

MINNESOTA PROGRAMS WITH PRESCRIPTION DRUG BENEFITS

Medicaid
MinnesotaCare
General Assistance Medical Care
Minnesota Comprehensive Health Association
Minnesota Prescription Drug Program

MEDICARE DISCOUNT CARD AND MEDICARE PART D PRESCRIPION DRUG BENEFIT (MMA)

On January 1, 2006, the Medicare prescription drug benefit will offer all Medicare-eligible patients prescription drug coverage.

Medicare is already providing seniors with access to prescription drugs through discount drug cards. All those Medicare eligible residents of the state who do not qualify for another program have access to the cards, which offer 15 to 25 percent, or more, discounts on all drugs. Twenty-four Medicare-approved drug discount cards offer qualified low-income members up to a 30-day supply of most medicines.

To receive information on how to sign up for the Medicare program call 1- 800-MEDICARE (1-800-633-4227) or go on the internet at www.medicare.gov or www.abcrx.org

Rx CONNECT

A clearinghouse program through the Minnesota Board on Aging. This program helps Minnesota citizens' access free and discounted medicines. In 2004, 45,530 total applications assisted with all RxConnect™ related programs. To contact RxConnect call 1-800-333-2433 or go the website www.mnaging.org.

FREE PRESCRIPTION DRUGS

Over 49 PhRMA member companies offer prescription medicines, through their Patient Assistance Programs, free of charge to patients who might not have access to needed medicines. In Minnesota, PhRMA member companies provided free medicines to more than **47,000** patients in 2004. On an average, most of these programs provide medication for patients up to 200 % of FPL. For additional information go to www.HelpingPatients.org or you can call to request a copy of the directory at 1-800-762-4636. The website is also available in Spanish.

DISCOUNTED PRESCRIPTION DRUGS

Together Rx Access: It is available to individuals or families up to 300% FPL, without prescription drug coverage, who are **not Medicare eligible**. Ten companies participate in the program. Both branded and generic products are available. The list includes over 275 brand name products. Card holders can save 25%-40%, and sometimes more, right at the pharmacy counter. There are no enrollment fees, no monthly fees, and no hidden fees. www.TogetherRxAccess.com or 1-800-444-4106

Together Rx-- is a prescription drugs savings program that offers **Medicare eligibles** a free, easy way to save approximately 20% to 40% on brand-name medicines and, in many cases, much more. You

generics. The program is offered by 7 companies. Individuals and couples up to 300% FPL without prescription drug coverage are eligible. The program will last until the Medicare prescription benefit takes effect in 2006. www.Togetherrx.com or 1-800-865-7211

LillyAnswers-- the program offers a flat $12 fee for a 30-day supply of any Lilly retail drug, which could provide up to $600 in annual savings for eligible citizens. U.S. citizens whose annual individual income falls below $18,000 — or whose household income is less than $24,000 — are eligible for LillyAnswers. Medicare-enrolled seniors and persons with disabilities also are eligible to apply for a LillyAnswers card. LillyAnswers currently has over 230,000 members and, in 2003, pr[illegible]ded more than 630,000 prescriptions valued at $67 million. For additional information please call 1-877-RX-LILLY or visit the website at www.lillyanswers.com

Pfizer Helpful Answers--a comprehensive program that provides the uninsured, regardless of age or income, help getting Pfizer medicines for free, or at significant savings. Call 1-866-706-2400 or at www.pfizerhelpfulanswers.com
- Free Pfizer medicines for those with the most financial need (families earning $31,000 or less, individuals earning $19,000 or less per year).
- Average of 37%, and up to 50%, off retail for families earning $45,000 or less per year.
- Average of 15%, and up to 25%, off retail for families earning more than $45,000 per year.

Sharing the Care--a partnership joining Pfizer, the National Association of Community Health Centers, and the National Governors Association. Through Sharing the Care, Pfizer makes its medicines available at no charge to low-income, uninsured patients through a network of more than 380 community, migrant and homeless health centers across the country. Community Health Centers interested in participating should call 1-800-984-1500.

ADDITIONAL INFORMATION ABOUT THE PHARMACEUTICAL INDUSTRY

According to the Milken Institute, the biopharmaceutical industry contributed a total of **$552,570,120** in real output to the Minnesota economy.

Pharmaceutical manufacturers already pay the state millions of dollars each year in federally-mandated Medicaid rebates and state supplemental rebates for the Medicaid program. In 2005, it is estimated that the pharmaceutical industry will pay **a total of over $80 million** for the Minnesota Medicaid program.

Adopted 4-1-05

03/31/05 [COUNSEL] KC SCS0065A-4

Senator Pappas moves to amend S.F. No. 65 as follows:

Page 11, after line 19, insert:

"(d) This section does not apply to health plan companies offering only limited dental or vision plans."

Senator ..... moves to amend S.F. No. 65 as follows:

Page 4, line 5, delete "prior authorization" and insert "health maintenance organizations for services provided in the prepaid health programs administered"

Page 16, after line 34, insert:

"Sec. 11. Minnesota Statutes 2004, section 62M.06, subdivision 2, is amended to read:

Subd. 2. [EXPEDITED APPEAL.] (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider. For review of initial determinations not to certify a service for prepaid health care programs under chapter 256B, 256D, or 256L, the health care provider must follow published evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by the professional association of the specialty that typically provides the service.

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

Sec. 12. Minnesota Statutes 2004, section 62M.06, subdivision 3, is amended to read:

Subd. 3. [STANDARD APPEAL.] The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(a) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal within 30 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 30-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

(b) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care professional.

(c) Prior to upholding the initial determination not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the initial determination not to certify. For review of initial determinations not to certify a service for prepaid health care programs under chapter 256B, 256D, or 256L, the physician must follow publicly available evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by the professional association of the specialty that typically provides the service.

(d) The process established by a utilization review organization may include defining a period within which an

appeal must be filed to be considered. The time period must be communicated to the enrollee and attending health care professional when the initial determination is made.

(e) An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must ensure that a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

(g) If the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process."

Page 19, line 26, delete "on prior authorization" and insert "by a prepaid health plan to deny or limit coverage"

Page 19, line 27, delete "covered under section 28,"

Page 19, line 28, delete "appropriately"

Page 49, line 19, delete "diagnosis/treatment pairings" and insert "services" and delete "for" and insert a period

Page 49, delete lines 20 and 21 and insert:

"(b) Prior authorization shall be conducted by the medical director of the Department of Human Services in conjunction with a medical policy advisory council. To the extent available, the medical director shall use publicly available evidence-based

guidelines developed by an independent, nonprofit organization or by the professional association of the specialty that typically provides the service or by a multistate Medicaid evidence-based practice center. If the commissioner does not have a medical director and medical policy director in place, the commissioner may contract prior authorization to a Minnesota-licensed utilization review organization."

Page 49, line 22, delete "(b)" and insert "(c)"

Page 49, delete line 27

Page 49, line 28, delete "(2)" and insert "(1)"

Page 49, line 29, delete "(3)" and insert "(2)"

Page 49, line 30, delete "(4)" and insert "(3)"

Page 49, line 31, delete "(5)" and insert "(4)"

Page 49, line 33, delete "(6)" and insert "(5)" and delete " and" and insert:

"(6) chiropractic visits beyond ten visits;

(7) circumcision; and"

Page 49, line 34, delete "(7)" and insert "(8)"

Page 50, line 1, delete "the public"

Page 50, delete line 2

Page 50, line 3, delete "256D, or 256L," and insert "the medical assistance benefit set"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Not Adopted 4-1-05

03/31/05 [COUNSEL] CBS SCS0065A-3

Senator Leclair ..... moves to amend S.F. No. 65 as follows:

Pages 1 to 3, delete section 1

Pages 4 to 11, delete sections 3 to 5

Pages 11 to 14, delete sections 7 and 8

Page 16, delete section 10

Pages 47 to 49, delete section 27

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator Scheid from the Committee on Commerce, to which was re-referred

S.F. No. 65: A bill for an act relating to health care; modifying premium rate restrictions; establishing expenditure limits; modifying cost containment provisions; modifying certain loan forgiveness programs; modifying medical assistance, general assistance medical care, and MinnesotaCare programs; requiring reports; appropriating money; amending Minnesota Statutes 2004, sections 62A.65, subdivision 3; 62D.12, subdivision 19; 62J.04, subdivision 3, by adding a subdivision; 62J.041; 62J.301, subdivision 3; 62J.38; 62J.692, subdivision 3; 62L.08, subdivision 8; 144.1501, subdivisions 2, 4; 256.045, subdivision 3a; 256.9693; 256B.0625, subdivision 3b, by adding a subdivision; 256B.0627, subdivisions 1, 4, 9; 256B.0631, by adding a subdivision; 256D.03, subdivision 4; 256L.07, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 256; 256B; 256L.

Reports the same back with the recommendation that the bill be amended as follows:

Page 4, line 5, delete "prior authorization" and insert "health maintenance organizations for services provided in the prepaid health programs administered"

Page 11, after line 19, insert:

"(d) This section does not apply to health plan companies offering only limited dental or vision plans."

Page 16, after line 34, insert:

"Sec. 11. Minnesota Statutes 2004, section 62M.06, subdivision 2, is amended to read:

Subd. 2. [EXPEDITED APPEAL.] (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider. For review of initial determinations not to certify a service for prepaid health care programs under chapter 256B, 256D, or 256L, the health care provider must follow published evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization or by the professional association of the specialty that typically

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Subd. 3. [STANDARD APPEAL.] The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

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(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must ensure that a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

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Page 49, delete lines 20 and 21 and insert:

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Page 50, line 1, delete "the public"

Page 50, delete line 2

Page 50, line 3, delete "256D, or 256L," and insert "the medical assistance benefit set"

Renumber the sections in sequence

Amend the title as follows:

Page 1, line 12, after "subdivision 8;" insert "62M.06, subdivisions 2, 3;"

And when so amended the bill do pass and be re-referred to the Committee on Finance. Amendments adopted. Report adopted.

.....
(Committee Chair)

April 1, 2005.....
(Date of Committee recommendation)

Senate Counsel, Research, and Fiscal Analysis

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Director

Senate

State of Minnesota

S.F. No. 1636 - Commerce Department Banking Bill

Author: Senator Dan Sparks

Prepared by: Matthew S. Grosser, Senate Research (651/296-1890) MG

Date: March 18, 2005

Section 1 clarifies the type of property that may be acquired or improved by certain financial institutions without prior approval by the Commissioner of Commerce.

Section 2 eliminates a requirement to report the scope of annual audits to the Commissioner of Commerce.

Section 3 eliminates the need for the Commissioner of Commerce to provide a copy of a notice to suspend the operation of a credit union to the advisory council and eliminates a provision requiring the advisory council to attend the suspension hearing.

Section 4 adds a new section of law prohibiting any individual convicted of a criminal offense involving dishonesty, breach of trust or fraud, or has entered into a pretrial diversion of similar program in connection with a prosecution for such offense, from serving as or being employed in the capacity of a residential mortgage originator without prior written consent of the Commissioner of Commerce. This section provides exceptions for minor, unrelated offenses.

Section 5 eliminates the need for insurance companies to seek approval to annually renew their license. Licenses will be considered renewed annually upon payment of all applicable fees.

Section 6 provides for the voluntary dissolution of a domestic fraternal benefit society upon application to the Commissioner of Commerce demonstrating that the society has satisfied or transferred its members' policy obligations.

Section 7 repeals a provision in statute that allowed for an advisory task force investigation of a credit union in lieu of immediate suspension of operations, and repeals a provision in Minnesota Rules that required a bank's board to prepare a written response to the findings and recommendations in its annual examination report.

MSG:cs

Senators Sparks, Metzen, Gaither, Scheid and Michel introduced--
S.F. No. 1636: Referred to the Committee on Commerce.

A bill for an act

relating to commerce; regulating the investment authority of, and annual reporting required for, certain financial institutions; removing obsolete references to the credit union advisory task force; regulating residential mortgage originators; providing for insurance license renewals; regulating for the voluntary dissolution of fraternal benefit societies; amending Minnesota Statutes 2004, sections 47.10, subdivision 1; 48.10; 52.062, subdivision 2; 60A.13, subdivision 5; 64B.30, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 58; repealing Minnesota Statutes 2004, sections 52.062, subdivision 3; Minnesota Rules, part 2675.2610, subpart 5.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 47.10, subdivision 1, is amended to read:

Subdivision 1. [AUTHORITY, APPROVAL, LIMITATIONS.] (a) Except as otherwise specially provided, the net book value of land and buildings for the transaction of the business of the corporation, including parking lots and premises leased to others, shall not be more than as follows:

(1) for a bank, trust company, savings bank, or stock savings association, if investment is for acquisition and improvements to establish a new ~~bank~~ banking office, or is for improvements to existing property or acquisition and improvements to adjacent property, approval by the commissioner of commerce is not required if the total investment does not exceed 50 percent of its existing capital stock and paid-in

surplus. Upon written prior approval of the commissioner of commerce, a bank, trust company, savings bank, or stock savings association may invest in the property and improvements in clause (1) or for acquisition of nonadjacent property for expansion or future use, if the aggregate of all such investments does not exceed 100 percent of its existing capital stock and paid-in surplus;

(2) for a mutual savings association, five percent of its net assets.

(b) For purposes of this subdivision, an intervening highway, street, road, alley, other public thoroughfare, or easement of any kind does not cause two parcels of real property to be nonadjacent.

Sec. 2. Minnesota Statutes 2004, section 48.10, is amended to read:

48.10 [ANNUAL AUDIT; REPORT.]

The board of directors of a bank, bank and trust, or trust company shall annually examine its books, either in person, or by appointing an examining committee, or an auditor, who may be an independent auditor or accountant. The examining committee or auditor shall be solely responsible to the directors. A report shall be made to the directors as to the scope of the examination or audit, and also to show those assets, excluding marketable securities and fixed assets, which are carried on the books for more than actual value. This report shall be retained as a permanent record or incorporated in the minutes of the meeting~~,-and-a-copy-of-the-report-shall-be-sent-to-the commissioner-of-commerce~~.

Sec. 3. Minnesota Statutes 2004, section 52.062, subdivision 2, is amended to read:

Subd. 2. [SUSPENSION.] The commissioner of commerce may suspend the operation of the credit union by giving notice to its board of directors by certified mail ~~with-a-copy-to-the advisory-council~~. Said notice shall include a list of reasons for said suspension and a list of any specific violations of law, bylaw, or rule, and shall specify which operations of the

credit union may be continued during the period of suspension. The notice shall also fix a time and place for a hearing before the commissioner of commerce or such person or persons as the commissioner of commerce may designate. The hearing shall be held within 60 days of the notice of suspension~~, and the advisory council shall sit at such hearing for the purpose of providing advice and counsel to the commissioner of commerce or a representative~~. Evidence may be produced at said hearing by any party thereto, and the commissioner of commerce shall base the decision as to the continued suspension of operation of the credit union upon said evidence. If the commissioner of commerce decides to continue the suspension, the commissioner shall give notice of the decision to the board of directors of the credit union.

Sec. 4. [58.125] [PROHIBITION ON SERVICE AS A RESIDENTIAL MORTGAGE ORIGINATOR.]

Subdivision 1. [DEFINITIONS.] (a) "Dishonesty" means directly or indirectly to cheat or defraud; to cheat or defraud for monetary gain or its equivalent; or to wrongfully take property belonging to another in violation of any criminal statute. Dishonesty includes acts involving want of integrity, lack of probity, or a disposition to distort, cheat, or act deceitfully or fraudulently, and may include crimes which federal, state, or local laws define as dishonest.

(b) "Breach of trust" means a wrongful act, use, misappropriation, or omission with respect to any property or fund which has been committed to a person in a fiduciary or official capacity, or the misuse of one's official or fiduciary position to engage in a wrongful act, use, misappropriation, or omission.

Subd. 2. [GENERALLY.] Except with the prior written consent of the commissioner under subdivision 4, any individual, who has been convicted of a criminal offense involving dishonesty or a breach of trust or money laundering, or has agreed to or entered into a pretrial diversion or similar program in connection with a prosecution for such offense, may

not serve as a residential mortgage originator or be employed in that capacity by a person licensed as a mortgage originator.

Subd. 3. [DE MINIMIS OFFENSES.] Approval is automatically granted and an application will not be required if the covered offense is considered de minimis because it meets all of the following criteria:

(1) there is only one conviction or program entry of record for a covered offense;

(2) the offense was punishable by imprisonment for a term of less than one year and/or a fine of less than $1,000, and the individual did not serve time in jail;

(3) the conviction or program was entered at least five years before the date an application would otherwise be required; and

(4) the offense did not involve a financial institution or residential mortgage loans.

Subd. 4. [PRIOR CONSENT.] An application for prior consent of the commissioner under this section must be in writing, under oath, and on a form obtained from and prescribed by the commissioner. The following factors must be considered by the commissioner when reviewing an application:

(1) the specific nature of the offense and the circumstances surrounding the offense;

(2) evidence of rehabilitation since the offense;

(3) the age of the person at the time of conviction; and

(4) whether or not restitution has been made.

Sec. 5. Minnesota Statutes 2004, section 60A.13, subdivision 5, is amended to read:

Subd. 5. [RENEWAL LICENSE ~~BASED ON APPROVED STATEMENT.~~] ~~Upon the approval of the statement the commissioner shall issue a renewal license for the succeeding year beginning June first. Any license to a company or its agent, issued after the approval of the statement, shall expire May 31 of the year following.~~ The license issued by the commissioner is perpetual and is considered renewed annually on June 1 upon payment of the renewal license fee, the annual filing fee, and all other fees

required by section 60A.14.

Sec. 6. Minnesota Statutes 2004, section 64B.30, is amended by adding a subdivision to read:

Subd. 3. [VOLUNTARY DISSOLUTION.] Upon application to the commissioner, a domestic society may request that it be dissolved and that its existence be terminated. Such application shall demonstrate that the applicant has satisfied its members' policy obligations or that it has transferred such obligations to another society, domestic or foreign, by means of assumption or bulk reinsurance or otherwise, that the applicant's supreme governing body has approved such termination and dissolution and that the application includes such other information that the commissioner requires. Any limitation in section 64B.13 related to reinsurance by a domestic society with another society shall not apply to reinsurance entered into in conjunction with the transfer of member policy obligations as a part of a voluntary dissolution. Upon the approval of the application by the commissioner, the society shall be deemed dissolved and its existence terminated upon the date set forth in the application.

Sec. 7. [REPEALER.]

(a) Minnesota Statutes 2004, section 52.062, subdivision 3, is repealed.

(b) Minnesota Rules, part 2675.2610, subpart 5, is repealed.

Sec. 8. [EFFECTIVE DATE.]

Section 4 is effective January 1, 2006.

APPENDIX
Repealed Minnesota Statutes for 05-0310

52.062 CREDIT UNIONS; SUSPENSION OF OPERATION.

Subd. 3. Investigation by advisory task force. In lieu of immediate suspension of the operation of the credit union, the commissioner of commerce may submit to the advisory task force, with a copy to the affected credit union, a statement with respect to said practices or violations for the purpose of investigation and review by the advisory task force so that it may attempt to cause the correction of said practices or violations. Unless said corrections shall be made within 60 days of the notice to the advisory task force and the credit union, the commissioner of commerce, if intending to proceed further, shall give written notice to the affected credit union of the intention to suspend the operation of the credit union, and fix a time and place for a hearing before the commissioner of commerce, or such person or persons as the commissioner of commerce may designate. The advisory task force shall sit at such hearing for the purpose of providing advice and counsel to the commissioner of commerce or a representative. Evidence may be produced at said hearing by any party thereto, and the commissioner of commerce shall base the decision as to the suspension of operation of the credit union upon said evidence. If the commissioner of commerce decides to suspend operation of the credit union, the board of directors shall be given notice by certified mail of such suspension, which notice shall include a list of reasons for such suspension and a list of any specific violations of law, bylaw, or rule, and shall specify which operations of the credit union may continue during the period of suspension.

Adopted 4-18-05

Sparks ..... moves to amend S. F. No. 1636 as follows:

Page 4, line 17, before "An" insert "(a)"

Page 4, after line 26, insert:

"(b) The receipt by an individual of prior consent of the commissioner under this section must not be construed as imposing upon an employer an affirmative obligation to employ that individual in any capacity. Nothing in this section precludes an employer from denying employment based upon the existence of a criminal offense specified in subdivision 2 or for any other lawful reason.

Sec. 5. Minnesota Statutes 2004, section 58.16, subdivision 4, is amended to read:

Subd. 4. [TRUST ACCOUNT.] The residential mortgage originator shall deposit in a trust account within three business days all fees received before the time a loan is actually funded. The trust account must be in a financial institution located within the state of Minnesota, and, with respect to advance fees, the account must be controlled by an unaffiliated accountant, attorney, or bank ~~officer or employee~~."

Page 5, after line 20, insert:

"Sec. 8. Minnesota Statutes 2004, section 82.17, subdivision 10, is amended to read:

Subd. 10. [LOAN BROKER.] "Loan broker" means a licensed real estate broker or salesperson who, for another and for ~~a~~

~~commission, fee, or other valuable consideration~~ an advance fee or with the intention or expectation of receiving the same, directly or indirectly, negotiates or offers or attempts to negotiate a loan secured or to be secured by a mortgage or other encumbrance on real estate, or represents himself or herself or otherwise holds himself or herself out as a licensed real estate broker or salesperson, either in connection with any transaction in which he or she directly or indirectly negotiates or offers or attempts to negotiate a loan, or in connection with the conduct of his or her ordinary business activities as a loan broker.

"Loan broker" does not include a licensed real estate broker or salesperson who, in the course of representing a purchaser or seller of real estate, incidentally assists the purchaser or seller in obtaining financing for the real property in question if the licensee does not receive a separate commission, fee, or other valuable consideration for this service.

For the purposes of this subdivision, an "advance fee" means a commission, fee, charge, or compensation of any kind paid before the closing of a loan, that is intended in whole or in part as payment for finding or attempting to find a loan for a borrower. Advance fee does not include pass-through fees or commitment or extended lock fees or other fees as determined by the commissioner.

Sec. 9. Minnesota Statutes 2004, section 82.17, subdivision 18, is amended to read:

Subd. 18. [REAL ESTATE BROKER; BROKER.] "Real estate broker" or "broker" means any person who:

(a) for another and for commission, fee, or other valuable consideration or with the intention or expectation of receiving the same directly or indirectly lists, sells, exchanges, buys or rents, manages, or offers or attempts to negotiate a sale, option, exchange, purchase or rental of an interest or estate in real estate, or advertises or holds out as engaged in these activities;

(b) for another and for commission, fee, or other valuable consideration or with the intention or expectation of receiving the same directly or indirectly negotiates or offers or attempts to negotiate a loan, secured or to be secured by a mortgage or other encumbrance on real estate, which is not a residential mortgage loan as defined by section 58.02, subdivision 18;

(c) "real estate broker" or "broker" as set forth in clause (b) shall not apply to the originating, making, processing, selling, or servicing of a loan in connection with the ~~broker's~~ ordinary business activities ~~by~~ of a mortgagee, lender, or servicer approved or certified by the secretary of Housing and Urban Development, or approved or certified by the administrator of Veterans Affairs, or approved or certified by the administrator of the Farmers Home Administration, or approved ~~or certified~~ as a multifamily seller/servicer by the Federal Home Loan Mortgage Corporation, or as a multifamily partner approved ~~or certified~~ by the Federal National Mortgage Association;

(d) for another and for commission, fee, or other valuable consideration or with the intention or expectation of receiving the same directly or indirectly lists, sells, exchanges, buys, rents, manages, offers or attempts to negotiate a sale, option, exchange, purchase or rental of any business opportunity or business, or its good will, inventory, or fixtures, or any interest therein;

(e) for another and for commission, fee, or other valuable consideration or with the intention or expectation of receiving the same directly or indirectly offers, sells or attempts to negotiate the sale of property that is subject to the registration requirements of chapter 83, concerning subdivided land;

(f) for another and for commission, fee, or other valuable consideration or with the intention or expectation of receiving the same, promotes the sale of real estate by advertising it in a publication issued primarily for this purpose, if the person:

(1) negotiates on behalf of any party to a transaction;

(2) disseminates any information regarding the property to

any party or potential party to a transaction subsequent to the publication of the advertisement, except that in response to an initial inquiry from a potential purchaser, the person may forward additional written information regarding the property which has been prepared prior to the publication by the seller or broker or a representative of either;

(3) counsels, advises, or offers suggestions to the seller or a representative of the seller with regard to the marketing, offer, sale, or lease of the real estate, whether prior to or subsequent to the publication of the advertisement;

(4) counsels, advises, or offers suggestions to a potential buyer or a representative of the seller with regard to the purchase or rental of any advertised real estate; or

(5) engages in any other activity otherwise subject to licensure under this chapter;

(g) engages wholly or in part in the business of selling real estate to the extent that a pattern of real estate sales is established, whether or not the real estate is owned by the person. A person shall be presumed to be engaged in the business of selling real estate if the person engages as principal in five or more transactions during any 12-month period, unless the person is represented by a licensed real estate broker or salesperson.

Sec. 10. Minnesota Statutes 2004, section 82.36, subdivision 4, is amended to read:

Subd. 4. [ESCROW ACCOUNT.] The loan broker shall deposit in an escrow account within 48 hours all fees received prior to the time a loan is actually funded. The escrow account shall be in a bank located within the state of Minnesota and shall be controlled by an unaffiliated accountant, lawyer, or bank ~~officer or employee~~.

Sec. 11. Minnesota Statutes 2004, section 82.41, subdivision 13, is amended to read:

Subd. 13. [FRAUDULENT, DECEPTIVE, AND DISHONEST PRACTICES.] (a) [PROHIBITIONS.] For the purposes of section ~~82.40~~ 82.35, subdivision 1, clause (b), the following acts and

practices constitute fraudulent, deceptive, or dishonest practices:

(1) act on behalf of more than one party to a transaction without the knowledge and consent of all parties;

(2) act in the dual capacity of licensee and undisclosed principal in any transaction;

(3) receive funds while acting as principal which funds would constitute trust funds if received by a licensee acting as an agent, unless the funds are placed in a trust account. Funds need not be placed in a trust account if a written agreement signed by all parties to the transaction specifies a different disposition of the funds, in accordance with section 82.35, subdivision 1;

(4) violate any state or federal law concerning discrimination intended to protect the rights of purchasers or renters of real estate;

(5) make a material misstatement in an application for a license or in any information furnished to the commissioner;

(6) procure or attempt to procure a real estate license for himself or herself or any person by fraud, misrepresentation, or deceit;

(7) represent membership in any real estate-related organization in which the licensee is not a member;

(8) advertise in any manner that is misleading or inaccurate with respect to properties, terms, values, policies, or services conducted by the licensee;

(9) make any material misrepresentation or permit or allow another to make any material misrepresentation;

(10) make any false or misleading statements, or permit or allow another to make any false or misleading statements, of a character likely to influence, persuade, or induce the consummation of a transaction contemplated by this chapter;

(11) fail within a reasonable time to account for or remit any money coming into the licensee's possession which belongs to another;

(12) commingle with his or her own money or property trust

funds or any other money or property of another held by the licensee;

(13) demand from a seller a commission to compensation which the licensee is not entitled, knowing that he or she is not entitled to the commission compensation;

(14) pay or give money or goods of value to an unlicensed person for any assistance or information relating to the procurement by a licensee of a listing of a property or of a prospective buyer of a property (this item does not apply to money or goods paid or given to the parties to the transaction);

(15) fail to maintain a trust account at all times, as provided by law;

(16) engage, with respect to the offer, sale, or rental of real estate, in an anticompetitive activity;

(17) represent on advertisements, cards, signs, circulars, letterheads, or in any other manner, that he or she is engaged in the business of financial planning unless he or she provides a disclosure document to the client. The document must be signed by the client and a copy must be left with the client. The disclosure document must contain the following:

(i) the basis of fees, commissions, or other compensation received by him or her in connection with rendering of financial planning services or financial counseling or advice in the following language:

"My compensation may be based on the following:

(a) ... commissions generated from the products I sell you;

(b) ... fees; or

(c) ... a combination of (a) and (b). [Comments]";

(ii) the name and address of any company or firm that supplies the financial services or products offered or sold by him or her in the following language:

"I am authorized to offer or sell products and/or services issued by or through the following firm(s):

[List]

The products will be traded, distributed, or placed through the clearing/trading firm(s) of:

[List]";

(iii) the license(s) held by the person under this chapter or chapter 60A or 80A in the following language:

"I am licensed in Minnesota as a(n):

(a) ... insurance agent;

(b) ... securities agent or broker/dealer;

(c) ... real estate broker or salesperson;

(d) ... investment adviser"; and

(iv) the specific identity of any financial products or services, by category, for example mutual funds, stocks, or limited partnerships, the person is authorized to offer or sell in the following language:

"The license(s) entitles me to offer and sell the following products and/or services:

(a) ... securities, specifically the following: [List];

(b) ... real property;

(c) ... insurance; and

(d) ... other: [List]."

(b) [DETERMINING VIOLATION.] A licensee shall be deemed to have violated this section if the licensee has been found to have violated sections 325D.49 to 325D.66, by a final decision or order of a court of competent jurisdiction.

(c) [COMMISSIONER'S AUTHORITY.] Nothing in this section limits the authority of the commissioner to take actions against a licensee for fraudulent, deceptive, or dishonest practices not specifically described in this section."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator Sparks moves to amend S.F. No. 1636 as follows:

Page 2, after line 13, insert:

"Sec. 2. Minnesota Statutes 2002, section 47.75, is amended to read:

47.75 [LIMITED TRUSTEESHIP.]

Subdivision 1. [RETIREMENT, HEALTH SAVINGS, AND MEDICAL SAVINGS ACCOUNTS.] (a) A commercial bank, savings bank, savings association, credit union, or industrial loan and thrift company may act as trustee or custodian:

(1) under the Federal Self-Employed Individual Tax Retirement Act of 1962, as amended~~,~~;

(2) of a medical savings account under the Federal Health Insurance Portability and Accountability Act of 1996, as amended~~,~~;

(3) of a health savings account under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended; and ~~also~~

(4) under the Federal Employee Retirement Income Security Act of 1974, as amended.

(b) The trustee or custodian may accept the trust funds if the funds are invested only in savings accounts or time deposits in the commercial bank, savings bank, savings association, credit union, or industrial loan and thrift company. All funds held in the fiduciary capacity may be commingled by the financial institution in the conduct of its business, but individual records shall be maintained by the fiduciary for each participant and shall show in detail all transactions engaged under authority of this subdivision."

Page 2, after line 28, insert:

"Sec. 4. Minnesota Statutes 2002, section 48.15, subdivision 4, is amended to read:

Subd. 4. [RETIREMENT, HEALTH SAVINGS, AND MEDICAL SAVINGS ACCOUNTS.] (a) A state bank may act as trustee or custodian:

(1) of a self-employed retirement plan under the Federal Self-Employed Individual Tax Retirement Act of 1962, as amended~~,~~;

(2) of a medical savings account under the Federal Health Insurance Portability and Accountability Act of 1996, as amended~~,~~;

(3) of a health savings account under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended; and

(4) of an individual retirement account under the Federal Employee Retirement Income Security Act of 1974, as amended, if the bank's duties as trustee or custodian are essentially ministerial or custodial in nature and the funds are invested only ~~(1)~~ (i) in the bank's own savings or time deposits; or ~~(2)~~ (ii) in any other assets at the direction of the customer if the bank does not exercise any investment discretion, invest the funds in collective investment funds administered by it, or provide any investment advice with respect to those account assets.

(b) Affiliated discount brokers may be utilized by the bank acting as trustee or custodian for self-directed IRAs, if specifically authorized and directed in appropriate documents. The relationship between the affiliated broker and the bank must be fully disclosed. Brokerage commissions to be charged to the IRA by the affiliated broker should be accurately disclosed. Provisions should be made for disclosure of any changes in commission rates prior to their becoming effective. The affiliated broker may not provide investment advice to the customer.

(c) All funds held in the fiduciary capacity may be commingled by the financial institution in the conduct of its business, but individual records shall be maintained by the fiduciary for each participant and shall show in detail all transactions engaged under authority of this subdivision.

(d) The authority granted by this section is in addition to, and not limited by section 47.75.

Sec. 5. Minnesota Statutes 2004, section 48.512, is amended by adding a subdivision to read:

Subd. 10. [FEDERAL LAW COMPLIANCE.] In lieu of the

identification rules in subdivision 2, a financial intermediary may choose to comply with the federal customer identification standards set forth in United States Code, title 31, section 5318, and its implementing regulation, Code of Federal Regulations, title 31, section 103.121, as amended from time to time."

Page 3, after line 14, insert:

"Sec. 7. Minnesota Statutes 2004, section 55.10, subdivision 4, is amended to read:

Subd. 4. [WILL SEARCHES, BURIAL DOCUMENTS PROCUREMENT, AND INVENTORY OF CONTENTS.] (a) Upon being furnished with satisfactory proof of death of a sole lessee or the last surviving co-lessee of a safe deposit box, an employee of the safe deposit company shall open the box and examine the contents in the presence of an individual who appears in person and furnishes an affidavit stating that the individual believes:

(1) the box may contain the will or deed to a burial lot or a document containing instructions for the burial of the lessee or that the box may contain property belonging to the estate of the lessee; and

(2) the individual is an interested person as defined in this section and wishes to open the box for any one or more of the following purposes:

(i) to conduct a will search;

(ii) to obtain a document required to facilitate the lessee's wishes regarding body, funeral, or burial arrangements; or

(iii) to obtain an inventory of the contents of the box.

(b) The safe deposit company may not open the box under this section if it has received a copy of letters of office of the representative of the deceased lessee's estate or other applicable court order.

(c) The safe deposit company need not open the box if:

(1) the box has previously been opened under this section for the same purpose;

(2) the safe deposit company has received notice of a

written or oral objection from any person or has reason to believe that there would be an objection; or

(3) the lessee's key or combination is not available.

(d) For purposes of this section, the term "interested person" means any of the following:

(1) a person named as personal representative in a purported will of the lessee;

(2) a person who immediately prior to the death of the lessee had the right of access to the box as a deputy;

(3) the surviving spouse of the lessee;

(4) a devisee of the lessee;

(5) an heir of the lessee;

(6) a person designated by the lessee in a writing acceptable to the safe deposit company which is filed with the safe deposit company before death; or

(7) a state or county agency with a claim authorized by section 256B.15.

(e) For purposes of this section, the term "will" includes a will or a codicil.

(f) If the box is opened for the purpose of conducting a will search, the safe deposit company shall remove any document that appears to be a will and make a true and correct machine copy thereof, replace the copy in the box, and then deliver the original thereof to the clerk of court for the county in which the lessee resided immediately before the lessee's death, if known to the safe deposit company, otherwise to the clerk of the court for the county in which the safe deposit box is located. The will must be personally delivered or sent by registered mail. If the interested person so requests, any deed to burial lot or document containing instructions for the burial of the lessee may be copied by the safe deposit box company and the copy or copies thereof delivered to the interested person.

(g) If the box is opened for the purpose of obtaining a document required to facilitate the lessee's wishes regarding the body, funeral, or burial arrangements, any such document may be removed from the box and delivered to the interested person

with a true and correct machine copy retained in the box. If the safe deposit box company discovers a document that appears to be a will, the safe deposit company shall act in accordance with paragraph (f).

(h) If the box is opened for the purpose of obtaining an inventory of the contents of the box, the employee of the safe deposit company shall make, or cause to be made, an inventory of the contents of the box, to which the employee and the interested person shall attest under penalty of perjury to be correct and complete. Within ten days of opening the box pursuant to this subdivision, the safe deposit company shall deliver the original inventory of the contents to the court administrator for the county in which the lessee resided immediately before the lessee's death, if known to the safe deposit company, otherwise to the court administrator for the county in which the safe deposit box is located. The inventory must be personally delivered or sent by registered mail. If the interested person so requests, the safe deposit company shall make a true and correct copy of any document in the box, and of the completed inventory form, and deliver that copy to the interested person. If the contents of the box include a document that appears to be a will, the safe deposit company shall act in accordance with paragraph (f).

(i) If a box opened for the purpose of conducting an inventory, will search, or burial document search is completely empty, the safe deposit company need not follow the procedures above. Instead, the employee of the safe deposit company can complete an inventory of the box contents indicating the fact that the box contained nothing. The form must be signed by the employee and the interested person. If the interested person so requests, the safe deposit company may provide a copy of the completed inventory form to the interested person. The interested person shall then complete the documentation needed by the safe deposit company to surrender the empty box. If another interested person inquires about the box after it has been surrendered, the safe deposit company may state that the

deceased renter had previously rented the box and that the box was surrendered because it was empty.

(j) The safe deposit company need not ascertain the truth of any statement in the affidavit required to be furnished under this subdivision and when acting in reliance upon an affidavit, it is discharged as if it dealt with the personal representative of the lessee. The safe deposit company is not responsible for the adequacy of the description of any property included in an inventory of the contents of a safe deposit box, nor for conversion of the property in connection with actions performed under this subdivision, except for conversion by intentional acts of the company or its employees, directors, officers, or agents. If the safe deposit company is not satisfied that the requirements of this subdivision have been met, it may decline to open the box.

~~(j)~~ (k) No contents of a box other than a will and a document required to facilitate the lessee's wishes regarding body, funeral, or burial arrangements may be removed pursuant to this subdivision. The entire contents of the box, however, may be removed pursuant to section 524.3-1201."

Page 5, after line 20, insert:

"Sec. 11. Minnesota Statutes 2004, section 325F.69, is amended by adding a subdivision to read:

Subd. 6. [DECEPTIVE USE OF FINANCIAL INSTITUTION NAME.] No person shall include the name, trade name, logo, or tagline of a financial institution as defined in section 49.01, subdivision 2, in a written solicitation for financial services directed to a customer who has obtained a loan from the financial institution without written permission from the financial institution, unless the solicitation clearly and conspicuously states that the person is not sponsored by or affiliated with the financial institution, which shall be identified by name. This statement shall be made in close proximity to, and in the same or larger font size as, the first and most prominent use or uses of the name, trade name, logo, or tagline in the solicitation, including on an envelope or through an envelope

window containing the solicitation. For purposes of this section, the term "financial institution" includes a financial institution's affiliates and subsidiaries. This subdivision shall not prohibit the use of a financial institution name, trade name, logo, or tagline of a financial institution if the use of that name is part of a fair and accurate comparison of like products or services.

Sec. 12. Minnesota Statutes 2004, section 299A.61, subdivision 3, is amended to read:

Subd. 3. [LIMIT ON LIABILITY OF FINANCIAL INSTITUTION.] A financial institution, including its employees or company agents, that provides or reasonably attempts to provide information regarding stolen, forged, or fraudulent ~~check information~~ checks for use by the crime alert network, check verification services, consumer reporting agencies, a banking industry anti-fraud database consistent with federal privacy law, or by law enforcement agencies that are investigating a crime is not liable to any person for disclosing the information, provided that the financial institution is acting in good faith."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator Scheid from the Committee on Commerce, to which was referred

S.F. No. 1636: A bill for an act relating to commerce; regulating the investment authority of, and annual reporting required for, certain financial institutions; removing obsolete references to the credit union advisory task force; regulating residential mortgage originators; providing for insurance license renewals; regulating for the voluntary dissolution of fraternal benefit societies; amending Minnesota Statutes 2004, sections 47.10, subdivision 1; 48.10; 52.062, subdivision 2; 60A.13, subdivision 5; 64B.30, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 58; repealing Minnesota Statutes 2004, sections 52.062, subdivision 3; Minnesota Rules, part 2675.2610, subpart 5.

Reports the same back with the recommendation that the bill be amended as follows:

Page 2, after line 13, insert:

"Sec. 2. Minnesota Statutes 2002, section 47.75, is amended to read:

47.75 [LIMITED TRUSTEESHIP.]

Subdivision 1. [RETIREMENT, HEALTH SAVINGS, AND MEDICAL SAVINGS ACCOUNTS.] (a) A commercial bank, savings bank, savings association, credit union, or industrial loan and thrift company may act as trustee or custodian:

(1) under the Federal Self-Employed Individual Tax Retirement Act of 1962, as amended~~,~~;

(2) of a medical savings account under the Federal Health Insurance Portability and Accountability Act of 1996, as amended~~,~~;

(3) of a health savings account under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended; and ~~also~~

(4) under the Federal Employee Retirement Income Security Act of 1974, as amended.

(b) The trustee or custodian may accept the trust funds if the funds are invested only in savings accounts or time deposits in the commercial bank, savings bank, savings association, credit union, or industrial loan and thrift company. All funds held in the fiduciary capacity may be commingled by the financial institution in the conduct of its business, but individual records shall be maintained by the fiduciary for each participant and shall show in detail all transactions engaged

under authority of this subdivision."

Page 2, after line 28, insert:

"Sec. 4. Minnesota Statutes 2002, section 48.15, subdivision 4, is amended to read:

Subd. 4. [RETIREMENT, HEALTH SAVINGS, AND MEDICAL SAVINGS ACCOUNTS.] (a) A state bank may act as trustee or custodian:

(1) of a self-employed retirement plan under the Federal Self-Employed Individual Tax Retirement Act of 1962, as amended~~,~~;

(2) of a medical savings account under the Federal Health Insurance Portability and Accountability Act of 1996, as amended~~,~~;

(3) of a health savings account under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended; and

(4) of an individual retirement account under the Federal Employee Retirement Income Security Act of 1974, as amended, if the bank's duties as trustee or custodian are essentially ministerial or custodial in nature and the funds are invested only ~~(1)~~ (i) in the bank's own savings or time deposits; or ~~(2)~~ (ii) in any other assets at the direction of the customer if the bank does not exercise any investment discretion, invest the funds in collective investment funds administered by it, or provide any investment advice with respect to those account assets.

(b) Affiliated discount brokers may be utilized by the bank acting as trustee or custodian for self-directed IRAs, if specifically authorized and directed in appropriate documents. The relationship between the affiliated broker and the bank must be fully disclosed. Brokerage commissions to be charged to the IRA by the affiliated broker should be accurately disclosed. Provisions should be made for disclosure of any changes in commission rates prior to their becoming effective. The affiliated broker may not provide investment advice to the customer.

(c) All funds held in the fiduciary capacity may be

commingled by the financial institution in the conduct of its business, but individual records shall be maintained by the fiduciary for each participant and shall show in detail all transactions engaged under authority of this subdivision.

(d) The authority granted by this section is in addition to, and not limited by section 47.75.

Sec. 5. Minnesota Statutes 2004, section 48.512, is amended by adding a subdivision to read:

Subd. 10. [FEDERAL LAW COMPLIANCE.] In lieu of the identification rules in subdivision 2, a financial intermediary may choose to comply with the federal customer identification standards set forth in United States Code, title 31, section 5318, and its implementing regulation, Code of Federal Regulations, title 31, section 103.121, as amended from time to time."

Page 3, after line 14, insert:

"Sec. 7. Minnesota Statutes 2004, section 55.10, subdivision 4, is amended to read:

Subd. 4. [WILL SEARCHES, BURIAL DOCUMENTS PROCUREMENT, AND INVENTORY OF CONTENTS.] (a) Upon being furnished with satisfactory proof of death of a sole lessee or the last surviving co-lessee of a safe deposit box, an employee of the safe deposit company shall open the box and examine the contents in the presence of an individual who appears in person and furnishes an affidavit stating that the individual believes:

(1) the box may contain the will or deed to a burial lot or a document containing instructions for the burial of the lessee or that the box may contain property belonging to the estate of the lessee; and

(2) the individual is an interested person as defined in this section and wishes to open the box for any one or more of the following purposes:

(i) to conduct a will search;

(ii) to obtain a document required to facilitate the lessee's wishes regarding body, funeral, or burial arrangements; or

(iii) to obtain an inventory of the contents of the box.

(b) The safe deposit company may not open the box under this section if it has received a copy of letters of office of the representative of the deceased lessee's estate or other applicable court order.

(c) The safe deposit company need not open the box if:

(1) the box has previously been opened under this section for the same purpose;

(2) the safe deposit company has received notice of a written or oral objection from any person or has reason to believe that there would be an objection; or

(3) the lessee's key or combination is not available.

(d) For purposes of this section, the term "interested person" means any of the following:

(1) a person named as personal representative in a purported will of the lessee;

(2) a person who immediately prior to the death of the lessee had the right of access to the box as a deputy;

(3) the surviving spouse of the lessee;

(4) a devisee of the lessee;

(5) an heir of the lessee;

(6) a person designated by the lessee in a writing acceptable to the safe deposit company which is filed with the safe deposit company before death; or

(7) a state or county agency with a claim authorized by section 256B.15.

(e) For purposes of this section, the term "will" includes a will or a codicil.

(f) If the box is opened for the purpose of conducting a will search, the safe deposit company shall remove any document that appears to be a will and make a true and correct machine copy thereof, replace the copy in the box, and then deliver the original thereof to the clerk of court for the county in which the lessee resided immediately before the lessee's death, if known to the safe deposit company, otherwise to the clerk of the court for the county in which the safe deposit box is located.

The will must be personally delivered or sent by registered mail. If the interested person so requests, any deed to burial lot or document containing instructions for the burial of the lessee may be copied by the safe deposit box company and the copy or copies thereof delivered to the interested person.

(g) If the box is opened for the purpose of obtaining a document required to facilitate the lessee's wishes regarding the body, funeral, or burial arrangements, any such document may be removed from the box and delivered to the interested person with a true and correct machine copy retained in the box. If the safe deposit box company discovers a document that appears to be a will, the safe deposit company shall act in accordance with paragraph (f).

(h) If the box is opened for the purpose of obtaining an inventory of the contents of the box, the employee of the safe deposit company shall make, or cause to be made, an inventory of the contents of the box, to which the employee and the interested person shall attest under penalty of perjury to be correct and complete. Within ten days of opening the box pursuant to this subdivision, the safe deposit company shall deliver the original inventory of the contents to the court administrator for the county in which the lessee resided immediately before the lessee's death, if known to the safe deposit company, otherwise to the court administrator for the county in which the safe deposit box is located. The inventory must be personally delivered or sent by registered mail. If the interested person so requests, the safe deposit company shall make a true and correct copy of any document in the box, and of the completed inventory form, and deliver that copy to the interested person. If the contents of the box include a document that appears to be a will, the safe deposit company shall act in accordance with paragraph (f).

(i) If a box opened for the purpose of conducting an inventory, will search, or burial document search is completely empty, the safe deposit company need not follow the procedures above. Instead, the employee of the safe deposit company can

complete an inventory of the box contents indicating the fact that the box contained nothing. The form must be signed by the employee and the interested person. If the interested person so requests, the safe deposit company may provide a copy of the completed inventory form to the interested person. The interested person shall then complete the documentation needed by the safe deposit company to surrender the empty box. If another interested person inquires about the box after it has been surrendered, the safe deposit company may state that the deceased renter had previously rented the box and that the box was surrendered because it was empty.

(j) The safe deposit company need not ascertain the truth of any statement in the affidavit required to be furnished under this subdivision and when acting in reliance upon an affidavit, it is discharged as if it dealt with the personal representative of the lessee. The safe deposit company is not responsible for the adequacy of the description of any property included in an inventory of the contents of a safe deposit box, nor for conversion of the property in connection with actions performed under this subdivision, except for conversion by intentional acts of the company or its employees, directors, officers, or agents. If the safe deposit company is not satisfied that the requirements of this subdivision have been met, it may decline to open the box.

~~(j)~~ (k) No contents of a box other than a will and a document required to facilitate the lessee's wishes regarding body, funeral, or burial arrangements may be removed pursuant to this subdivision. The entire contents of the box, however, may be removed pursuant to section 524.3-1201."

Page 4, line 17, before "An" insert "(a)"

Page 4, after line 26, insert:

"(b) The receipt by an individual of prior consent of the commissioner under this section must not be construed as imposing upon an employer an affirmative obligation to employ that individual in any capacity. Nothing in this section precludes an employer from denying employment based upon the

existence of a criminal offense specified in subdivision 2 or for any other lawful reason.

Sec. 9. Minnesota Statutes 2004, section 58.16, subdivision 4, is amended to read:

Subd. 4. [TRUST ACCOUNT.] The residential mortgage originator shall deposit in a trust account within three business days all fees received before the time a loan is actually funded. The trust account must be in a financial institution located within the state of Minnesota, and, with respect to advance fees, the account must be controlled by an unaffiliated accountant, attorney, or bank ~~officer-or-employee.~~"

Page 5, after line 20, insert:

"Sec. 12. Minnesota Statutes 2004, section 82.17, subdivision 10, is amended to read:

Subd. 10. [LOAN BROKER.] "Loan broker" means a licensed real estate broker or salesperson who, for another and for a ~~commission,-fee,-or-other-valuable-consideration~~ an advance fee or with the intention or expectation of receiving the same, directly or indirectly, negotiates or offers or attempts to negotiate a loan secured or to be secured by a mortgage or other encumbrance on real estate, or represents himself or herself or otherwise holds himself or herself out as a licensed real estate broker or salesperson, either in connection with any transaction in which he or she directly or indirectly negotiates or offers or attempts to negotiate a loan, or in connection with the conduct of his or her ordinary business activities as a loan broker.

"Loan broker" does not include a licensed real estate broker or salesperson who, in the course of representing a purchaser or seller of real estate, incidentally assists the purchaser or seller in obtaining financing for the real property in question if the licensee does not receive a separate commission, fee, or other valuable consideration for this service.

For the purposes of this subdivision, an "advance fee" means a commission, fee, charge, or compensation of any kind

paid before the closing of a loan, that is intended in whole or in part as payment for finding or attempting to find a loan for a borrower. Advance fee does not include pass-through fees or commitment or extended lock fees or other fees as determined by the commissioner.

Sec. 13. Minnesota Statutes 2004, section 82.17, subdivision 18, is amended to read:

Subd. 18. [REAL ESTATE BROKER; BROKER.] "Real estate broker" or "broker" means any person who:

(a) for another and for commission, fee, or other valuable consideration or with the intention or expectation of receiving the same directly or indirectly lists, sells, exchanges, buys or rents, manages, or offers or attempts to negotiate a sale, option, exchange, purchase or rental of an interest or estate in real estate, or advertises or holds out as engaged in these activities;

(b) for another and for commission, fee, or other valuable consideration or with the intention or expectation of receiving the same directly or indirectly negotiates or offers or attempts to negotiate a loan, secured or to be secured by a mortgage or other encumbrance on real estate, which is not a residential mortgage loan as defined by section 58.02, subdivision 18;

(c) "real estate broker" or "broker" as set forth in clause (b) shall not apply to the originating, making, processing, selling, or servicing of a loan in connection with the ~~broker's~~ ordinary business activities ~~by~~ of a mortgagee, lender, or servicer approved or certified by the secretary of Housing and Urban Development, or approved or certified by the administrator of Veterans Affairs, or approved or certified by the administrator of the Farmers Home Administration, or approved ~~or certified~~ as a multifamily seller/servicer by the Federal Home Loan Mortgage Corporation, or as a multifamily partner approved ~~or certified~~ by the Federal National Mortgage Association;

(d) for another and for commission, fee, or other valuable consideration or with the intention or expectation of receiving the same directly or indirectly lists, sells, exchanges, buys,

rents, manages, offers or attempts to negotiate a sale, option, exchange, purchase or rental of any business opportunity or business, or its good will, inventory, or fixtures, or any interest therein;

(e) for another and for commission, fee, or other valuable consideration or with the intention or expectation of receiving the same directly or indirectly offers, sells or attempts to negotiate the sale of property that is subject to the registration requirements of chapter 83, concerning subdivided land;

(f) for another and for commission, fee, or other valuable consideration or with the intention or expectation of receiving the same, promotes the sale of real estate by advertising it in a publication issued primarily for this purpose, if the person:

(1) negotiates on behalf of any party to a transaction;

(2) disseminates any information regarding the property to any party or potential party to a transaction subsequent to the publication of the advertisement, except that in response to an initial inquiry from a potential purchaser, the person may forward additional written information regarding the property which has been prepared prior to the publication by the seller or broker or a representative of either;

(3) counsels, advises, or offers suggestions to the seller or a representative of the seller with regard to the marketing, offer, sale, or lease of the real estate, whether prior to or subsequent to the publication of the advertisement;

(4) counsels, advises, or offers suggestions to a potential buyer or a representative of the seller with regard to the purchase or rental of any advertised real estate; or

(5) engages in any other activity otherwise subject to licensure under this chapter;

(g) engages wholly or in part in the business of selling real estate to the extent that a pattern of real estate sales is established, whether or not the real estate is owned by the person. A person shall be presumed to be engaged in the business of selling real estate if the person engages as

principal in five or more transactions during any 12-month period, unless the person is represented by a licensed real estate broker or salesperson.

Sec. 14. Minnesota Statutes 2004, section 82.36, subdivision 4, is amended to read:

Subd. 4. [ESCROW ACCOUNT.] The loan broker shall deposit in an escrow account within 48 hours all fees received prior to the time a loan is actually funded. The escrow account shall be in a bank located within the state of Minnesota and shall be controlled by an unaffiliated accountant, lawyer, or bank ~~officer or employee~~.

Sec. 15. Minnesota Statutes 2004, section 82.41, subdivision 13, is amended to read:

Subd. 13. [FRAUDULENT, DECEPTIVE, AND DISHONEST PRACTICES.] (a) [PROHIBITIONS.] For the purposes of section ~~82.40~~ 82.35, subdivision 1, clause (b), the following acts and practices constitute fraudulent, deceptive, or dishonest practices:

(1) act on behalf of more than one party to a transaction without the knowledge and consent of all parties;

(2) act in the dual capacity of licensee and undisclosed principal in any transaction;

(3) receive funds while acting as principal which funds would constitute trust funds if received by a licensee acting as an agent, unless the funds are placed in a trust account. Funds need not be placed in a trust account if a written agreement signed by all parties to the transaction specifies a different disposition of the funds, in accordance with section 82.35, subdivision 1;

(4) violate any state or federal law concerning discrimination intended to protect the rights of purchasers or renters of real estate;

(5) make a material misstatement in an application for a license or in any information furnished to the commissioner;

(6) procure or attempt to procure a real estate license for himself or herself or any person by fraud, misrepresentation, or

deceit;

(7) represent membership in any real estate-related organization in which the licensee is not a member;

(8) advertise in any manner that is misleading or inaccurate with respect to properties, terms, values, policies, or services conducted by the licensee;

(9) make any material misrepresentation or permit or allow another to make any material misrepresentation;

(10) make any false or misleading statements, or permit or allow another to make any false or misleading statements, of a character likely to influence, persuade, or induce the consummation of a transaction contemplated by this chapter;

(11) fail within a reasonable time to account for or remit any money coming into the licensee's possession which belongs to another;

(12) commingle with his or her own money or property trust funds or any other money or property of another held by the licensee;

(13) demand from a seller a commission to compensation which the licensee is not entitled, knowing that he or she is not entitled to the commission compensation;

(14) pay or give money or goods of value to an unlicensed person for any assistance or information relating to the procurement by a licensee of a listing of a property or of a prospective buyer of a property (this item does not apply to money or goods paid or given to the parties to the transaction);

(15) fail to maintain a trust account at all times, as provided by law;

(16) engage, with respect to the offer, sale, or rental of real estate, in an anticompetitive activity;

(17) represent on advertisements, cards, signs, circulars, letterheads, or in any other manner, that he or she is engaged in the business of financial planning unless he or she provides a disclosure document to the client. The document must be signed by the client and a copy must be left with the client. The disclosure document must contain the following:

(i) the basis of fees, commissions, or other compensation received by him or her in connection with rendering of financial planning services or financial counseling or advice in the following language:

"My compensation may be based on the following:

(a) ... commissions generated from the products I sell you;

(b) ... fees; or

(c) ... a combination of (a) and (b). [Comments]";

(ii) the name and address of any company or firm that supplies the financial services or products offered or sold by him or her in the following language:

"I am authorized to offer or sell products and/or services issued by or through the following firm(s):

[List]

The products will be traded, distributed, or placed through the clearing/trading firm(s) of:

[List]";

(iii) the license(s) held by the person under this chapter or chapter 60A or 80A in the following language:

"I am licensed in Minnesota as a(n):

(a) ... insurance agent;

(b) ... securities agent or broker/dealer;

(c) ... real estate broker or salesperson;

(d) ... investment adviser"; and

(iv) the specific identity of any financial products or services, by category, for example mutual funds, stocks, or limited partnerships, the person is authorized to offer or sell in the following language:

"The license(s) entitles me to offer and sell the following products and/or services:

(a) ... securities, specifically the following: [List];

(b) ... real property;

(c) ... insurance; and

(d) ... other: [List]."

(b) [DETERMINING VIOLATION.] A licensee shall be deemed to have violated this section if the licensee has been found to

have violated sections 325D.49 to 325D.66, by a final decision or order of a court of competent jurisdiction.

(c) [COMMISSIONER'S AUTHORITY.] Nothing in this section limits the authority of the commissioner to take actions against a licensee for fraudulent, deceptive, or dishonest practices not specifically described in this section.

Sec. 16. Minnesota Statutes 2004, section 325F.69, is amended by adding a subdivision to read:

Subd. 6. [DECEPTIVE USE OF FINANCIAL INSTITUTION NAME.] No person shall include the name, trade name, logo, or tagline of a financial institution as defined in section 49.01, subdivision 2, in a written solicitation for financial services directed to a customer who has obtained a loan from the financial institution without written permission from the financial institution, unless the solicitation clearly and conspicuously states that the person is not sponsored by or affiliated with the financial institution, which shall be identified by name. This statement shall be made in close proximity to, and in the same or larger font size as, the first and most prominent use or uses of the name, trade name, logo, or tagline in the solicitation, including on an envelope or through an envelope window containing the solicitation. For purposes of this section, the term "financial institution" includes a financial institution's affiliates and subsidiaries. This subdivision shall not prohibit the use of a financial institution name, trade name, logo, or tagline of a financial institution if the use of that name is part of a fair and accurate comparison of like products or services."

Page 5, line 26, delete "4" and insert "8"

Renumber the sections in sequence

Amend the title as follows:

Page 1, line 2, delete everything after "regulating"

Page 1, delete line 3

Page 1, line 10, delete everything after the first semicolon and insert "47.75; 48.10; 48.15, subdivision 4; 48.512, by adding a subdivision; 52.062, subdivision 2; 55.10,

subdivision 4; 58.16, subdivision 4; 60A.13,"

Page 1, line 11, after the second semicolon, insert "82.17, subdivisions 10, 18; 82.36, subdivision 4; 82.41, subdivision 13; 325F.69, by adding a subdivision;"

And when so amended the bill do pass. Amendments adopted. Report adopted.

.....
(Committee Chair)

April 1, 2005.....
(Date of Committee recommendation)

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S.F. No. 1794 - Insurance Verification Program

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Date: March 17, 2005

Section 1, Subdivision 1 requires each insurance company that issues motor vehicle insurance in the state to provide, at least monthly, to the agent of the Commissioner of Public Safety, a record of each vehicle insurance policy in force.

Subdivision 2 exempts reporting insurance companies and administrators of self-insurance plans from liability for complying with subdivision 1.

Section 2 directs the commissioner to impose a 50-cent surcharge on registration taxes effective January 1, 2006. The surcharge is reduced to 25 cents on and after January 1, 2007. The surcharge proceeds are credited in the vehicle insurance verification account and appropriated to the commissioner to administer the vehicle insurance verification program.

Section 3 includes a cross-reference.

Section 4 grants rulemaking authority to the commissioner to implement statutory sections in sections 6-8 of this bill.

Section 5 allows an insurance company to release information to the department's designated agent to verify insurance coverage.

Section 6 requires a vehicle owner to provide any information the commissioner reasonably requires to determine that a vehicle is covered by insurance.

Section 7 creates the vehicle insurance verification program.

Subdivision 1 directs the commissioner to contract with an agent to administer the program, which will involve creating a vehicle insurance and registration database to verify compliance with insurance requirements.

Subdivision 2 defines the agent's duties, to maintain a vehicle insurance database and a vehicle registration database, and compare them monthly to identify registered vehicles with owners who have not complied with insurance requirements. The agent must transmit on a monthly basis a list of registered, uninsured vehicles, to the commissioner, and issue noncompliance notices.

Subdivision 3 requires the commissioner to transmit certain information at least monthly to the agent, concerning registered vehicles and self-insurers.

Subdivision 4 directs the agent to mail a notice of noncompliance to a vehicle owner who, for two consecutive months, has not provided insurance for a registered vehicle. The notice must direct the owner to provide proof of insurance within 45 days, or proof of exemption from the requirement, and it must explain penalties for operating a vehicle without insurance. The envelope must clearly state that the contents of the envelope are time-sensitive and require a response, and the envelope must display information to enable the post office to forward or return it to the sender.

Subdivision 5 requires the agent to issue an additional notice of noncompliance, containing information on applicable penalties, to a vehicle owner who has not provided proof of required insurance within 45 days of the date of the first notice. The commissioner must record the issuance of the additional notice on the vehicle record.

Section 8 relates to insurance information disclosure and penalties.

Subdivision 1 restricts disclosure of information in the database except for enumerated exceptions:

(a) The agent must verify coverage for a state or local government agency that is litigating or enforcing the insurance requirement;

(b) The agent must issue a certification of insurance status of an individual or vehicle for a designated time period to a state or local government agency that is litigating or enforcing the insurance requirement; and

(c) The department shall disclose on request a person's insurance status to that person, a minor's parent or legal guardian, an incapacitated person's legal guardian, a person with power-of-attorney from the insured, a person with a notarized release from the insured person; or a person suffering loss or injury in a motor vehicle accident involving the insured.

Subdivision 2 makes it a gross misdemeanor to knowingly release information from the database for an unauthorized purpose or to an unauthorized recipient.

Subdivision 3 exempts an insurer from liability for complying with this section by providing information to the agent.

Subdivision 4 exempts that the state and department's agent from liability for utilizing the database as authorized by law.

Section 9 directs the commissioner to reinstate, without proof of insurance or payment of a reinstatement fee, any driver's license suspended under the current sampling program, which is repealed in this bill.

Section 10 declares all charges, complaints, and citations issued under the current sampling program and related violations, including driving after suspension, to be void.

Section 11 requires the commissioner to purge from a person's driving record, any notation of a violation of the sampling program or related violation. An insurer may not increase an insurance policy premium for a violation of the sampling program by a named insured. Any previous increases based on violations related to the sampling program must be rescinded.

Section 12 requires the commissioner to report to the Legislature by September 1, 2007, concerning the operation of the vehicle insurance verification program, and its impact on the identification and number of uninsured motorists.

Section 13 repeals the insurance verification sampling program.

Section 14 gives immediate effect to sections 9, 10, 11, and 13. Remaining provisions are effective on August 1, 2005.

BB/AV:rer

A bill for an act

relating to motor vehicles; requiring insurance companies to report information; creating vehicle insurance verification program and special revenue account; requiring preparation of database to identify uninsured motorists; requiring commissioner of public safety to discontinue insurance verification sampling program; declaring charges for violations of sampling program laws to be void; reinstating certain drivers' licenses; authorizing rulemaking; requiring report; imposing criminal penalty; appropriating money; amending Minnesota Statutes 2004, sections 168.013, by adding a subdivision; 169.09, subdivision 13; 169.795; 169.796, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 65B; 169; repealing Minnesota Statutes 2004, section 169.796, subdivision 3.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [65B.90] [MANDATORY DISCLOSURE.]

Subdivision 1. [INFORMATION REPORTING REQUIREMENT.] On at least a monthly basis, each insurance company that issues policies of reparation security in this state and each administrator of a self-insurance plan registered with the commissioner of public safety must provide to the agent designated by the commissioner of public safety under section 169.7991 a record of each reparation security policy in force. The record must include the name, date of birth, and driver's license number of each named insured individual; make, year, and identification number of each insured vehicle; and policy number, effective date, and expiration date of each policy.

Subd. 2. [NONLIABILITY.] Neither an insurance company nor

an administrator of a self-insurance plan is liable to any person for complying with this section.

Sec. 2. Minnesota Statutes 2004, section 168.013, is amended by adding a subdivision to read:

Subd. 8a. [VEHICLE INSURANCE VERIFICATION ACCOUNT; SURCHARGE.] The commissioner shall impose a surcharge of 50 cents on registration taxes authorized under this section for registration taxes collected January 1, 2006, or later. For registration taxes collected on and after January 1, 2007, the surcharge is reduced to 25 cents. The commissioner shall forward the proceeds of the surcharge to the commissioner of finance on a monthly basis. Upon receipt, the commissioner of finance shall credit the surcharge proceeds to a special revenue account, to be known as the vehicle insurance verification account. Money in the account is appropriated to the commissioner of public safety to be used to administer the vehicle insurance verification program, including to contract with an agent to carry out this program.

Sec. 3. Minnesota Statutes 2004, section 169.09, subdivision 13, is amended to read:

Subd. 13. [REPORTS CONFIDENTIAL; EVIDENCE, FEE, PENALTY, APPROPRIATION.] (a) All written reports and supplemental reports required under this section shall be for the use of the commissioner of public safety and other appropriate state, federal, county, and municipal governmental agencies for accident analysis purposes, except:

(1) the commissioner of public safety or any law enforcement agency shall, upon written request of any person involved in an accident or upon written request of the representative of the person's estate, surviving spouse, or one or more surviving next of kin, or a trustee appointed pursuant to section 573.02, disclose to the requester, the requester's legal counsel, or a representative of the requester's insurer the report required under subdivision 8;

(2) the commissioner of public safety shall, upon written request, provide the driver filing a report under subdivision 7

with a copy of the report filed by the driver;

(3) the commissioner of public safety may verify with insurance companies vehicle insurance information to enforce sections 65B.48, 169.792, 169.793, 169.796, ~~and~~ 169.797, and 169.7991;

(4) the commissioner of public safety shall provide the commissioner of transportation the information obtained for each traffic accident involving a commercial motor vehicle, for purposes of administering commercial vehicle safety regulations; and

(5) the commissioner of public safety may give to the United States Department of Transportation commercial vehicle accident information in connection with federal grant programs relating to safety.

(b) Accident reports and data contained in the reports shall not be discoverable under any provision of law or rule of court. No report shall be used as evidence in any trial, civil or criminal, arising out of an accident, except that the commissioner of public safety shall furnish upon the demand of any person who has, or claims to have, made a report, or, upon demand of any court, a certificate showing that a specified accident report has or has not been made to the commissioner solely to prove compliance or failure to comply with the requirements that the report be made to the commissioner.

(c) Nothing in this subdivision prevents any person who has made a report pursuant to this section from providing information to any persons involved in an accident or their representatives or from testifying in any trial, civil or criminal, arising out of an accident, as to facts within the person's knowledge. It is intended by this subdivision to render privileged the reports required, but it is not intended to prohibit proof of the facts to which the reports relate.

(d) Disclosing any information contained in any accident report, except as provided in this subdivision, section 13.82, subdivision 3 or 6, or other statutes, is a misdemeanor.

(e) The commissioner of public safety may charge authorized

persons a $5 fee for a copy of an accident report. The commissioner may also furnish copies of the modified accident records database to private agencies as provided in paragraph (g), for not less than the cost of preparing the copies on a bulk basis.

(f) The commissioner and law enforcement agencies may charge commercial users who request access to response or incident data relating to accidents a fee not to exceed 50 cents per report. "Commercial user" is a user who in one location requests access to data in more than five accident reports per month, unless the user establishes that access is not for a commercial purpose. Money collected by the commissioner under this paragraph is appropriated to the commissioner.

(g) The commissioner may provide a modified copy of the accident records database that does not contain names, driver's license numbers, vehicle license plate numbers, addresses, or other identifying data to the public upon request. However, unless the accident records data base includes the motor vehicle identification number, the commissioner shall include the vehicle license plate number if a private agency certifies and agrees that the agency:

(1) is in the business of collecting accident and damage information on vehicles;

(2) will use the vehicle license plate number only for the purpose of identifying vehicles that have been involved in accidents or damaged in order to provide this information to persons seeking access to a vehicle's history and not for the purpose of identifying individuals or for any other purpose; and

(3) will be subject to the penalties and remedies under sections 13.08 and 13.09.

Sec. 4. Minnesota Statutes 2004, section 169.795, is amended to read:

169.795 [VEHICLE INSURANCE RULES.]

The commissioner of public safety shall adopt rules necessary to implement sections 168.041, subdivision 4; 169.09, subdivision 14; and 169.791 to ~~169.796~~ 169.7992.

Sec. 5. Minnesota Statutes 2004, section 169.796, subdivision 1, is amended to read:

Subdivision 1. [RELEASE OF INFORMATION.] An insurance company shall release information to the Department of Public Safety, its agent designated under section 169.7991, or the law enforcement authorities necessary to the verification of insurance coverage. An insurance company or its agent acting on its behalf, or an authorized person who releases the above information, whether oral or written, acting in good faith, is immune from any liability, civil or criminal, arising in connection with the release of the information.

Sec. 6. [169.7967] [INFORMATION MAY BE REQUIRED.]

A vehicle owner shall provide any information the commissioner reasonably requires to determine that a motor vehicle or motorcycle is covered by a plan of reparation security. This information includes the name and address of the owner, the name of the reparation obligor, the insurance policy number, and any other data the commissioner requires.

Sec. 7. [169.7991] [VEHICLE INSURANCE VERIFICATION PROGRAM.]

Subdivision 1. [ADMINISTRATION OF PROGRAM; CONTRACT.] The commissioner of public safety shall contract with an agent to create and administer a vehicle insurance verification program. The program will involve the establishment of a vehicle insurance and registration database to verify compliance with a motor vehicle owner's or operator's security requirements under section 65B.48.

Subd. 2. [AGENT DUTIES.] The agent shall:

(1) create, maintain, and update monthly a database of vehicle insurance policies in force in this state from information provided by insurance companies, administrators of self-insurance plans under section 65B.90, and the commissioner of public safety with regard to self-insurers;

(2) create, maintain, and update monthly a database of vehicles registered in this state from information supplied by the commissioner of public safety;

(3) compare, on a monthly basis, the vehicle registration database with the vehicle insurance database to identify vehicles registered in this state with owners who are not in compliance with security requirements under section 65B.48;

(4) transmit, on a monthly basis, to the commissioner a record of all vehicles registered in this state, but not insured in this state; and

(5) issue notices as described in subdivisions 4 and 5.

Subd. 3. [COMMISSIONER DUTIES.] The commissioner of public safety shall provide the agent, at least monthly, with the following information:

(1) on each vehicle registered within the state: vehicle make, model, and identification number; owner's name, date of birth, address, and driver's license number; and date of next required registration renewal; and

(2) on each individual self-insurer registered with the department under section 65B.48, subdivision 3: name and date of birth; driver's license number; and make, year, and identification number of each insured vehicle.

Subd. 4. [NONCOMPLIANCE NOTICE.] When a comparison under subdivision 2 identifies a vehicle registered within this state without a plan of reparation security required under section 65B.48 for two consecutive months, the agent shall mail notice of noncompliance to the vehicle owner stating that the owner must provide to the agent within 45 days proof of reparation security required by section 65B.48 or proof of exemption from the compulsory reparation security requirement. The notice must state that operation of a vehicle without required insurance may subject the owner to criminal penalties, driver's license revocation, vehicle registration revocation, and reinstatement fees. The envelope in which the notice is mailed must clearly state on the front that the contents of the envelope are time-sensitive and a response is required. The envelope must display information necessary to enable the postal service to return undeliverable mail to the sender. The commissioner may not block forwarding of the mailed notice.

Subd. 5. [ADDITIONAL NOTICE.] If, at least 45 days after the date of a notice to a vehicle owner issued under subdivision 4, the agent has not received proof of required reparation security or exemption from the requirement, the agent shall issue an additional notice of noncompliance to the vehicle owner. The notice must contain a statement of the applicable penalties, including criminal penalties, driver's license revocation, vehicle registration revocation, and reinstatement fees for operating a vehicle without required insurance. The agent shall notify the commissioner of the issuance of an additional notice of noncompliance. The commissioner shall record the issuance of the notice and date of issuance on the vehicle record.

Sec. 8. [169.7992] [INSURANCE INFORMATION DISCLOSURE; PENALTY.]

Subdivision 1. [RESTRICTION ON DISCLOSURE.] The information in the database established in section 169.7991 may not be disclosed under chapter 13 or otherwise, except as follows:

(a) For investigating, litigating, or enforcing the compulsory reparation security requirement under section 65B.48, the agent shall verify insurance coverage for a state or local government agency.

(b) For investigating, litigating, or enforcing the compulsory reparation security requirement under section 65B.48, the agent, upon request of a state or local government agency, shall issue to the requesting agency a certification of insurance status, as contained in the database, of a specific individual or vehicle for a time period designated by the government agency.

(c) Upon request, the department shall disclose whether or not a person is insured to:

(1) that person;

(2) the parent or legal guardian of that person, if the person is an unemancipated minor;

(3) the legal guardian of that person, if the person is

legally incapacitated;

(4) a person who has power of attorney from the insured person;

(5) a person who submits a notarized release from the insured person dated no more than 90 days before the date the request is made; or

(6) a person suffering loss or injury in a motor vehicle accident in which the insured person is involved, but only as part of an accident report as authorized in section 169.09.

Subd. 2. [CRIMINAL PENALTY.] A person who knowingly releases or discloses information from the database for a purpose other than those authorized in this section, or to a person who is not entitled to it, is guilty of a gross misdemeanor.

Subd. 3. [INSURER NONLIABILITY.] An insurer is not liable to any person for complying with this section by providing information to the agent.

Subd. 4. [STATE AND DEPARTMENT NONLIABILITY.] Neither the state nor the department's agent is liable to any person for gathering, managing, or using the information in the database as provided in this section and section 169.7991, or for the consequences of any act carried out under the authority of section 169.796, subdivision 3.

Sec. 9. [REINSTATEMENT OF SUSPENDED LICENSES.]

The commissioner of public safety, without requiring proof of insurance or payment of a reinstatement fee, shall reinstate the driver's license of every vehicle owner whose license is suspended under Minnesota Statutes, section 169.796, subdivision 3.

Sec. 10. [DISMISSAL OF CHARGES.]

All charges, complaints, and citations issued for a violation of Minnesota Statutes, section 169.796, subdivision 3, or a related violation, including driving after a license suspension imposed for failure to comply with the provisions of Minnesota Statutes, section 169.796, subdivision 3, are void and must be dismissed.

Sec. 11. [REMOVAL OF PREVIOUS VIOLATIONS.]

The commissioner shall purge from a person's driving record any notation of a violation of Minnesota Statutes, section 169.796, subdivision 3, and any notation of a related violation, including driving after a license suspension imposed for failure to comply with the provisions of Minnesota Statutes, section 169.796, subdivision 3. An insurer may not increase a premium for a policy of vehicle insurance on the basis of a violation described in this section by a named insured if the violation occurred before the effective date of this section, and any such increase previously imposed must be rescinded.

Sec. 12. [REPORT TO LEGISLATURE.]

The commissioner of public safety shall report to the chairs of the house of representatives and senate committees with jurisdiction over transportation policy by September 1, 2007, concerning the operation of the vehicle insurance verification program, and the impact of the program on the identification and number of uninsured motorists.

Sec. 13. [REPEALER.]

Minnesota Statutes 2004, section 169.796, subdivision 3, is repealed.

Sec. 14. [EFFECTIVE DATE.]

Sections 9, 10, 11, and 13 are effective the day following final enactment.

APPENDIX
Repealed Minnesota Statutes for S1794-1

169.796 VERIFICATION OF INSURANCE COVERAGE.

Subd. 3. **Sampling to verify insurance coverage.** (a) The commissioner of public safety shall implement a monthly sampling program to verify insurance coverage. The sample must annually include at least two percent of all drivers who own motor vehicles, as defined in section 168.011, licensed in the state, one-half of whom during the previous year have been convicted of at least one vehicle insurance law violation, have had a driver's license revoked or suspended due to habitual violation of traffic laws, have had no insurance in effect at the time of a reportable crash, or have been convicted of an alcohol-related motor vehicle offense. No sample may be selected based on race, religion, physical or mental disability, economic status, or geographic location.

(b) The commissioner shall request each vehicle owner included in the sample to furnish insurance coverage information to the commissioner within 30 days. The request must require the owner to state whether or not all motor vehicles owned by that person were insured on the verification date stated in the commissioner's request. The request may require, but is not limited to, a signed statement by the owner that the information is true and correct, the names and addresses of insurers, policy numbers, and expiration or renewal dates of insurance coverage.

(c) The commissioner shall conduct a verification of the response by transmitting necessary information to the insurance companies named in the owner's response.

(d) The insurance companies shall electronically notify the commissioner, within 30 days of the commissioner's request, of any false statements regarding coverage.

(e) The commissioner shall suspend, without preliminary hearing, the driver's license, if any, of a vehicle owner who falsely claims coverage, who indicates that coverage was not in effect at the time specified in the request, or who fails to respond to the commissioner's request to furnish proof of insurance. The commissioner shall comply with the notice requirement of section 171.18, subdivision 2.

(f) Before reinstatement of the driver's license, there must be filed with the commissioner of public safety the written certificate of an insurance carrier authorized to do business in the state stating that security has been provided as required by section 65B.48. The commissioner of public safety may require the certificate of insurance provided to satisfy this subdivision to be certified by the insurance carrier for a period not to exceed one year. The commissioner of public safety may also require a certificate of insurance to be filed with respect to all vehicles required to be insured under section 65B.48 and owned by any person whose driving privileges have been suspended as provided in this section before reinstating the person's driver's license.

Adopted 4-1-05

04/01/05 [COUNSEL] BB SCS1794A-2

Senator Metzen moves to amend S.F. No. 1794 as follows:

Page 1, line 26, before the period, insert ", with the exception of policies that insure vehicles rated on a commercial or fleet basis"

Senator Scheid from the Committee on Commerce, to which was re-referred

S.F. No. 1794: A bill for an act relating to motor vehicles; requiring insurance companies to report information; creating vehicle insurance verification program and special revenue account; requiring preparation of database to identify uninsured motorists; requiring commissioner of public safety to discontinue insurance verification sampling program; declaring charges for violations of sampling program laws to be void; reinstating certain drivers' licenses; authorizing rulemaking; requiring report; imposing criminal penalty; appropriating money; amending Minnesota Statutes 2004, sections 168.013, by adding a subdivision; 169.09, subdivision 13; 169.795; 169.796, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 65B; 169; repealing Minnesota Statutes 2004, section 169.796, subdivision 3.

Reports the same back with the recommendation that the bill be amended as follows:

Page 1, line 26, before the period, insert "<u>, with the exception of policies that insure vehicles rated on a commercial or fleet basis</u>"

And when so amended the bill do pass and be re-referred to the Committee on State and Local Government Operations. Amendments adopted. Report adopted.

Linda Scheid
(Committee Chair)

April 1, 2005
(Date of Committee recommendation)

Senate Counsel, Research, and Fiscal Analysis

G-17 State Capitol
75 Rev. Dr. Martin Luther King, Jr. Blvd.
St. Paul, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
Jo Anne Zoff Sellner
Director

Senate

State of Minnesota

S.F. No. 1380 - Auto Insurance Claims Practices

Author: Senator Dan Sparks

Prepared by: Christopher B. Stang, Senate Counsel (651/296-0539)

Date: March 31, 2005

This bill prohibits an automobile insurer from engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an insured to use a particular contractor or repair shop. At the time a claim is reported, the insurer is required to provide a specified advisory. After the insured has indicated that a repair shop has been selected, the insurer is required to cease all efforts to influence the choice of repair shop.

CBS:cs

SENATE COMMERCE COMMITTEE

TESTIFIERS - PLEASE SIGN

Date: 4/1/05

NAME	ORGANIZATION	ADDRESS	PHONE
Brad Lehto	MN AFL-CIO	175 Aurora Avenue St. Paul, MN 55103	651-227-7647
Jon Youngdahl	SEIU MN State Council	2233 University Ave W, #422 St. Paul, MN 55114	651-203-0403
Twea Braze	CCHC	1954 University Ave St. Paul MN	651-646-8935
Beth Hartwig	MBP	3610 IDS Mpls 55402	612 370 0840
Phil Stalboerger	BCTSSM	3535 Blue Cross Rd EAGAN	651 662.2157
Geoff Bartsch	Health Partners	8100 34th Ave S Mpls, MN 55440	952-883-7239
Joe With	MN Bankers Assoc.	7601 France Ave. #200 55435	952-835-3900

Senators Sparks, Metzen, Scheid, Belanger and Solon introduced--
S.F. No. 1380: Referred to the Committee on Commerce.

A bill for an act

relating to insurance; regulating claims practices; amending Minnesota Statutes 2004, section 72A.201, subdivision 6.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 72A.201, subdivision 6, is amended to read:

Subd. 6. [STANDARDS FOR AUTOMOBILE INSURANCE CLAIMS HANDLING, SETTLEMENT OFFERS, AND AGREEMENTS.] In addition to the acts specified in subdivisions 4, 5, 7, 8, and 9, the following acts by an insurer, adjuster, or a self-insured or self-insurance administrator constitute unfair settlement practices:

(1) if an automobile insurance policy provides for the adjustment and settlement of an automobile total loss on the basis of actual cash value or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) comparable and available replacement automobile, with all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to the transfer or evidence of ownership of the automobile paid, at no cost to the insured other than the deductible amount as provided in the policy;

(b) a cash settlement based upon the actual cost of

purchase of a comparable automobile, including all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to transfer of evidence of ownership, less the deductible amount as provided in the policy. The costs must be determined by:

(i) the cost of a comparable automobile, adjusted for mileage, condition, and options, in the local market area of the insured, if such an automobile is available in that area; or

(ii) one of two or more quotations obtained from two or more qualified sources located within the local market area when a comparable automobile is not available in the local market area. The insured shall be provided the information contained in all quotations prior to settlement; or

(iii) any settlement or offer of settlement which deviates from the procedure above must be documented and justified in detail. The basis for the settlement or offer of settlement must be explained to the insured;

(2) if an automobile insurance policy provides for the adjustment and settlement of an automobile partial loss on the basis of repair or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) to assume all costs, including reasonable towing costs, for the satisfactory repair of the motor vehicle. Satisfactory repair includes repair of both obvious and hidden damage as caused by the claim incident. This assumption of cost may be reduced by applicable policy provision; or

(b) to offer a cash settlement sufficient to pay for satisfactory repair of the vehicle. Satisfactory repair includes repair of obvious and hidden damage caused by the claim incident, and includes reasonable towing costs;

(3) regardless of whether the loss was total or partial, in the event that a damaged vehicle of an insured cannot be safely driven, failing to exercise the right to inspect automobile damage prior to repair within five business days following receipt of notification of claim. In other cases the inspection

must be made in 15 days;

(4) regardless of whether the loss was total or partial, requiring unreasonable travel of a claimant or insured to inspect a replacement automobile, to obtain a repair estimate, to allow an insurer to inspect a repair estimate, to allow an insurer to inspect repairs made pursuant to policy requirements, or to have the automobile repaired;

(5) regardless of whether the loss was total or partial, if loss of use coverage exists under the insurance policy, failing to notify an insured at the time of the insurer's acknowledgment of claim, or sooner if inquiry is made, of the fact of the coverage, including the policy terms and conditions affecting the coverage and the manner in which the insured can apply for this coverage;

(6) regardless of whether the loss was total or partial, failing to include the insured's deductible in the insurer's demands under its subrogation rights. Subrogation recovery must be shared at least on a proportionate basis with the insured, unless the deductible amount has been otherwise recovered by the insured, except that when an insurer is recovering directly from an uninsured third party by means of installments, the insured must receive the full deductible share as soon as that amount is collected and before any part of the total recovery is applied to any other use. No deduction for expenses may be made from the deductible recovery unless an attorney is retained to collect the recovery, in which case deduction may be made only for a pro rata share of the cost of retaining the attorney. An insured is not bound by any settlement of its insurer's subrogation claim with respect to the deductible amount, unless the insured receives, as a result of the subrogation settlement, the full amount of the deductible. Recovery by the insurer and receipt by the insured of less than all of the insured's deductible amount does not affect the insured's rights to recover any unreimbursed portion of the deductible from parties liable for the loss;

(7) requiring as a condition of payment of a claim that

repairs to any damaged vehicle must be made by a particular contractor or repair shop or that parts, other than window glass, must be replaced with parts other than original equipment parts or engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an insured to use a particular contractor or repair shop. At the time a claim is reported, the insurer must provide the following advisory to the insured or claimant:

"Minnesota law gives you the right to choose a repair shop to fix your vehicle and prohibits me from pressuring you to choose a particular shop. Your policy will cover the reasonable costs of restoring your vehicle to its pre-accident condition no matter where you have repairs made. Have you selected a repair shop or would you like a referral?"

After an insured has indicated that the insured has selected a repair shop, the insurer must cease all efforts to influence the insured's or claimant's choice of repair shop;

(8) where liability is reasonably clear, failing to inform the claimant in an automobile property damage liability claim that the claimant may have a claim for loss of use of the vehicle;

(9) failing to make a good faith assignment of comparative negligence percentages in ascertaining the issue of liability;

(10) failing to pay any interest required by statute on overdue payment for an automobile personal injury protection claim;

(11) if an automobile insurance policy contains either or both of the time limitation provisions as permitted by section 65B.55, subdivisions 1 and 2, failing to notify the insured in writing of those limitations at least 60 days prior to the expiration of that time limitation;

(12) if an insurer chooses to have an insured examined as permitted by section 65B.56, subdivision 1, failing to notify the insured of all of the insured's rights and obligations under that statute, including the right to request, in writing, and to receive a copy of the report of the examination;

(13) failing to provide, to an insured who has submitted a claim for benefits described in section 65B.44, a complete copy of the insurer's claim file on the insured, excluding internal company memoranda, all materials that relate to any insurance fraud investigation, materials that constitute attorney work-product or that qualify for the attorney-client privilege, and medical reviews that are subject to section 145.64, within ten business days of receiving a written request from the insured. The insurer may charge the insured a reasonable copying fee. This clause supersedes any inconsistent provisions of sections 72A.49 to 72A.505;

(14) if an automobile policy provides for the adjustment or settlement of an automobile loss due to damaged window glass, failing to provide payment to the insured's chosen vendor based on a competitive price that is fair and reasonable within the local industry at large.

Where facts establish that a different rate in a specific geographic area actually served by the vendor is required by that market, that geographic area must be considered. This clause does not prohibit an insurer from recommending a vendor to the insured or from agreeing with a vendor to perform work at an agreed-upon price, provided, however, that before recommending a vendor, the insurer shall offer its insured the opportunity to choose the vendor. If the insurer recommends a vendor, the insurer must also provide the following advisory:

"Minnesota law gives you the right to go to any glass vendor you choose, and prohibits me from pressuring you to choose a particular vendor.";

(15) requiring that the repair or replacement of motor vehicle glass and related products and services be made in a particular place or shop or by a particular entity, or by otherwise limiting the ability of the insured to select the place, shop, or entity to repair or replace the motor vehicle glass and related products and services; or

(16) engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an

insured to use a particular company or location to provide the motor vehicle glass repair or replacement services or products. For purposes of this section, a warranty shall not be considered an inducement or incentive.

Sec. 2. [EFFECTIVE DATE.]

Section 1 is effective the day following final enactment.

Adopted 4-1-05

03/30/05 [COUNSEL] CBS SCS1380A-1

Senator Sparks moves to amend S.F. No. 1380 as follows:

Page 4, line 10, delete everything after "vehicle" and insert a period

Page 4, line 11, delete everything before "Your"

Page 4, line 12, delete "restoring" and insert "repairing"

Senator Scheid from the Committee on Commerce, to which was referred

S.F. No. 1380: A bill for an act relating to insurance; regulating claims practices; amending Minnesota Statutes 2004, section 72A.201, subdivision 6.

Reports the same back with the recommendation that the bill be amended as follows:

Page 4, line 10, delete everything after "vehicle" and insert a period

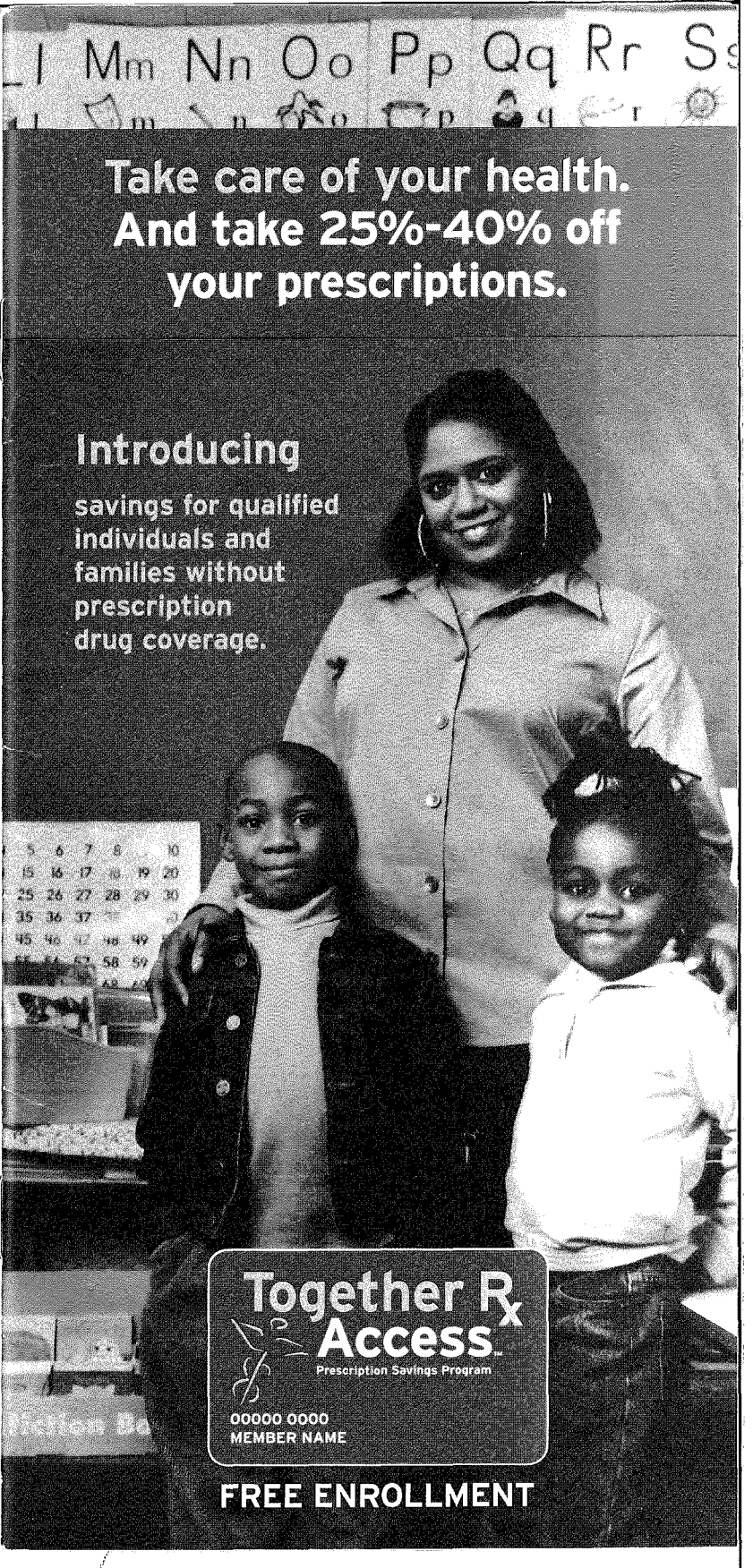
Page 4, line 11, delete everything before "Your"

Page 4, line 12, delete "restoring" and insert "repairing"

And when so amended the bill do pass. Amendments adopted. Report adopted.

.....Linda Scheid.....
(Committee Chair)

April 1, 2005.....
(Date of Committee recommendation)


Mm Nn Oo Pp Qq Rr
Take care of your health.
And take 25%-40% off
your prescriptions.
Introducing
savings for qualified
individuals and
families without
prescription
drug coverage.
Together Rx
Access.
Prescription Savings Program
00000 0000
MEMBER NAME
FREE ENROLLMENT

Better access.

Save 25%-40% and sometimes more on prescription medicines.

With the FREE Together Rx Access™ Card, you can save approximately 25%-40% and sometimes more* on over 275 brand-name prescription drugs and other prescription products, as well as save on a wide range of generic drugs. There are no enrollment fees, no monthly fees, and no hidden charges. To see if your medicine is included, please see the list at the back of this brochure.

Instant savings right at the pharmacy counter.

Apply for the card using the enrollment form included in this brochure. Once you receive your Together Rx Access Card, simply bring it to a participating pharmacy with your prescription, and your pharmacist will calculate your savings. It's that easy – and the majority of pharmacies accept the card.

Sponsored by major pharmaceutical companies.

Together Rx Access helps you take care of what's most important – your health. And some of the world's largest pharmaceutical companies are making it possible.

For more information, call 1-800-444-4106, or visit www.TogetherRxAccess.com.

* Savings may vary depending on the pharmacy's customary pricing for each product and savings offered by the participating company that makes it. Participating companies independently set the level of savings offered and the products included in the program. Those decisions are subject to change.

To more medicines.

ABBOTT LABORATORIES

AstraZeneca

Bristol-Myers Squibb Company

gsk GlaxoSmithKline

JANSSEN PHARMACEUTICA PRODUCTS, L.P.

NOVARTIS

ORTHO-McNEIL PHARMACEUTICAL, INC.

Pfizer

sanofi aventis
Because health matters

Takeda

TAP

Getting started on your savings.

Are you eligible?

Finding out if you're eligible for Together Rx Access is easy. If you can check all of the boxes below, then you are eligible:

☐ Not eligible for Medicare

☐ No prescription drug coverage (public or private)

☐ Household income* equal to or less than

- $30,000 for a single person
- $40,000 for a family of two
- $50,000 for a family of three
- $60,000 for a family of four
- $70,000 for a family of five

For families of six or more, contact Together Rx Access at **1-800-444-4106** to determine eligibility.

☐ Legal US resident

How do you apply?

For your convenience, an enrollment form is included in this brochure. It's easy and takes just a few minutes to complete.

For more information, call **1-800-444-4106**, or visit **www.TogetherRxAccess.com.**

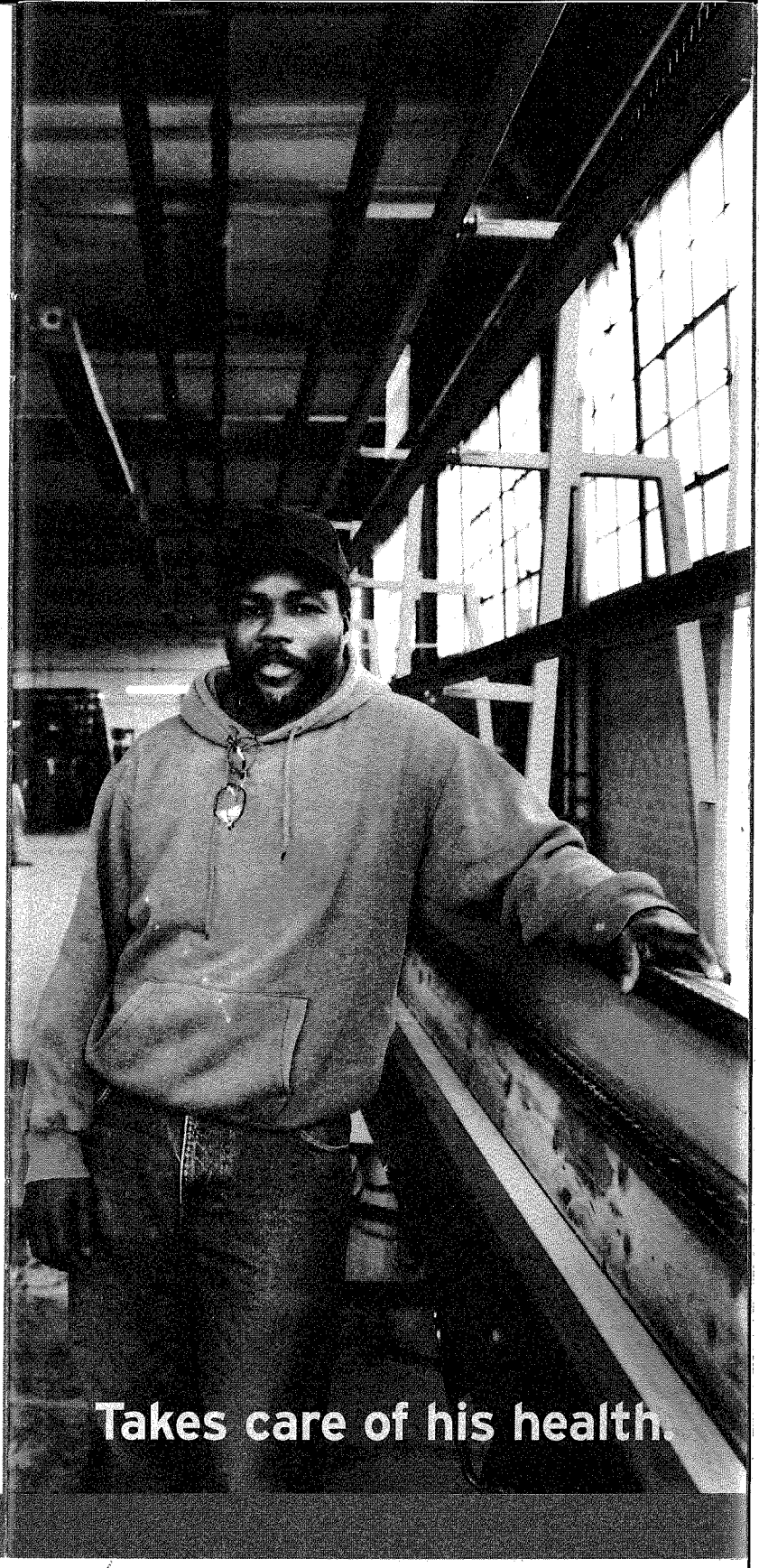
* Income limits may be higher in Alaska and Hawaii.

Savings on prescriptions. With no strings attached.

When you apply for the Together Rx Access Card, you can rest assured there are no enrollment fees, no monthly fees, and no hidden fees. Your privacy is important to us. Information that identifies you will not be shared with companies outside the program. Together Rx Access is simply about real savings from some of the world's largest pharmaceutical companies.

Have questions?

If you have questions about Together Rx Access, please call **1-800-444-4106** or visit **www.TogetherRxAccess.com.**



Start saving. Enroll today.

Applying is simple.

Just complete and mail (no postage necessary) the simple enrollment form on the next page to start saving on your prescription medicines with Together Rx Access. Applying is free, and there are no hidden fees.

Your privacy is important to us. Information that identifies you will not be shared with companies outside the program.

For questions about enrolling, or to get additional enrollment forms, call **1-800-444-4106.**

You may also apply online at **www.TogetherRxAccess.com.**

Apply today – by mail or online at www.TogetherRxAccess.com.

NE

DEPENDENTS (WHO MEET ELIGIBILITY REQUIREMENTS):

ADDITIONAL DEPENDENTS: You may enroll additional family members in the Together Rx Access Program if: 1) you can claim them as a financial dependent on tax returns or other government programs; 2) they are not eligible for Medicare; 3) they do not have prescription drug coverage; and 4) they are a legal US resident. If you have a dependent who meets these criteria, please list below.

FO

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 59049 WILMINGTON, DE

POSTAGE WILL BE PAID BY ADDRESSEE

TOGETHER RX ACCESS LLC
PO BOX 9426
WILMINGTON DE 19809-9944

FOLD AND TEAR ALONG DOTTED LINE

PROGRAM INFORMATION

ENROLLMENT
I understand that Together Rx Access has hired an Administrator to administer the Together Rx Access program, who will review my enrollment form, determine my eligibility, and notify me based on the information I provide. The Administrator may at any time require additional information to determine or confirm my eligibility. If I am eligible, I will receive a membership packet and Card by mail.

LIMITATIONS
Savings under the Program do not apply to prescription products reimbursed under any federal or state program, including Medicare or Medicaid ("Government Program"), or any private insurance, HMO, Medigap, employer, or other third-party arrangement ("Private Insurance"). By signing the enrollment form, I certify that I am not, nor are any of my family members listed on this application, eligible for Medicare, and I do not have prescription drug coverage through any Government Program or Private Insurance, nor do any of my family members listed on this application.

The Card may be used only for outpatient prescription products included in the Program. Participating companies independently determine which products to include and the savings offered. Products and savings may change at any time.

The Card may not be used with other prescription discount cards or pharmacy coupons. Coupons redeemed directly by a participating company are subject to the terms and conditions of the coupon.

The Card is valid only in the US and Puerto Rico. The Program may be terminated or modified at any time.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION
I understand that Together Rx Access and the Administrator will receive information about me and the prescription products that I receive using the Card. By signing this application, I authorize Together Rx Access and the Administrator to:

- use that information to administer the Program and to communicate with me, and
- share that information with participating companies for market research or analysis.

This authorization is in addition to any authorization that I have given under the heading "May We Contact You?" on the reverse side of this application. Together Rx Access does not provide/sell information that identifies you to third party companies not associated with the Program.

I may revoke this authorization by ending my participation in the Program by writing to Together Rx Access at the address provided in my membership packet.

ADDITIONAL DEPENDENTS: You may enroll additional family members in the Together Rx Access Program if: 1) you can claim them as a financial dependent on tax returns or other government programs; 2) they are not eligible for Medicare; 3) they do not have prescription drug coverage; and 4) they are a legal US resident. If you have a dependent who meets these criteria, please list below.

DEPENDENTS (WHO MEET ELIGIBILITY REQUIREMENTS):

First Name	M.I.	Last Name	Gender: M ☐ F ☐	Date of Birth (mm/dd/yyyy)
First Name	M.I.	Last Name	Gender: M ☐ F ☐	Date of Birth (mm/dd/yyyy)
First Name	M.I.	Last Name	Gender: M ☐ F ☐	Date of Birth (mm/dd/yyyy)
First Name	M.I.	Last Name	Gender: M ☐ F ☐	Date of Birth (mm/dd/yyyy)
First Name	M.I.	Last Name	Gender: M ☐ F ☐	Date of Birth (mm/dd/yyyy)
First Name	M.I.	Last Name	Gender: M ☐ F ☐	Date of Birth (mm/dd/yyyy)
First Name	M.I.	Last Name	Gender: M ☐ F ☐	Date of Birth (mm/dd/yyyy)
First Name	M.I.	Last Name	Gender: M ☐ F ☐	Date of Birth (mm/dd/yyyy)
First Name	M.I.	Last Name	Gender: M ☐ F ☐	Date of Birth (mm/dd/yyyy)
First Name	M.I.	Last Name	Gender: M ☐ F ☐	Date of Birth (mm/dd/yyyy)
First Name	M.I.	Last Name	Gender: M ☐ F ☐	Date of Birth (mm/dd/yyyy)

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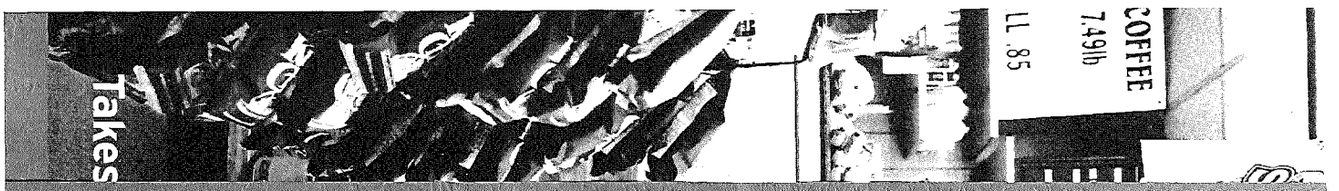

ENROLLMENT INSTRUCTIONS

Together Rx Access
Prescription Savings Program
00000 0000
MEMBER NAME

YES, I'd like to be considered for the Together Rx Access™ Card. I understand that the card is absolutely FREE.

You may also enroll online at **www.TogetherRxAccess.com**

1. REMOVE the enrollment form by tearing along the dotted line below.
2. Remove the blank strip on each side of the form.
3. THEN FILL OUT the form – ONE per family. All fields must be completed to be considered for the Together Rx Access Card. Information to be completed by applicant or legal representative. Review the Program Information on the back of the application form. **Please note: You must use a blue or black ink pen. DO NOT attach any other information.**
4. Check to make sure you have completed the enrollment form. If you have any questions, call **1-800-444-4106.**
5. SEPARATE the envelope from the form by tearing along the dotted line.
6. Fold the form, and slide it inside the envelope. Then moisten the adhesive flap, fold, and seal.
7. Drop your Together Rx Access enrollment form in the mail. No postage is necessary.

FOLD AND TEAR ALONG DOTTED LINE

FOLD AND TEAR ALONG DOTTED LINE

Together Rx Access
Prescription Savings Program
00000 0000
MEMBER NAME

ENROLLMENT FORM

You may also enroll online at **www.TogetherRxAccess.com**

YOUR INFORMATION

First Name M.I. Last Name

Address (Street Number / Street Name / Apartment Number)

City State Zip Code

Telephone - - Date of Birth (mm/dd/yyyy) - - Social Security Number - -

Gender: ☐ M ☐ F Race: (Optional) ☐ Caucasian ☐ Black ☐ Asian ☐ Hispanic ☐ Other

Are you a legal US resident? Yes ☐ No ☐

Are you eligible for Medicare? Yes ☐ No ☐

Do you have prescription drug coverage of any kind (public/private)? Yes ☐ No ☐

HOUSEHOLD ANNUAL INCOME: Please provide your annual (12 months) gross income from your last Federal Income Tax Return. If you did not file a tax return due to minimum filing requirements, please estimate your household income. $,
Note: If you are married and reside with your spouse, you must include both incomes regardless of tax filing status.

SPOUSE OR DEPENDENTS: You may enroll additional family members in the Together Rx Access Program if: 1) you can claim them as a financial dependent on tax returns or other government programs; 2) they are not eligible for Medicare; 3) they do not have prescription drug coverage; and 4) they are a legal US resident. If you have a spouse and/or dependent who meets these criteria, please list below. (To enroll more than 4 dependents, please use the space on the back of this form.)

SPOUSE (IF ELIGIBLE):

First Name M.I. Last Name Gender: ☐ M ☐ F Date of Birth (mm/dd/yyyy) - -

DEPENDENTS (WHO MEET ABOVE ELIGIBILITY REQUIREMENTS):

First Name M.I. Last Name Gender: ☐ M ☐ F Date of Birth (mm/dd/yyyy) - -

First Name M.I. Last Name Gender: ☐ M ☐ F Date of Birth (mm/dd/yyyy) - -

First Name M.I. Last Name Gender: ☐ M ☐ F Date of Birth (mm/dd/yyyy) - -

First Name M.I. Last Name Gender: ☐ M ☐ F Date of Birth (mm/dd/yyyy) - -

MAY WE CONTACT YOU?
By checking YES, you agree that Together Rx Access and its business partners may contact you about new programs and services, additional product and health information, or for market research purposes. Yes ☐ No ☐

I have read, understand, and accept the Program Information including the limitations and authorization to use and disclose information sections on the back of this form. I certify that the information on this enrollment form is accurate and complete. I understand and agree that an Administrator of the Together Rx Access program may contact me in the future to verify this information.

Signature of Applicant or Representative **Signature of Spouse** (if applicable) Today's Date (mm/dd/yyyy) - -

TAC-EN0305

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Save on these brand-name prescription medicines with Together Rx Access.™

List of medicines as of February 1, 2005.
For the most current list of medicines and products, visit www.TogetherRxAccess.com.

Abilify®
(aripiprazole)

Accolate® Tablets
(zafirlukast)

Accupril®
(quinapril HCl)

Accuretic™
(quinapril HCl/hydrochlorothiazide)

Actos®
(pioglitazone hydrochloride tablets)

Advair Diskus®
(fluticasone propionate and salmeterol inhalation powder)

Agenerase®
(amprenavir)

Alamast®
(pemirolast potassium ophthalmic solution)

Albenza®
(albendazole)

Aldactazide®
(spironolactone and hydrochlorothiazide)

Aldactone®
(spironolactone)

Allegra® 180mg, 60mg, and 30mg
(fexofenadine HCl)

Allegra D®
(fexofenadine HCl/pseudophedrine hydrochloride)

Amaryl®
(glimepiride)

Ambien®
(zolpidem)

Amerge®
(naratriptan hydrochloride)

Amoxil®
(amoxicillin)

Ansaid®
(flurbiprofen)

Antivert®
(meclizine HCl)

Anzemet®
(dolasetron mesylate injection/tablets)

Arava®
(leflunomide)

Arimidex® Tablets
(anastrozole)

Arixtra®
(fondaparinux sodium)

Arthrotec®
(diclofenac sodium and misoprostol)

Atacand HCT® Tablets
(candesartan cilexetil-hydrochlorothiazide)

Atacand® Tablets
(candesartan cilexetil)

Augmentin®
(amoxicillin/clavulanate potassium)

Augmentin ES®
(amoxicillin/clavulanate potassium)

Augmentin XR®
(amoxicillin/clavulanate potassium)

Avalide®
(irbesartan-hydrochlorothiazide)

Avandamet™
(rosiglitazone maleate/metformin HCl)

Avandia®
(rosiglitazone maleate)

Avapro®
(irbesartan)

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℗ 1-866-815-6874 | F 1-800-544-2987

Wyeth
Wyeth Patient Assistance Program | ℗ 1-800-568-9938

PhRMA
New Medicines. New Hope.®
1100 Fifteenth Street, NW
Washington, DC 20005

Rx CONNECT™

Helping Minnesotans get the prescription drugs they need

Call

1-800-333-2433

or on the web

www.MinnesotaHelp.info™

A service of the State of Minnesota and the official State Health Insurance Assistance Program (SHIP) for all Minnesota Medicare Beneficiaries as certified by the Centers for Medicare & Medicaid Services.

Are you confused by the many prescription drug programs, discount cards, and the many other options?

If so, RxConnect™ can help you...

Get informed.

Minnesota consumers can now choose from hundreds of drug manufacturer

programs, Medicare approved and other prescription drug discount cards. *RxConnect™* is a state sponsored, objective and neutral service for people of all ages which provides information and assistance needed to make informed decisions regarding affordable prescription drugs.

Get connected.

RxConnect™ staff are trained and certified as Health Insurance Counselors and can provide you with information on your prescription drug care options and connect you with appropriate resources. *RxConnect™* provides valuable insight and information on prescription drug cards endorsed by the Centers for Medicare & Medicaid Services. If you qualify for the drug manufacturers' patient assistance programs, *RxConnect™* specialists can help you get qualified and connected.

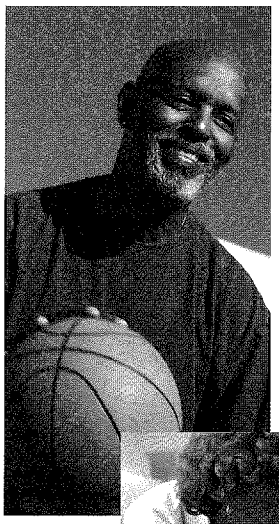
Who is RxConnect™ for?

- People of all ages
- People of low to moderate income
- People who have a tough time paying for their prescriptions
- People who want access to the large number of public and privately funded programs
- People who want to know about all of their options

What will RxConnect™ cost me?

There is no charge for *RxConnect™* services.

As the manager of *RxConnect™*



and the Senior LinkAge Line,® the Minnesota Board on Aging believes that all consumers should have access to affordable prescription drugs to ensure their quality of life.

Connecting people of all ages with the prescription drugs they need!

People of all ages who need assistance in finding help with their prescription drug costs can call *RxConnect™*. Trained and certified Health Insurance Counselors will discuss all pharmaceutical options, which may include:

- comparing prices using web sites
- understanding benefits available through a health plan or Medicare supplement or HMO plan
- enrolling in publicly funded programs
- reviewing mail order options
- negotiating with a local pharmacist
- getting help from the drug manufacturer programs
- discussing prescription drug purhcase issues or concerns
- enrolling in one of the discount card options such as the Medicare Approved Drug Discount card or a prescription savings discount card offered by a private provider

Depending on the options available to you, *RxConnect™* specialists can help complete the paperwork and prepare the information for mailing. Help is available on a one-on-one basis, over the phone or in person.

How do I sign up?

Call *RxConnect™* at 1-800-333-2433

RxConnect™ specialists are good listeners and will do their best to match your income and prescribed drugs to the right option which could be a public or privately funded service, offer, or program or a new purchasing strategy.

Have these ready when you call:

- income and financial information
- prescription bottles
- doctor and clinic name and address

How do I know which prescription card to get or

which program? I'm so confused.

Real Minnesotans... ...real help from

RxCONNECT™

Find out more about RxConnect™:

Phone **1-800-333-2433**

Internet **www.MinnesotaHelp.info™**

This information is available in other forms to people with disabilities

Contact us at:

Phone	**651-296-2770**
Toll Free	**1-800-882-6262**
TDD Users	**Call Minnesota Relay at 711**
Speech to Speech Relay	**1-877-627-3848**

RxConnect™ is a free service available statewide through Senior LinkAge Line®, a service offered by the Minnesota Board on Aging and the Area Agencies on Aging.

RxCONNECT™

helping you get the prescription drugs you need

1-800-333-2433

Real Minnesotans... ...real help from RxCONNECT™

My father suffered a stroke and was hospitalized. ...He had not filled his prescriptions for 11 months because he did not have the money to pay for them. He was on Lipitor and Glucophage and had not filled either of them. ...[RxConnect™] *found out my father was over the income limit for the Prescription Drug Program. He did qualify for the drug companies free drug programs and now is able to get his prescriptions at no charge. What a wonderful relief!*

St. Cloud nurse who now cares for her father

Attention.
Do you need information in other languages?

If you want free help translating this information, call 1-800-333-2433.

إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، اتصل بالرقم ١-٨٠٠-٣٣٣-٢٤٣٣

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពិតមាននេះដោយមិនគិតថ្លៃ, សូមទូរស័ព្ទ ១-៨០០-៣៣៣-២៤៣៣ ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ovih informacija, nazovite 1-800-333-2433.

Ceeb toom. Yog tias koj xav tau kev pab txhais cov ntaub ntawv no dawb rau koj, hu 1-800-333-2433.

“ໂປຣດຊາບ. ຖ້າທ່ານຕ້ອງການໃຫ້ຊ່ວຍແປ ຂໍ້ມູນນີ້ຟຣີ, ໂທຫາ 1-800-333-2433”

Hubaddhu, Yo akka odeeffannoon kun sii biikamu gargaarsa tolaa feeta ta'e, bilbila kana bilbili 1-800-333-2433.

Внимание! Если Вам нужна бесплатная помощь в переводе данной информации, позвоните по телефону: 1-800-333-2433.

Ogow. Haddii aad dooneyso kaalmo bilaash ah turjamadda macluumaadkani wac 1-800-333-2433.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame a 1-800-333-2433.

Chú Ý: Nếu quý vị cần dịch thông-tin này miễn phí, xin gọi 1-800-333-2433

Senior LinkAge Line®
1-800-333-2433
www.MinnesotaHelp.info™