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S.F. No. 880 - (first engrossment) Changing State Law to Conform with Federal Medicare Prescription Drug Coverage

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S.F. No. 880 changes Minnesota law to conform or respond to the recent changes in federal law involving Medicare prescription drug coverage (Medicare Part D).

Article 1 makes technical changes in state law involving Medicare supplement ("Medigap") insurance.

Section 1 (62A.31, subdivision 1f) states that a suspended Medicare supplement policy must be replaced by an equivalent policy (current law), except that it must not cover outpatient prescription drugs if the insured has enrolled in Medicare Part D.

Section 2 (62A.31, subdivision 1k) makes technical formatting changes. States that guaranteed renewability is satisfied if a policy is renewed without coverage of outpatient prescription drugs.

Section 3 (62A.31, subdivision 1n) states that receipt of outpatient drug benefits is not counted in calculating a continuous loss for purposes of extension of coverage beyond a policy's termination date. Clarifies existing language.

Section 4 (62A.31, subdivision 1s) specifies what happens to drug coverage under Medicare supplement policies in various situations. The general principles are: (1) enrollees may keep that existing coverage if they choose not to enroll in Medicare Part D; (2) no new Medicare supplement policies that cover outpatient prescription drugs may be issued; and (3) individuals who choose to enroll in Part D may renew their existing Medicare supplement policy, but without the drug coverage and with a corresponding premium reduction.

Section 5 (62A.31, subdivision 1t) amends the required notice that a policy does not cover drugs to include the effects of the federal changes. Removes obsolete language.

Section 6 (62A.31, subdivision 1u) paragraph (a), makes a clarifying change and a change to conform to federal law.

Paragraph (b) makes changes to conform to the federal name change from Medicare+Choice to Medicare Advantage and creates a new way to be eligible for guaranteed issue involving an individual who had Medicare supplement insurance with prescription drug coverage, who enrolls in Medicare Part D, and therefore needs a new Medicare supplement policy without drug coverage.

Paragraph (c) makes federally required changes regarding when a guaranteed issue period begins and ends.

Paragraph (e) makes federally required changes regarding what kind of Medicare supplement policy in which an individual has guaranteed issue rights to enroll.

Section 7 (62A.31, subdivision 3) makes a number of technical and clarifying changes to definitions. Creates a new definition of "outpatient prescription drugs" to clarify how that term relates to Medicare coverage.

Section 8 (62A.31, subdivision 4) permits Medicare supplement policies issued before January 1, 2006, to cover outpatient prescription drugs even though Medicare Part D covers them.

Section 9 (62A.31, subdivision 7) eliminates language made obsolete by the federal Medicare changes.

Sections 10 and 11 (62A.315 and 62A.316) make changes to conform to federal law by prohibiting the sale of a new Medicare supplement policy that covers outpatient prescription drugs after the end of 2005. Section 10 applies to the extended basic plan and section 11 applies to the basic plan.

Section 12 (62A.318) divides the existing law into subdivisions and paragraphs. Makes changes to conform to federal law by prohibiting the sale of Medicare Select products with drug coverage after 2005.

Section 13 (62A.36) makes technical clarifications. Clarifies how the deletion of prescription drug coverage and related premium reductions will be handled for purposes of regulation. Provides a catch-all failsafe requirement that enrollees be given all federally required notices.

Section 14 instructs the Revisor of Statutes to reorder definitions and make necessary changes in cross-references.

Section 15 states that the effective date of this article is January 1, 2006, except for certain provisions that need to be in place to prepare for that date.

Article 2 creates a procedure for licensing and solvency regulation of stand alone prescription drug plans that could provide prescription drug coverage under Medicare Part D or Medicare Part D prescription drug plans (PDPs).

Section 1 (62A.451) defines terms. Adds a definition of "limited health service," which limits the services to pharmaceutical services covered under Medicare Part D.

Section 2 (62A.4511) requires insurers offering PDPs to be licensed under these sections.

Section 3 (62A.4512) lists what has to be in an application for licensure.

Section 4 (62A.4513) requires the commissioner to approve or deny an application within 90 days, or the application is deemed approved. Requires the commissioner to issue a license if the applicant meets the requirements. Permits the applicant to appeal a denial of the application.

Section 5 (62A.4514) provides a way for an entity that is already licensed under a law that does not permit offering a PDP plan to use a simplified application process to apply for approval from the commissioner.

Section 6 (62A.4515) requires a PDP plan to file with the commissioner for approval any modifications in the information filed at the time of licensing.

Section 7 (62A.4516) requires the PDP plans to provide enrollees with evidence of coverage required under federal law.

Section 8 (62A.4517) provides an exemption from other insurance laws unless another law specifically says it applies to these organizations. States that operating a PDP plan is not a "healing art" and that PDP plans are not covered by laws regulating advertising by health professionals.

Section 9 (62A.4518) permits other group insurance to exclude coverage of things covered by PDP plans if the group is covered separately by group PDP coverage for those benefits.

Section 10 (62A.4519) requires insurers issuing PDPs to comply with federal Medicare requirements regarding complaints from enrollees.

Section 11 (62A.4520) permits the commissioner to examine the records of an entity licensed under these sections.

Section 12 (62A.4521) requires the entity's assets to be invested under the guidelines that apply to health maintenance organizations (HMOs).

Section 13 (62A.4522) requires that PDP coverage be sold only through persons authorized to sell health coverage in this state.

Section 14 (62A.4523) requires that entities maintain net worth of the greater of $100,000 or two percent of its premium income, not to exceed the amount of capital and surplus required of a health insurance company. Requires additional net equity of 25 percent of uncovered expenses in excess of $100,000. Requires a deposit of liquid assets of $50,000 plus 25 percent of required tangible net equity, but the required deposit cannot exceed $200,000. Specifies the status of the deposit. Permits the commissioner to waive the net equity requirement under certain circumstances, including a guarantee provided by a guaranteeing organization. Defines "uncovered expenses."

Section 15 (62A.4524) requires a fidelity bond or an equivalent deposit for that purpose.

Section 16 (62A.4525) requires filing of an annual financial report with the commissioner.

Section 17 (62A.4526) provides the grounds and procedures involved in suspending or revoking a license under these sections.

Section 18 (62A.4527) provides for administrative enforcement of these sections by the commissioner.

Section 19 (62A.4528) states that insolvency of an entity licensed under these sections is handled as insolvency of a regular insurance company. States that the obligations of these entities are not covered by the life and health insurance guaranty association.

Section 20 states that the effective date for this act is March 15, 2005, for licensure procedures to begin, but that no entity can operate a PDP plan until 2006. (Under federal law, an entity can apply for a federal waiver of state licensing of a PDP if there is no state licensing procedure available as of March 15, 2005.)

Article 3 makes miscellaneous technical conforming changes.

Section 1 (62L.12, subdivision 2) updates references to federal Medicare laws.

Section 2 (62Q.01, subdivision 6) updates references to federal Medicare laws.

Section 3 (256.9657, subdivision 3) updates references to federal Medicare laws in a section involving the medical assistance surcharge.

KC:cs

SF 880 (1)
(LeClair)

Summary of Medicare Technical Change Legislation

What is this legislation about?

- This bill **conforms Minnesota state law to the requirements of the Medicare Modernization Act (MMA)** of 2003.

- **It is technical in nature** and is consistent with the modifications proposed by the National Association of Insurance Commissioners (NAIC).

- **The Departments of Commerce, Human Services, Health, and Employee Relations have all worked on this legislation as have numerous outside legal counsel. Every effort has been made to limit this bill to only those technical changes that must be enacted.**

Why is this legislation needed?

- The legislation is needed **to bring state law into compliance with federal law** as well as provide state oversight over Prescription Drug Plan (PDP) sponsors. All 50 states are passing state legislation or amending regulations to conform to the new federal law.

- Importantly, **the bill spells out the rights Minnesota seniors with existing Medigap coverage have** as changes in the program are introduced.

- **Passage of the legislation will assure that there is no conflict in law between the new federal requirements and existing state law.** This is important due to the very complex nature of the new Medicare benefits.

- Without this legislation, conflicts in law would only add to the confusion of what options are legally available for Minnesota seniors.

- Such conflicts also leave health plans subject to contradictory requirements, and impose on state insurance regulators the burden of repeatedly analyzing the application of federal preemption every time a related issue arises.

- Failure to pass a licensure provision for a limited benefit plan will likely result in federal, not state, oversight of a PDP sponsor offering the new prescription drug benefit beginning on January 1, 2006.

What this legislation does

- This bill brings Minnesota state law into compliance with the requirements of the (MMA) regarding the sale of policies with prescription drug coverage by Medigap carriers after January 1, 2006.

- It spells out the rights of Medigap policyholders regarding guaranteed issue rights they have for continuing their existing coverage, switching to other policies, or carving existing drug coverage out of their policy.

- The legislation also deletes state law requirements for offering certain benefits in a Medigap policy because those benefits are now included in the Medicare program itself. All of these changes are consistent with the changes that are recommended by the NAIC.

- The legislation does not change Minnesota's status as a waivered state for Medicare supplement plans.

In addition to these changes, the bill includes a licensure provision for a limited benefit plan that offers only prescription drug coverage under the Medicare program:

- The MMA creates a stand-alone prescription drug benefit/plan (PDP) that may be offered by a PDP-sponsor that is a risk-bearing entity licensed under state law and adheres to state solvency requirements.
- If the state does not have a licensure process in place, an organization that wishes to offer this stand-alone drug benefit may request a waiver that would allow for federal, not state, regulation.
- Under the MMA, there will be a stand-alone drug benefit option in each CMS designated region in the country. The provision in this bill is limited to only licensure and solvency requirements because federal law preempts any other state oversight of this stand-alone PDP sponsor.

Background

- The Medicare Modernization Act was signed into law in December 2003. This legislation created a new voluntary prescription drug benefit in the Medicare program beginning January 1. 2006.

- As part of this very expansive piece of legislation, Medicare Supplement (Medigap) carriers will be prohibited by federal law from selling new policies with drug coverage after January 1, 2006 but may renew existing policies.

- Medicare supplement policies are regulated at the state level and the requirements for these policies are found in Minnesota state statute. However, the Medicare Modernization Act preempts state law with respect to the continued sale of new Medigap policies with drug coverage after January 1, 2006. Consequently, Minnesota state law must be amended to incorporate the changes required under the federal legislation.

- The legislation directed the NAIC to draft model rules/legislation for all states to use in implementing these changes. Minnesota is one of three states that operates as a "waivered" state that does not conform with NAIC model Medigap policies. This means that in certain instances, including prescription drug benefits, Minnesota's requirements are richer than the NAIC model act.

A bill for an act

relating to insurance; making federally conforming changes in Medicare-related coverage; providing financial solvency regulation for stand-alone Medicare Part D prescription drug plans; making related technical changes; amending Minnesota Statutes 2004, sections 62A.31, subdivisions 1f, 1k, 1n, 1s, 1t, 1u, 3, 4, 7; 62A.315; 62A.316; 62A.318; 62A.36, subdivision 1; 62L.12, subdivision 2; 62Q.01, subdivision 6; 256.9657, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 62A.

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

ARTICLE 1

FEDERALLY CONFORMING CHANGES IN MEDICARE-RELATED COVERAGES

Section 1. Minnesota Statutes 2004, section 62A.31, subdivision 1f, is amended to read:

Subd. 1f. [SUSPENSION BASED ON ENTITLEMENT TO MEDICAL ASSISTANCE.] (a) The policy or certificate must provide that benefits and premiums under the policy or certificate shall be suspended for any period that may be provided by federal regulation at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to this assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to this medical assistance, the policy or certificate shall be automatically reinstated, effective as of the date of termination of this entitlement, if the policyholder or certificate holder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) The policy must provide that upon reinstatement (1) there is no additional waiting period with respect to treatment of preexisting conditions, (2) coverage is provided which is substantially equivalent to coverage in effect before the date of the suspension. If the suspended policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide coverage substantially equivalent to the coverage in effect before the date of suspension, and (3) premiums are classified on terms that are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had coverage not been suspended.

Sec. 2. Minnesota Statutes 2004, section 62A.31, subdivision 1k, is amended to read:

Subd. 1k. [GUARANTEED RENEWABILITY.] The policy must guarantee renewability.

(a) Only the ~~following~~ standards for renewability provided in this subdivision may be used in Medicare supplement insurance policy forms.

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

(c) If a group Medicare supplement insurance policy is terminated by the group policyholder and is not replaced as provided in this clause, the issuer shall offer certificate

holders an individual Medicare supplement policy which, at the option of the certificate holder, provides for continuation of the benefits contained in the group policy; or provides for such benefits and benefit packages as otherwise meet the requirements of this clause.

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

(e) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the policy as modified for that purpose is deemed to satisfy the guaranteed renewal requirements of this subdivision.

Sec. 3. Minnesota Statutes 2004, section 62A.31, subdivision 1n, is amended to read:

Subd. 1n. [TERMINATION OF COVERAGE.] (a) Termination by an issuer of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that began while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy or certificate was in force may be conditioned on the continuous total disability of the insured, limited to the duration of the policy or certificate benefit period, if any, or payment of the maximum benefits. The extension of benefits does not apply when the termination is based on fraud, misrepresentation, or nonpayment of premium. Receipt of Medicare Part D benefits is not considered in determining a continuous loss.

(b) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days before discontinuing the availability of the form of the policy or certificate. An issuer that discontinues the availability of a

policy form or certificate form shall not file for approval a new policy form or certificate form of the same type for the same Medicare supplement benefit plan as the discontinued form for five years after the issuer provides notice to the commissioner of the discontinuance. ~~The~~ This period of ~~discontinuance~~ ineligibility to file a form for approval may be reduced if the commissioner determines that a shorter period is appropriate. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section. A change in the rating structure or methodology shall be considered a discontinuance under this section unless the issuer complies with the following requirements:

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

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

Sec. 4. Minnesota Statutes 2004, section 62A.31, subdivision 1s, is amended to read:

Subd. 1s. [PRESCRIPTION DRUG COVERAGE.] ~~Beginning January 1, 1993, a health maintenance organization that issues Medicare related coverage must offer, to each person to whom it offers any contract described in this subdivision, at least one contract that either:~~

~~(1) covers 80 percent of the reasonable and customary charge for prescription drugs or the co payment equivalency; or~~

~~(2) offers the coverage described in clause (1) as an optional rider that may be purchased separately from other optional coverages~~ (a) Subject to subdivisions 1k, 1m, 1n, and

lp, a Medicare supplement policy with benefits for outpatient prescription drugs, in existence prior to January 1, 2006, must be renewed, at the option of the policyholder, for current policyholders who do not enroll in Medicare Part D.

(b) A Medicare supplement policy with benefits for outpatient prescription drugs must not be issued after December 31, 2005.

(c) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs must not be renewed after the policyholder enrolls in Medicare Part D unless:

(1) the policy is modified to eliminate outpatient prescription drug coverage for expenses of outpatient prescription drugs incurred on or after the effective date of the individual's coverage under Medicare Part D; and

(2) premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

(d) An issuer of a Medicare supplement policy or certificate must comply with the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended, including any federal regulations, as amended, adopted under that act. This paragraph does not require compliance with any provision of that act until the date upon which that act requires compliance with that provision. The commissioner has authority to enforce this paragraph.

Sec. 5. Minnesota Statutes 2004, section 62A.31, subdivision 1t, is amended to read:

Subd. 1t. [NOTICE OF LACK OF DRUG COVERAGE.] Each policy or contract issued without prescription drug coverage by any insurer, health service plan corporation, health maintenance organization, or fraternal benefit society must contain, displayed prominently by type or other appropriate means, on the first page of the contract, the following:

"Notice to buyer: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription

drugs may be available to you by retaining existing coverage you may have or by enrolling in Medicare Part D. Please ask for further details."

~~From January 1, 1993 to February 28, 1993, compliance with this paragraph is optional. If a health maintenance organization does not comply with this paragraph during that period, the health maintenance organization must extend any person's six-month eligibility period provided under subdivision 1h that began prior to or during that period and ends during or after that period. The length of the extension must be no less than that portion of the person's six-month eligibility period during which the health carrier did not comply with this paragraph. The extended eligibility period applies only to contracts that provide the prescription drug coverage required by this paragraph.~~

Sec. 6. Minnesota Statutes 2004, section 62A.31, subdivision 1u, is amended to read:

Subd. 1u. [GUARANTEED ISSUE FOR ELIGIBLE PERSONS.] (a)(1) Eligible persons are those individuals described in paragraph (b) who seek to enroll under the policy during the period specified in paragraph (c) and who submit evidence of the date of termination or disenrollment described in paragraph (b), or of the date of Medicare Part D enrollment, with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not: deny or condition the issuance or effectiveness of a Medicare supplement policy described in paragraph (c) that is offered and is available for issuance to new enrollees by the issuer; discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, medical condition, or age; or impose an exclusion of benefits based upon a preexisting condition under such a Medicare supplement policy.

(b) An eligible person is an individual described in any of the following:

(1) the individual is enrolled under an employee welfare

benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(2) the individual is enrolled with a ~~Medicare+Choice~~ Medicare Advantage organization under a ~~Medicare+Choice~~ Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the federal Social Security Act, and there are circumstances similar to those described in this clause that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a ~~Medicare+Choice~~ Medicare Advantage plan:

(i) the organization's or plan's certification under Medicare Part C has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(ii) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act, United States Code, title 42, section 1395w-21(g)(3)(b) (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the federal Social Security Act, United States Code, title 42, section 1395w-26), or the plan is terminated for all individuals within a residence area;

(iii) the individual demonstrates, in accordance with guidelines established by the Secretary, that:

(A) the organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an

enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(B) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(iv) the individual meets such other exceptional conditions as the secretary may provide;

(3)(i) the individual is enrolled with:

(A) an eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) an organization under an agreement under section 1833(a)(1)(A) of the federal Social Security Act, United States Code, title 42, section 1395l(a)(1)(A) (health care prepayment plan); or

(D) an organization under a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under clause (2);

(4) the individual is enrolled under a Medicare supplement policy, and the enrollment ceases because:

(i)(A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(B) of other involuntary termination of coverage or enrollment under the policy;

(ii) the issuer of the policy substantially violated a material provision of the policy; or

(iii) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5)(i) the individual was enrolled under a Medicare

supplement policy and terminates that enrollment and subsequently enrolls, for the first time, with any ~~Medicare+Choice~~ Medicare Advantage organization under a ~~Medicare+Choice~~ Medicare Advantage plan under Medicare Part C; any eligible organization under a contract under section 1876 of the federal Social Security Act, United States Code, title 42, section 1395mm (Medicare cost); any similar organization operating under demonstration project authority; any PACE provider under section 1894 of the federal Social Security Act, or a Medicare Select policy under section 62A.318 or the similar law of another state; and

(ii) the subsequent enrollment under item (i) is terminated by the enrollee during any period within the first 12 months of the subsequent enrollment during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the federal Social Security Act; ~~or~~

(6) the individual, upon first enrolling for benefits under Medicare Part B, enrolls in a ~~Medicare+Choice~~ Medicare Advantage plan under Medicare Part C, or with a PACE provider under section 1894 of the federal Social Security Act, and disenrolls from the plan by not later than 12 months after the effective date of enrollment; or

(7) the individual enrolls in a Medicare Part D plan during the initial Part D enrollment period, as defined under United States Code, title 42, section 1395ss(v)(6)(D), and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (e), clause (4).

(c)(1) In the case of an individual described in paragraph (b), clause (1), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, notice that a claim has been denied

because of a termination or cessation~~,~~; or (ii) the date that the applicable coverage terminates or ceases; and ends 63 days after the ~~date of the applicable notice~~ later of those two dates.

(2) In the case of an individual described in paragraph (b), clause (2), (3), (5), or (6), whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in paragraph (b), clause (4), item (i), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and (ii) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(4) In the case of an individual described in paragraph (b), clause (2), (4), (5), or (6), who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(5) In the case of an individual described in paragraph (b), clause (7), the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in paragraph (b) but not described in this paragraph, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(d)(1) In the case of an individual described in paragraph (b), clause (5), or deemed to be so described, pursuant to this paragraph, whose enrollment with an organization or provider

described in paragraph (b), clause (5), item (i), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (5).

(2) In the case of an individual described in paragraph (b), clause (6), or deemed to be so described, pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (b), clause (6), is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment is deemed to be an initial enrollment described in paragraph (b), clause (6).

(3) For purposes of paragraph (b), clauses (5) and (6), no enrollment of an individual with an organization or provider described in paragraph (b), clause (5), item (i), or with a plan or in a program described in paragraph (b), clause (6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with the organization, provider, plan, or program.

(e) The Medicare supplement policy to which eligible persons are entitled under:

(1) paragraph (b), clauses (1) to (4), is any Medicare supplement policy that has a benefit package consisting of the basic Medicare supplement plan described in section 62A.316, paragraph (a), plus any combination of the three optional riders described in section 62A.316, paragraph (b), clauses (1) to (3), offered by any issuer;

(2) paragraph (b), clause (5), is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, any policy described in clause (1) offered by any issuer~~;~~, except that after December 31, 2005, if the individual was most recently enrolled in a Medicare supplement

policy with an outpatient prescription drug benefit, a Medicare supplement policy to which the individual is entitled under paragraph (b), clause (5), is:

(i) the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) at the election of the policyholder, a policy described in clause (4), except that the policy may be one that is offered and available for issuance to new enrollees that is offered by any issuer;

(3) paragraph (b), clause (6), ~~shall include~~ is any Medicare supplement policy offered by any issuer;

(4) paragraph (b), clause (7), is a Medicare supplement policy that has a benefit package classified as a basic plan under section 62A.316 if the enrollee's existing Medicare supplement policy is a basic plan or, if the enrollee's existing Medicare supplement policy is an extended basic plan under section 62A.315, a basic or extended basic plan at the option of the enrollee, provided that the policy is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage. The issuer must permit the enrollee to retain all optional benefits contained in the enrollee's existing coverage, other than outpatient prescription drugs, subject to the provision that the coverage be offered and available for issuance to new enrollees by the same issuer.

(f)(1) At the time of an event described in paragraph (b), because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in paragraph (b),

because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this subdivision, and of the obligations of issuers of Medicare supplement policies under paragraph (a). The notice must be communicated within ten working days of the issuer receiving notification of disenrollment.

(g) Reference in this subdivision to a situation in which, or to a basis upon which, an individual's coverage has been terminated does not provide authority under the laws of this state for the termination in that situation or upon that basis.

(h) An individual's rights under this subdivision are in addition to, and do not modify or limit, the individual's rights under subdivision 1h.

Sec. 7. Minnesota Statutes 2004, section 62A.31, subdivision 3, is amended to read:

Subd. 3. [DEFINITIONS.] (a) The definitions provided in this subdivision apply to sections 62A.31 to 62A.44.

(b) "Accident," "accidental injury," or "accidental means" means to employ "result" language and does not include words that establish an accidental means test or use words such as "external," "violent," "visible wounds," or similar words of description or characterization.

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

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

(c) "Applicant" means:

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

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

(d) "Bankruptcy" means a situation in which a ~~Medicare+Choice~~ Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

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

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

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

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

(i) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in United States Code, title 29, section 1002 (Employee Retirement Income Security Act).

(j) "Health care expenses" means, for purposes of section 62A.36, expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers. The expenses shall not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; and

(7) claims processing costs.

(k) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

(l) "Insolvency" means a situation in which an issuer, licensed to transact the business of insurance in this state, including the right to transact business as any type of issuer, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

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

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

(o) "Medicare eligible expenses" means health care expenses covered by Medicare Part A or B, to the extent recognized as reasonable and medically necessary by Medicare.

(p) "~~Medicare+Choice~~ Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in section 1859 of the federal Social Security Act, United States Code, title 42, section 1395w-28, and includes:

(1) coordinated care plans which provide health care services, including, but not limited to, health maintenance organization plans, with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) medical savings account plans coupled with a contribution into a ~~Medicare+Choice~~ Medicare Advantage medical savings account; and

(3) ~~Medicare+Choice~~ Medicare Advantage private fee-for-service plans.

(q) "Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.31 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by section 1833 (known as "cost" or "HCPP" contracts) or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended; or Section 4001 of the Balanced Budget Act of 1997 (BBA)(Public Law 105-33), Sections 1851 to 1859 of the Social Security Act establishing part C of the Medicare program, known as the "~~Medicare+Choice~~ Medicare Advantage program."

(r) "Medicare supplement policy or certificate" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, ~~or~~ other than those policies or certificates covered by section 1833 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., or an issued policy under a demonstration project specified under amendments to the federal Social Security Act, which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan that provides benefits under an agreement under section 1833(a)(1)(A) of the Social Security Act.

(s) "Physician" shall not be defined more restrictively

than as defined in the Medicare program or section 62A.04, subdivision 1, or 62A.15, subdivision 3a.

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

(u) "Secretary" means the Secretary of the United States Department of Health and Human Services.

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

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

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

(w) "Outpatient prescription drug" means a prescription drug prescribed or administered under circumstances that qualify for coverage under Medicare Part D and not under Medicare Part A or Part B.

Sec. 8. Minnesota Statutes 2004, section 62A.31, subdivision 4, is amended to read:

Subd. 4. [PROHIBITED POLICY PROVISIONS.] (a) A Medicare supplement policy or certificate in force in the state shall not contain benefits that duplicate benefits provided by Medicare or contain exclusions on coverage that are more restrictive than those of Medicare. Duplication of benefits is permitted to the extent permitted under subdivision 1s, paragraph (a), for benefits provided by Medicare Part D.

(b) No Medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions, except as permitted under subdivision 1b.

Sec. 9. Minnesota Statutes 2004, section 62A.31, subdivision 7, is amended to read:

Subd. 7. [MEDICARE PRESCRIPTION DRUG BENEFIT.] If Congress enacts legislation creating a prescription drug benefit in the

Medicare program, nothing in this section or any other section shall prohibit an issuer of a Medicare supplement policy from offering this prescription drug benefit consistent with the applicable federal law or regulations. ~~If an issuer offers the federal benefit, such an offer shall be deemed to meet the issuer's mandatory offer obligations under this section and may, at the discretion of the issuer, constitute replacement coverage as defined in subdivision ii for any existing policy containing a prescription drug benefit.~~

Sec. 10. Minnesota Statutes 2004, section 62A.315, is amended to read:

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

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

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

(2) coverage for the daily co-payment amount of Medicare Part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, and the Medicare Part B deductible amount;

(4) 80 percent of the usual and customary hospital and medical expenses and supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation established by the Medicare program or state law~~,~~; the usual and customary hospital and medical expenses and supplies, described in section 62E.06, subdivision 1, while in a foreign country~~,~~; and prescription drug expenses, not covered by Medicare. An outpatient prescription drug benefit must not be included for

sale or issuance in a Medicare supplement policy or certificate issued on or after January 1, 2006;

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

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

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

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

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

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

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

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

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

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

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

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

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

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

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

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

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

(ii) coverage requirements and limitations:

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

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

(C) coverage is limited to:

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

treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $100 per visit;

(III) $4,000 per calendar year;

(IV) seven visits in any one week;

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

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

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

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

(iii) coverage is excluded for:

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

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

Sec. 11. Minnesota Statutes 2004, section 62A.316, is amended to read:

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

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

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

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

(3) coverage for the coinsurance amount, or in the case of outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare part B regardless of hospital confinement,

subject to the Medicare part B deductible amount;

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

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

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

(7) 80 percent of coverage for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes. Coverage must include persons with gestational, type I, or type II diabetes.

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

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

(2) a minimum of 80 percent of eligible medical expenses and supplies not covered by Medicare part B, not to exceed any charge limitation established by the Medicare program or state law;

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

(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses. An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare policy or certificate issued on or after January 1, 2006;

(5) coverage for the following preventive health services:

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

(ii) any one or a combination of the following preventive

screening tests or preventive services, the frequency of which is considered medically appropriate:

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

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

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

(D) serum cholesterol screening every five years;

(E) thyroid function test;

(F) diabetes screening;

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

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

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

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

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

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

(C) "home" means a place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital

or skilled nursing facility shall not be considered the insured's place of residence;

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

(ii) Coverage requirements and limitations:

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

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

(C) coverage is limited to:

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

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

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

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

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

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

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

(iii) Coverage is excluded for:

(A) home care visits paid for by Medicare or other

government programs; and

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

(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses to a maximum of $1,200 paid by the issuer annually under this benefit. An issuer of Medicare supplement insurance policies that elects to offer this benefit rider shall also make available coverage that contains the rider specified in clause (4). An outpatient prescription drug benefit must not be included for sale or issuance in a Medicare policy or certificate issued on or after January 1, 2006.

Sec. 12. Minnesota Statutes 2004, section 62A.318, is amended to read:

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

Subdivision 1. [APPLICABILITY AND ADVERTISING LIMITATION.] (a) This section applies to Medicare select policies and certificates, as defined in this section, including those issued by health maintenance organizations.

(b) No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

~~(b)~~ Subd. 2. [DEFINITIONS.] For the purposes of this section:

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

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

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

(4) "Medicare select policy" or "Medicare select certificate" means a Medicare supplement policy or certificate

that contains restricted network provisions;

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

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

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

~~(c)~~ Subd. 3. [REVIEW BY COMMISSIONER.] The commissioner may authorize an issuer to offer a Medicare select policy or certificate pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, Public Law 101-508, if the commissioner finds that the issuer has satisfied all of the requirements of Minnesota Statutes.

~~(d)~~ Subd. 4. [APPROVAL; PLAN OF OPERATION.] A Medicare select issuer shall not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

~~(e)~~ Subd. 5. [CONTENTS OF PLAN OF OPERATION.] A Medicare select issuer shall file a proposed plan of operation with the commissioner, in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

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

(i) the services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

(ii) the number of network providers in the service area is

sufficient, with respect to current and expected policyholders, either:

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

(B) to make appropriate referrals;

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

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

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

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

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

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

(i) the formal organizational structure;

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

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

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

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

(7) any other information requested by the commissioner.

~~(f)~~ Subd. 6. [FILING OF PROPOSED CHANGES; DEEMED APPROVAL.] A Medicare select issuer shall file proposed changes to the plan of operation, except for changes to the list of

network providers, with the commissioner before implementing the changes. The changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

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

~~(g)~~ Subd. 7. [NONNETWORK PROVIDERS; LIMITS ON COVERAGE RESTRICTIONS.] A Medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

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

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

~~(h)~~ Subd. 8. [FULL PAYMENT; SERVICES NOT AVAILABLE IN NETWORK.] A Medicare select policy or certificate shall provide payment for full coverage under the policy or certificate for covered services that are not available through network providers.

~~(i)~~ Subd. 9. [REQUIRED DISCLOSURES.] A Medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare select policy or certificate to each applicant. This disclosure must include at least the following:

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

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

(ii) other Medicare select policies or certificates;

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

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when

providers other than network providers are used;

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

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

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

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

~~(j)~~ Subd. 10. [PROOF OF DISCLOSURE.] Before the sale of a Medicare select policy or certificate, a Medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to paragraph (i) and that the applicant understands the restrictions of the Medicare select policy or certificate.

~~(k)~~ Subd. 11. [GRIEVANCE PROCEDURES.] A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

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

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

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

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

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

(6) The issuer shall report no later than March 31 of each year to the commissioner regarding the grievance procedure. The

report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of the grievances.

~~(l)~~ Subd. 12. [OFFER OF ALTERNATIVE PRODUCT REQUIRED.] At the time of initial purchase, a Medicare select issuer shall make available to each applicant for a Medicare select policy or certificate the opportunity to purchase a Medicare supplement policy or certificate otherwise offered by the issuer.

~~(m)(l)~~ Subd. 13. [RIGHT TO REPLACE WITH NONNETWORK COVERAGE.] (a) At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare ~~supplement~~ select policy or certificate has been in force for six months. If the issuer does not have available for sale a policy or certificate without restrictive network provisions, the issuer shall provide enrollment information for the Minnesota comprehensive health association Medicare supplement plans.

~~(2)~~ (b) For the purposes of this ~~paragraph~~ subdivision, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for part B excess charges. Coverage for outpatient prescription drugs is not permitted in Medicare supplement policies or certificates issued on or after January 1, 2006.

~~(n)~~ Subd. 14. [CONTINUATION OF COVERAGE UNDER CERTAIN CIRCUMSTANCES.] (a) Medicare select policies and certificates

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

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

~~(2)~~ (c) For the purposes of this ~~paragraph~~ subdivision, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare select policy or certificate being replaced. For the purposes of this ~~paragraph~~ subdivision, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for part B excess charges. Coverage for outpatient prescription drugs must not be included for sale or issuance of a Medicare supplement policy or certificate issued on or after January 1, 2006.

~~(o)~~ Subd. 15. [PROVISION OF DATA REQUIRED.] A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare select program.

~~(p)~~ Subd. 16. [REGULATION BY COMMERCE DEPARTMENT.] Medicare select policies and certificates under this section shall be regulated and approved by the Department of Commerce.

~~(q)~~ Subd. 17. [TYPES OF PLANS.] Medicare select policies and certificates must be either a basic plan or an extended basic plan. Before a Medicare select policy or certificate is

sold or issued in this state, the applicant must be provided with an explanation of coverage for both a Medicare select basic and a Medicare select extended basic policy or certificate and must be provided with the opportunity of purchasing either a Medicare select basic or a Medicare select extended basic policy. The basic plan may also include any of the optional benefit riders authorized by section 62A.316. Preventive care provided by Medicare select policies or certificates must be provided as set forth in section 62A.315 or 62A.316, except that the benefits are as defined in chapter 62D.

~~(r)--(Expired)~~

Sec. 13. Minnesota Statutes 2004, section 62A.36, subdivision 1, is amended to read:

Subdivision 1. [LOSS RATIO STANDARDS AND REFUND PROVISIONS.] (a) For purposes of this section, "Medicare supplement policy or certificate" has the meaning given in section 62A.31, subdivision 3, but also includes a policy, contract, or certificate issued under a contract under section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

(1) at least 75 percent of the aggregate amount of premiums earned in the case of group policies; and

(2) at least 65 percent of the aggregate amount of premiums earned in the case of individual policies~~,-calculated-on-the basis-of~~.

These ratios must be calculated based upon incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums for the

period and according to accepted actuarial principles and practices. For purposes of this calculation, "health care expenses" has the meaning given in section 62A.31, subdivision 3, paragraph (j). An insurer shall demonstrate that the third year loss ratio is greater than or equal to the applicable percentage.

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

An application form for a Medicare supplement policy or certificate, as defined in this section, must prominently disclose the anticipated loss ratio and explain what it means.

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

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

A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar

year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week treasury bills. A refund or credit against premiums due shall be made by September 30 following the experience year on which the refund or credit is based.

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

As soon as practicable, but before the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

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

(2) if an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order

premium adjustments, refunds, or premium credits considered necessary to achieve the loss ratio required by this section;

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

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

(e) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with, and approved by, the commissioner according to the filing requirements and procedures prescribed by the commissioner.

(f) An issuer must file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

(g) Issuers are permitted to continue to issue currently approved policy and certificate forms as appropriate through December 31, 2005.

(h) Issuers must comply with any requirements to notify enrollees under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Sec. 14. [REVISOR INSTRUCTION.]

The revisor of statutes shall, in producing Minnesota Statutes 2006, place in alphabetical order the terms defined in Minnesota Statutes, section 62A.31, subdivision 3, and make any necessary resulting changes in cross-references.

Sec. 15. [EFFECTIVE DATE.]

Sections 1 to 13 are effective January 1, 2006, except that section 13, paragraphs (f), (g), and (h), are effective the day following final enactment.

ARTICLE 2

REGULATION OF STAND-ALONE MEDICARE PART D PRESCRIPTION DRUG PLANS

Section 1. [62A.451] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] For purposes of sections 62A.451 to 62A.4528, the terms defined in this section have the meanings given.

Subd. 2. [COMMISSIONER.] "Commissioner" means the commissioner of commerce.

Subd. 3. [ENROLLEE.] "Enrollee" means an individual who is entitled to limited health services under a contract with an entity authorized to provide or arrange for such services under sections 62A.451 to 62A.4528.

Subd. 4. [EVIDENCE OF COVERAGE.] "Evidence of coverage" means the certificate, agreement, or contract issued under section 62A.4516 setting forth the coverage to which an enrollee is entitled.

Subd. 5. [LIMITED HEALTH SERVICE.] "Limited health service" means pharmaceutical services covered under Medicare Part D. Limited health service does not include hospital, medical, surgical, or emergency services.

Subd. 6. [PREPAID LIMITED HEALTH SERVICE ORGANIZATION.] "Prepaid limited health service organization" means any corporation, partnership, or other entity that, in return for a prepayment, undertakes to provide or arrange for the provision of limited health services to enrollees. Prepaid limited health service organization does not include:

(1) an entity otherwise authorized under the laws of this

state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service;

(2) an entity that meets the requirements of section 62A.4514; or

(3) a provider or entity when providing or arranging for the provision of limited health services under a contract with a prepaid limited health service organization or with an entity described in clause (1) or (2).

Subd. 7. [PROVIDER.] "Provider" means a physician, pharmacist, health facility, or other person or institution that is licensed or otherwise authorized to deliver or furnish limited health services under sections 62A.451 to 62A.4528.

Subd. 8. [SUBSCRIBER.] "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services under a contract with an entity authorized to provide or arrange for such services under sections 62A.451 to 62A.4528.

Sec. 2. [62A.4511] [CERTIFICATE OF AUTHORITY REQUIRED.]

No person, corporation, partnership, or other entity may operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner under sections 62A.451 to 62A.4528.

Sec. 3. [62A.4512] [APPLICATION FOR CERTIFICATE OF AUTHORITY.]

An application for a certificate of authority to operate a prepaid limited health service organization must be filed with the commissioner on a form prescribed by the commissioner. The application must be verified by an officer or authorized representative of the applicant and must set forth, or be accompanied by, the following:

(1) a copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments to these documents;

(2) a copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs;

(3) a list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association;

(4) a statement generally describing the applicant, its facilities, personnel, and the limited health services to be offered;

(5) a copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees;

(6) a copy of the form of any contract made, or to be made between the applicant and any person listed in clause (3);

(7) a copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any functions including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of limited health services to enrollees;

(8) a copy of the form of any group contract that is to be issued to employers, unions, trustees, or other organizations and a copy of any form of evidence of coverage to be issued to subscribers;

(9) a copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited

financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, satisfies this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of sections 62A.451 to 62A.4528;

(10) a copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

(11) a statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served in accordance with section 45.028;

(12) a description of how the applicant will comply with section 62A.4523; and

(13) such other information as the commissioner may reasonably require to make the determinations required by sections 62A.451 to 62A.4528.

Sec. 4. [62A.4513] [ISSUANCE OF CERTIFICATE OF AUTHORITY; DENIAL.]

Subdivision 1. [ISSUANCE.] Following receipt of an application filed under section 62A.4512, the commissioner shall review the application and notify the applicant of any deficiencies. The commissioner must approve or deny an application within 90 days after receipt of a substantially complete application, or the application is deemed approved. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:

(1) the requirements of section 62A.4512 have been fulfilled;

(2) the individuals responsible for conducting the applicant's affairs are competent, trustworthy, and possess good reputations, and have had appropriate experience, training, or education;

(3) the applicant is financially responsible and may

reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:

(i) the financial soundness of the applicant's arrangements for limited health services;

(ii) the adequacy of working capital, other sources of funding, and provisions for contingencies;

(iii) any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization; and

(iv) the manner in which the requirements of section 62A.4523 have been fulfilled; and

(4) any deficiencies identified by the commissioner have been corrected.

Subd. 2. [DENIALS.] If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The prepaid limited health service organization has 30 days from the date of receipt of the notice to request a hearing before the commissioner under chapter 14.

Sec. 5. [62A.4514] [FILING REQUIREMENTS FOR AUTHORIZED ENTITIES.]

(a) An entity authorized under the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health service plan corporation, a fraternal benefit society, or a multiple employer welfare arrangement, and that is not otherwise authorized under the laws of this state to offer limited health services on a per capita or fixed prepayment basis, may do so by filing for approval with the commissioner the information requested by section 62A.4512, clauses (4), (5), (7), (8), and (10), and any subsequent material modification or addition to those provisions.

(b) If the commissioner disapproves the filing, the procedures provided in section 62A.4513, subdivision 2, must be followed.

Sec. 6. [62A.4515] [MATERIAL MODIFICATIONS.]

Subdivision 1. [MATERIAL MODIFICATIONS.] A prepaid limited health service organization shall file with the commissioner prior to use, a notice of any material modification of any matter or document furnished under section 62A.4512, together with supporting documents necessary to fully explain the modification. If the commissioner does not disapprove the filing within 60 days of its filing, the filing is deemed approved.

Subd. 2. [PROCEDURE FOR DISAPPROVAL.] If a filing under this section is disapproved, the commissioner shall notify the prepaid limited health service organization and specify the reasons for disapproval in the notice. The prepaid limited health service organization has 30 days from the date of receipt of notice to request a hearing before the commissioner under chapter 14.

Sec. 7. [62A.4516] [EVIDENCE OF COVERAGE.]

Every subscriber must be issued an evidence of coverage consistent with the requirements of Medicare Part D.

Sec. 8. [62A.4517] [CONSTRUCTION WITH OTHER LAWS.]

Subdivision 1. [APPLICATION OF OTHER INSURANCE LAWS.] (a) A prepaid limited health service organization organized under the laws of this state is deemed to be a domestic insurer for purposes of chapter 60D unless specifically exempted in writing from one or more of the provisions of that chapter by the commissioner, based upon a determination that the provision is not applicable to the organization or to providing coverage under Medicare Part D.

(b) No other provision of chapters 60 to 72C applies to a prepaid limited health service organization unless such an organization is specifically mentioned in the provision.

Subd. 2. [NOT A HEALING ART.] The provision of limited health services by a prepaid limited health service organization or other entity under sections 62A.451 to 62A.4528 must not be deemed to be the practice of medicine or other healing arts.

Subd. 3. [SOLICITATION AND ADVERTISING.] Solicitation to

arrange for or provide limited health services in accordance with sections 62A.451 to 62A.4528 shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

Sec. 9. [62A.4518] [NONDUPLICATION OF COVERAGE.]

Notwithstanding any other law of this state, a prepaid limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health service plan corporation, or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services, whether in the form of services, supplies, or reimbursement, insofar as the coverage or service is provided in accordance with sections 62A.451 to 62A.4528 under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization, a health maintenance organization, an accident and health insurance company, a nonprofit health service corporation, or a fraternal benefit society.

Sec. 10. [62A.4519] [COMPLAINT SYSTEM.]

Every prepaid limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers, consistent with the requirements of Medicare Part D.

Sec. 11. [62A.4520] [EXAMINATION OF ORGANIZATION.]

(a) The commissioner may examine the affairs of any prepaid limited health service organization as often as is reasonably necessary to protect the interests of the people of this state, but not less frequently than once every three years.

(b) Every prepaid limited health service organization shall make its relevant books and records available for an examination and in every way cooperate with the commissioner to facilitate an examination.

(c) In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another

state.

Sec. 12. [62A.4521] [INVESTMENTS.]

The funds of a prepaid limited health service organization shall be invested only in accordance with the guidelines under chapter 62D for investments by health maintenance organizations.

Sec. 13. [62A.4522] [AGENTS.]

No individual may apply, procure, negotiate, or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license or is otherwise authorized to sell accident and health insurance policies, nonprofit health service plan contracts, or health maintenance organization contracts.

Sec. 14. [62A.4523] [PROTECTION AGAINST INSOLVENCY; DEPOSIT.]

Subdivision 1. [NET EQUITY.] (a) Except as approved in accordance with subdivision 4, each prepaid limited health service organization shall at all times have and maintain tangible net equity equal to the greater of:

(1) $100,000; or

(2) two percent of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

(b) A prepaid limited health service organization that has uncovered expenses in excess of $100,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to 25 percent of the uncovered expense in excess of $100,000 in addition to the tangible net equity required by paragraph (a).

Subd. 2. [DEFINITIONS.] For the purpose of this section:

(1) "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner; and

(2) "tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; start-up costs; long-term prepayments of deferred charges;

nonreturnable deposits; and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates and that are not past due.

Subd. 3. [DEPOSIT.] (a) Each prepaid limited health service organization shall deposit with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the commissioner, in an amount equal to $50,000 plus 25 percent of the tangible net equity required in subdivision 1; provided, however, that the deposit must not be required to exceed $200,000.

(b) The deposit is an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.

(c) All income from deposits is an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or any part of it after making a substitute deposit of equal amount and value. Any securities must be approved by the commissioner before being substituted.

(d) The deposit must be used to protect the interests of the prepaid limited health service organization's enrollees and to ensure continuation of limited health care services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit is an asset subject to provisions of chapter 60B.

(e) The commissioner may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to that effect,

duly authenticated by the appropriate state official holding the deposit.

Subd. 4. [WAIVER OF NET EQUITY REQUIREMENT.] Upon application by a prepaid limited health service organization, the commissioner may waive some or all of the requirements of subdivision 1 for any period of time the commissioner deems proper upon a finding that either:

(1) the prepaid limited health service organization has a net equity of at least $10,000,000; or

(2) an entity having a net equity of at least $10,000,000 furnishes to the commissioner a written commitment, acceptable to the commissioner, to provide for the uncovered expenses of the prepaid limited health service organization.

Subd. 5. [DEFINITION; UNCOVERED EXPENSES.] For the purposes of this section, "uncovered expense" means the cost of health care services that are the obligation of a prepaid limited health organization (1) for which an enrollee may be liable in the event of the insolvency of the organization and (2) for which alternative arrangements acceptable to the commissioner have not been made to cover the costs. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, must be considered a covered expense.

Sec. 15. [62A.4524] [OFFICERS AND EMPLOYEES FIDELITY BOND.]

(a) A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than $20,000,000 or in any other amount prescribed by the commissioner. Except as otherwise provided by this paragraph, the bond must be issued by an insurance company that is licensed to do business in this state or, if the fidelity bond required by this paragraph is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed surplus lines agent resident in this state in compliance with sections 60A.195 to 60A.2095 satisfies the requirements of this

paragraph.

(b) In lieu of the bond specified in paragraph (a), a prepaid limited health service organization may deposit with the commissioner cash or securities or other investments of the types set forth in section 62A.4521. Such a deposit must be maintained by the commissioner in the amount and subject to the same conditions required for a bond under this paragraph.

Sec. 16. [62A.4525] [REPORTS.]

(a) Every prepaid limited health service organization shall file with the commissioner annually, on or before April 1, a report verified by at least two principal officers covering the preceding calendar year.

(b) The report must be on forms prescribed by the commissioner and must include:

(1) a financial statement of the organization, including its balance sheet, income statement, and statement of changes in financial position for the preceding year, certified by an independent public accountant, or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which must be consolidating financial statements of the prepaid limited health service organization;

(2) the number of subscribers at the beginning of the year, the number of subscribers at the end of the year, and the number of enrollments terminated during the year; and

(3) such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out the commissioner's duties under sections 62A.451 to 62A.4528.

(c) The commissioner may require more frequent reports containing information necessary to enable the commissioner to carry out the commissioner's duties under sections 62A.451 to 62A.4528.

(d) The commissioner may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

Sec. 17. [62A.4526] [SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY.]

Subdivision 1. [GROUNDS FOR SUSPENSION OR REVOCATION.] The commissioner may suspend or revoke the certificate of authority issued to a prepaid limited health service organization under sections 62A.451 to 62A.4528 upon determining that any of the following conditions exist:

(1) the prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62A.4512, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the prepaid limited health service organization issues an evidence of coverage that does not comply with the requirements of section 62A.4516;

(3) the prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services;

(4) the prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(5) the tangible net equity of the prepaid limited health service organization is less than that required by section 62A.4523 or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

(6) the prepaid limited health service organization has failed to implement in a reasonable manner the complaint system required by section 62A.4519;

(7) the continued operation of the prepaid limited health service organization would be hazardous to its enrollees; or

(8) the prepaid limited health service organization has otherwise failed to comply with sections 62A.451 to 62A.4528.

Subd. 2. [PROCEDURE FOR SUSPENSION OR REVOCATION.] If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than 60 days after the date of notification for a hearing on the matter in accordance with chapter 14.

Subd. 3. [WINDING UP AFTER REVOCATION.] When the certificate of authority of a prepaid limited health service organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

Sec. 18. [62A.4527] [PENALTIES.]

In lieu of any penalty specified elsewhere in sections 62A.451 to 62A.4528, or when no penalty is specifically provided, whenever a prepaid limited health service organization or other person, corporation, partnership, or entity subject to those sections has been found, pursuant to chapter 14, to have violated any provision of sections 62A.451 to 62A.4528, the commissioner may:

(1) issue and cause to be served upon the organization, person, or entity charged with the violation a copy of the findings and an order requiring the organization, person, or entity to cease and desist from engaging in the act or practice that constitutes the violation; and

(2) impose a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of

$10,000.

Sec. 19. [62A.4528] [REHABILITATION, CONSERVATION, OR LIQUIDATION.]

(a) Any rehabilitation, conservation, or liquidation of a prepaid limited health service organization must be deemed to be the rehabilitation, conservation, or liquidation of an insurance company and must be conducted under chapter 60B.

(b) A prepaid limited health service organization is not subject to the laws and rules governing insurance insolvency guaranty funds, nor shall any insurance insolvency guaranty fund provide protection to individuals entitled to receive limited health services from a prepaid limited health service organization.

Sec. 20. [EFFECTIVE DATE.]

Sections 1 to 19 are effective March 15, 2005, but no coverage may become effective prior to January 1, 2006.

ARTICLE 3

TECHNICAL AND CONFORMING CHANGES

Section 1. Minnesota Statutes 2004, section 62L.12, subdivision 2, is amended to read:

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

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

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

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

(e) A health carrier may sell, issue, or renew individual health plans if the coverage is appropriate due to an unexpired

preexisting condition limitation or exclusion applicable to the person under the employer's group health plan or due to the person's need for health care services not covered under the employer's group health plan.

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

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

(h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage issued as a supplement to Medicare under sections 62A.31 to 62A.44, or policies or contracts that supplement Medicare issued by health maintenance organizations, or those contracts governed by section 1833, 1851 to 1859, 1860D, or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., as amended.

(i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans necessary to comply with a court order.

(j) A health carrier may offer, issue, sell, or renew an individual health plan to persons eligible for an employer group health plan, if the individual health plan is a high deductible health plan for use in connection with an existing health savings account, in compliance with the Internal Revenue Code, section 223. In that situation, the same or a different health carrier may offer, issue, sell, or renew a group health plan to cover the other eligible employees in the group.

Sec. 2. Minnesota Statutes 2004, section 62Q.01, subdivision 6, is amended to read:

Subd. 6. [MEDICARE-RELATED COVERAGE.] "Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.31 to 62A.44, including Medicare select coverage; policies, contracts,

or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by section 1833 (known as "cost" or "HCPP" contracts), 1851 to 1859 (Medicare Advantage), 1860D (Medicare Part D), or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended; or Section 4001 of the Balanced Budget Act of 1997 (BBA)(Public Law 105-33), Sections 1851 to 1859 of the Social Security Act establishing part C of the Medicare program, known as the "~~Medicare+Choice~~ Medicare Advantage program."

Sec. 3. Minnesota Statutes 2004, section 256.9657, subdivision 3, is amended to read:

Subd. 3. [HEALTH MAINTENANCE ORGANIZATION; COMMUNITY INTEGRATED SERVICE NETWORK SURCHARGE.] (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each community integrated service network licensed by the commissioner under chapter 62N shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of the health maintenance organization or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

(b) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization or community integrated service network from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wrap-around subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization or a community integrated

service network and the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections ~~4001 and 4002 of Public Law 105-33 received by a health maintenance organization or community integrated service network through risk sharing or Medicare Choice Plus contracts~~ 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

(c) When a health maintenance organization or community integrated service network merges or consolidates with or is acquired by another health maintenance organization or community integrated service network, the surviving corporation or the new corporation shall be responsible for the annual surcharge originally imposed on each of the entities or corporations subject to the merger, consolidation, or acquisition, regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(d) Effective July 1 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the second previous calendar year by all of the entities or corporations subject to the merger, consolidation, or acquisition regardless of whether one of the entities or corporations does not retain a certificate of

authority under chapter 62D or a license under chapter 62N until the total premium revenues of the surviving corporation include the total premium revenues of all the merged entities as reported to the commissioner of health.

(e) When a health maintenance organization or community integrated service network, which is subject to liability for the surcharge under this chapter, transfers, assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer of the health maintenance organization or community integrated service network.

(f) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(g) The surcharge assessed to a health maintenance organization or community integrated service network ends when the entity ceases providing services for premiums and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

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

S.F. No. 880: A bill for an act relating to insurance; making federally conforming changes in Medicare-related coverage; providing financial solvency regulation for stand-alone Medicare Part D prescription drug plans; making related technical changes; amending Minnesota Statutes 2004, sections 62A.31, subdivisions 1f, 1k, 1n, 1s, 1t, 1u, 3, 4, 7; 62A.315; 62A.316; 62A.318; 62A.36, subdivision 1; 62L.12, subdivision 2; 62Q.01, subdivision 6; 256.9657, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 62A.

Reports the same back with the recommendation that the bill do pass and be placed on the Consent Calendar. Report adopted.

.....
(Committee Chair)

March 9, 2005.....
(Date of Committee recommendation)

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Senate

State of Minnesota

S.F. No. 1164 - MCHA Assessment; Premium Tax; HSAs; and Cigarette Taxes

Author: Senator Sheila M. Kiscaden

Prepared by: Christopher B. Stang, Senate Counsel (651/296-0539)

Date: March 4, 2005

Overview

This bill:

- eliminates the Minnesota Comprehensive Health Association (MCHA) assessment on health insurance;
- makes structural changes in MCHA to reflect the elimination of assessments;
- eliminates the premium tax on health insurance, health maintenance organizations, and nonprofit health services corporations;
- conforms the Minnesota income tax to the federal tax treatment of Health Savings Accounts (HSAs); and
- increases the cigarette excise tax by 99 cents per pack to $1.47 per pack to offset the cost to the state of paying MCHA deficits and the revenue losses from conforming to HSAs and eliminating the premium tax.

Section 1 requires that health plan companies pass along to their customers in the form of lower premiums, savings from the elimination of taxes and assessments on health coverage accomplished in this bill.

Section 2 is a technical conforming change to amend a definition to eliminate a reference to insurers as being "contributing members" of the MCHA. Eliminates unnecessary language.

Section 3 eliminates a reference to solvency of contributing members as a factor for the Commissioner of Commerce to consider in approving MCHA premiums. Under this bill, insurers will not be assessed to cover MCHA's deficits, so their financial solvency will no longer be relevant.

Section 4 eliminates the list of types of insurers who are currently members of MCHA and provides that MCHA will no longer have members.

Section 5 eliminates designated insurance-related board positions on the MCHA board and provides that all board members will be selected by the Commissioner of Commerce. Retains the current requirements that at least two board members be MCHA enrollees and that at least two live outside the seven-county metropolitan area. Eliminates references to features of MCHA that are no longer relevant under this bill.

Section 6 eliminates the requirement that insurers be members of MCHA as a condition of doing business in this state.

Section 7 is a conforming change.

Section 8 eliminates obsolete language relating to MCHA providing reinsurance to member-insurers.

Sections 9 to 12 are conforming changes.

Section 13 provides an open general fund appropriation to the Commissioner of Commerce in whatever amount is necessary to offset the MCHA deficit for a fiscal year.

Sections 14 and 15 are conforming changes.

Section 16 provides that the effective date of Minnesota's conformity with the federal income tax treatment of HSAs would be retroactive to January 1, 2004.

Section 17 conforms Minnesota's income tax treatment of HSAs to the federal income tax laws.

Section 18 increases the excise tax rates on cigarettes by 99 cents per pack. This will raise the tax from 48 cents per pack of 20 to $1.47. This increase is effective on December 1, 2005.

Section 19 adjusts the dedication of the cigarette tax revenues to the Academic Health Center at the University of Minnesota and to the medical education and research account in the special revenue fund to hold the revenues of those funds constant in light of the tax increase in section 18. These funds both receive a share of the cigarette tax revenues, based on the number of cigarettes sold. Since increasing the excise tax will reduce purchases of cigarettes, this section raises the rates of the dedications by the amounts estimated to hold the two funds' revenues constant.

Section 20 exempts the premiums paid to health insurers for a "health plan" from the two percent premium tax.

Section 21 imposes a 99 cent per pack floor stocks cigarette tax on the stocks of cigarettes possessed by cigarette distributors, subjobbers, retailers, and others on December 1, 2005 (the day the new excise tax rate takes effect under section 18). The floor stocks tax is intended to prevent distributors, subjobbers, and retailers from purchasing large stocks of cigarettes in anticipation of the excise tax rate increase to avoid the tax.

Section 22 appropriates $210,309,000 to the Commissioner of Commerce to pay for the estimated MCHA deficit in the next biennium. The Governor is directed to include a recommendation for this item in the next biennial budget submitted to the Legislature. $41,151,000 is appropriated to the Health Care Access Fund (HCAF) for fiscal year 2006 and $73,934,000 for fiscal year 2007. This is to offset HCAF's loss of receipts from the premiums tax on HMOs and nonprofit health service corporations, which is repealed by section 23.

Section 23, paragraph (a), repeals current laws involving MCHA that involve the assessment or MCHA members.

Section 23, paragraph (b), repeals the premiums tax on HMOs and nonprofit health service corporations.

CBS:cs

Senators Kiscaden, Belanger, Michel, Kelley and Moua introduced--

S.F. No. 1164: Referred to the Committee on **Commerce**

A bill for an act

relating to health; changing the governance structure of the Minnesota Comprehensive Health Association; increasing the cigarette tax; conforming to federal law on health savings accounts; providing a health insurance exemption from the insurance premiums tax; repealing the assessment for the Minnesota Comprehensive Health Association; appropriating money; amending Minnesota Statutes 2004, sections 62A.02, by adding a subdivision; 62E.02, subdivision 23; 62E.091; 62E.10, subdivisions 1, 2, 3, 6, 7; 62E.11, subdivisions 9, 10; 62E.13, subdivisions 2, 3a, by adding a subdivision; 62E.14, subdivisions 1, 6; 290.01, subdivisions 19, 31; 297F.05, subdivision 1; 297F.10, subdivision 1; 297I.15, subdivision 4; repealing Minnesota Statutes 2004, sections 62E.02, subdivision 23; 62E.11, subdivisions 5, 6, 13; 62E.13, subdivision 1; 297I.01, subdivision 10; 297I.05, subdivision 5.

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

Section 1. Minnesota Statutes 2004, section 62A.02, is amended by adding a subdivision to read:

Subd. 8. [EFFECTS ON PREMIUM RATES OF CERTAIN LAW CHANGES.] In approving premium rates under this section and sections 62A.021; 62A.65, subdivision 3; and 62L.08, subdivision 8, the commissioners of commerce and health shall ensure that the provisions of this act eliminating the Comprehensive Health Association assessment and reducing the scope of the premium tax are reflected in the premium rates charged by health plan companies.

[EFFECTIVE DATE.] This section is effective for coverage issued on or after January 1, 2006.

Sec. 2. Minnesota Statutes 2004, section 62E.02, subdivision 23, is amended to read:

Subd. 23. [~~CONTRIBUTING-MEMBER~~ HEALTH PLAN COMPANY.] "~~Contributing-member~~ Health plan company" means those companies regulated under chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance; health maintenance organizations regulated under chapter 62D; nonprofit health service plan corporations regulated under chapter 62C; community integrated service networks regulated under chapter 62N; fraternal benefit societies regulated under chapter 64B; the Minnesota employees insurance program established in section 43A.317, effective July 1, 1993; and joint self-insurance plans regulated under chapter 62H. ~~For the purposes of determining liability of contributing members pursuant to section 62E.11 payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization or community integrated service network shall be considered to be accident and health insurance premiums.~~

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 3. Minnesota Statutes 2004, section 62E.091, is amended to read:

62E.091 [APPROVAL OF STATE PLAN PREMIUMS.]

The association shall submit to the commissioner any premiums it proposes to become effective for coverage under the comprehensive health insurance plan, pursuant to section 62E.08, subdivision 3. No later than 45 days before the effective date for premiums specified in section 62E.08, subdivision 3, the commissioner shall approve, modify, or reject the proposed premiums on the basis of the following criteria:

(a) whether the association has complied with the provisions of section 62E.11, subdivision 11;

(b) whether the association has submitted the proposed premiums in a manner which provides sufficient time for individuals covered under the comprehensive insurance plan to receive notice of any premium increase no less than 30 days prior to the effective date of the increase;

(c) the degree to which the association's computations and conclusions are consistent with section 62E.08;

(d) the degree to which any sample used to compute a weighted average by the association pursuant to section 62E.08 reasonably reflects circumstances existing in the private marketplace for individual coverage;

(e) the degree to which a weighted average computed pursuant to section 62E.08 that uses information pertaining to individual coverage available only on a renewal basis reflects the circumstances existing in the private marketplace for individual coverage;

(f) a comparison of the proposed increases with increases in the cost of medical care and increases experienced in the private marketplace for individual coverage;

(g) the financial consequences to enrollees of the proposed increase;

(h) the actuarially projected effect of the proposed increase upon both total enrollment in, and the nature of the risks assumed by, the comprehensive health insurance plan; and

(i) ~~the relative solvency of the contributing members; and~~

~~(j)~~ other factors deemed relevant by the commissioner.

In no case, however, may the commissioner approve premiums for those plans of coverage described in section 62E.08, subdivision 1, paragraphs (a) to (d), that are lower than 101 percent or greater than 125 percent of the weighted averages computed by the association pursuant to section 62E.08. The commissioner shall support a decision to approve, modify, or reject any premium proposed by the association with written findings and conclusions addressing each criterion specified in this section. If the commissioner does not approve, modify, or reject the premiums proposed by the association sooner than 45 days before the effective date for premiums specified in section 62E.08, subdivision 3, the premiums proposed by the association under this section become effective.

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 4. Minnesota Statutes 2004, section 62E.10,

subdivision 1, is amended to read:

Subdivision 1. [CREATION; TAX EXEMPTION.] There is established a Comprehensive Health Association to promote the public health and welfare of the state of Minnesota with ~~membership consisting of all insurers, self-insurers, fraternals, joint self-insurance plans regulated under chapter 62H, the Minnesota employees insurance program established in section 43A.317, effective July 1, 1993, health maintenance organizations, and community integrated service networks licensed or authorized to do business in this state.~~ The association shall have no members. The Comprehensive Health Association is exempt from the taxes imposed under chapter 297I and any other laws of this state and all property owned by the association is exempt from taxation.

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 5. Minnesota Statutes 2004, section 62E.10, subdivision 2, is amended to read:

Subd. 2. [BOARD OF DIRECTORS; ORGANIZATION.] The board of directors of the association shall be made up of ~~eleven members as follows: six directors selected by contributing members, subject to approval by the commissioner, one of which must be a health actuary, five public directors~~ 11 individuals selected by the commissioner, at least two of whom must be plan enrollees, ~~two of whom must be representatives of employers whose accident and health insurance premiums are part of the association's assessment base, and one of whom must be a licensed insurance agent.~~ At least two of the ~~public~~ directors must reside outside of the seven county metropolitan area. ~~In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self insurance, accident and health insurance premium, subscriber contract charges, health maintenance contract payment, or community integrated service network payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. In approving directors of the board, the~~

~~commissioner shall consider, among other things, whether all types of members are fairly represented. Directors selected by contributing members may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.~~

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 6. Minnesota Statutes 2004, section 62E.10, subdivision 3, is amended to read:

Subd. 3. **[~~MANDATORY MEMBERSHIP~~ ORGANIZATIONAL DOCUMENTS.]** ~~All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, health maintenance organization, or community integrated service network business in this state.~~ The association shall submit its articles, bylaws, and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws, and operating rules by the association and ~~the~~ their approval by the commissioner ~~thereof shall be~~ is exempt from ~~the provisions of~~ sections 14.001 to 14.69.

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 7. Minnesota Statutes 2004, section 62E.10, subdivision 6, is amended to read:

Subd. 6. **[ANTITRUST EXEMPTION.]** In the performance of their duties as ~~members~~ directors of the association, the ~~members~~ directors and their employers shall be exempt from the provisions of sections 325D.49 to 325D.66.

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 8. Minnesota Statutes 2004, section 62E.10, subdivision 7, is amended to read:

Subd. 7. **[GENERAL POWERS.]** The association may:

(a) Exercise the powers granted to insurers under the laws of this state;

(b) Sue or be sued;

(c) Enter into contracts with insurers, similar associations in other states, or with other persons for the performance of administrative functions ~~including the functions provided for in clauses (e) and (f)~~; and

(d) Establish administrative and accounting procedures for the operation of the association~~;~~.

~~(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by sections 62E.04 and 62E.16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:~~

~~(1) individual qualified plans, excluding group conversions;~~

~~(2) group conversions;~~

~~(3) group qualified plans with fewer than 50 employees or members; and~~

~~(4) major medical coverage.~~

~~A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the~~

~~total-anticipated-expenses-incurred-by-the-association-for-the reinsurance;-and~~

~~(f)-Provide-for-the-administration-by-the-association-of policies-which-are-reinsured-pursuant-to-clause-(e).--Each member-electing-to-reinsure-one-or-more-categories-of-coverage in-the-association-may-elect-to-have-the-association-administer the-categories-of-coverage-on-the-member's-behalf.--If-a-member elects-to-have-the-association-administer-the-categories-of coverage,-it-must-do-so-for-every-life-covered-under-every policy-issued-in-that-category.--The-fee-for-the-administration shall-not-be-less-than-110-percent-of-the-total-anticipated expenses-incurred-by-the-association-for-the-administration.~~

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 9. Minnesota Statutes 2004, section 62E.11, subdivision 9, is amended to read:

Subd. 9. [SPECIAL ASSESSMENT UPON TERMINATION OF INDIVIDUAL HEALTH COVERAGE.] Each ~~contributing-member~~ health plan company that terminates individual health coverage for reasons other than (a) nonpayment of premium; (b) failure to make co-payments; (c) enrollee moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership; and does not provide or arrange for replacement coverage that meets the requirements of section 62D.121; shall pay a special assessment to the state plan based upon the number of terminated individuals who join the comprehensive health insurance plan as authorized under section 62E.14, subdivisions 1, paragraph (d), and 6. Such a ~~contributing-member~~ health plan company shall pay the association an amount equal to the average cost of an enrollee in the state plan in the year in which the ~~member~~ health plan company terminated enrollees multiplied by the total number of terminated enrollees who enroll in the state plan.

The average cost of an enrollee in the state comprehensive health insurance plan shall be determined by dividing the state plan's total annual losses by the total number of enrollees from that year. ~~This-cost-will-be-assessed-to-the-contributing~~

~~member-who-has-terminated-health-coverage-before-the-association makes-the-annual-determination-of-each-contributing-member's liability-as-required-under-this-section.~~

In the event that the ~~contributing-member~~ health plan company is terminating health coverage because of a loss of health care providers, the commissioner may review whether or not the special assessment established under this subdivision will have an adverse impact on the ~~contributing-member~~ health plan company or its enrollees or insureds, including but not limited to causing the ~~contributing-member~~ health plan company to fall below statutory net worth requirements. If the commissioner determines that the special assessment would have an adverse impact on the ~~contributing-member~~ health plan company or its enrollees or insureds, the commissioner may adjust the amount of the special assessment, or establish alternative payment arrangements to the state plan. For health maintenance organizations regulated under chapter 62D, the commissioner of health shall make the determination regarding any adjustment in the special assessment and shall transmit that determination to the commissioner of commerce.

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 10. Minnesota Statutes 2004, section 62E.11, subdivision 10, is amended to read:

Subd. 10. [TERMINATION OF INDIVIDUAL PLAN WITHOUT REPLACEMENT COVERAGE.] Any ~~contributing-members~~ health plan companies who have terminated individual health plans and do not provide or arrange for replacement coverage that meets the requirements of section 62D.121, and whose former insureds or enrollees enroll in the state comprehensive health insurance plan with a waiver of the preexisting conditions pursuant to section 62E.14, subdivisions 1, paragraph (d), and 6, will be liable for the costs of any preexisting conditions of their former enrollees or insureds treated during the first six months of coverage under the state plan. ~~The-liability-for-preexisting conditions-will-be-assessed-before-the-association-makes-the annual-determination-of-each-contributing-member's-liability-as~~

~~required under this section.~~

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 11. Minnesota Statutes 2004, section 62E.13, subdivision 2, is amended to read:

Subd. 2. [SELECTION OF WRITING CARRIER.] The association may ~~select policies and contracts, or parts thereof, submitted by a member or members of the association, or by the association or others, to~~ develop specifications for bids from any entity which wishes to be selected as a writing carrier to administer the state plan. The selection of the writing carrier shall be based upon criteria established by the board of directors of the association and approved by the commissioner. The criteria shall outline specific qualifications that an entity must satisfy in order to be selected and, at a minimum, shall include the entity's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans and the $2,000, $5,000, and $10,000 deductible plans, the qualified Medicare supplement plan, and the health maintenance organization contract.

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 12. Minnesota Statutes 2004, section 62E.13, subdivision 3a, is amended to read:

Subd. 3a. [EXTENSION OF WRITING CARRIER CONTRACT.] Subject to the approval of the commissioner, and subject to the consent of the writing carrier, the association may extend the effective writing carrier contract for a period not to exceed three years, if the association and the commissioner determine that it would be in the best interest of the association's enrollees and ~~contributing members~~ of the state. This subdivision applies notwithstanding anything to the contrary in subdivisions 2 and 3.

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 13. Minnesota Statutes 2004, section 62E.13, is amended by adding a subdivision to read:

Subd. 14. [APPROPRIATION.] An amount sufficient to offset

any deficit of the association for the fiscal year is appropriated to the commissioner of commerce for payment to the association.

Sec. 14. Minnesota Statutes 2004, section 62E.14, subdivision 1, is amended to read:

Subdivision 1. [APPLICATION, CONTENTS.] The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person shall enroll by submission of an application to the writing carrier. The application must provide the following:

(a) name, address, age, list of residences for the immediately preceding six months and length of time at current residence of the applicant;

(b) name, address, and age of spouse and children if any, if they are to be insured;

(c) evidence of rejection, a requirement of restrictive riders, a rate up, or a preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least one ~~association-member~~ health plan company within six months of the date of the application, or other eligibility requirements adopted by rule by the commissioner which are not inconsistent with this chapter and which evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk;

(d) if the applicant has been terminated from individual health coverage which does not provide replacement coverage, evidence that no replacement coverage that meets the requirements of section 62D.121 was offered, and evidence of termination of individual health coverage by an insurer, nonprofit health service plan corporation, or health maintenance organization, provided that the contract or policy has been terminated for reasons other than (1) failure to pay the charge for health care coverage; (2) failure to make co-payments required by the health care plan; (3) enrollee moving out of the

area served; or (4) a materially false statement or misrepresentation by the enrollee in the application for the terminated contract or policy; and

(e) a designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan. Upon ceasing to be a resident of Minnesota a person is no longer eligible to purchase or renew coverage under the state plan, except as required by state or federal law with respect to renewal of Medicare supplement coverage.

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 15. Minnesota Statutes 2004, section 62E.14, subdivision 6, is amended to read:

Subd. 6. [TERMINATION OF INDIVIDUAL POLICY OR CONTRACT.] A Minnesota resident who holds an individual health maintenance contract, individual nonprofit health service corporation contract, or an individual insurance policy previously approved by the commissioners of health or commerce, may enroll in the comprehensive health insurance plan with a waiver of the preexisting condition as described in subdivision 3, without interruption in coverage, provided (1) no replacement coverage that meets the requirements of section 62D.121 was offered by the ~~contributing member~~ health plan company, and (2) the policy or contract has been terminated for reasons other than (a) nonpayment of premium; (b) failure to make co-payments required by the health care plan; (c) moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for the terminated policy or contract; and, provided further, that the option to enroll in the plan is exercised by submitting an application that is received by the writing carrier no later than 90 days after termination of the existing policy or contract.

Coverage allowed under this section is effective when the contract or policy is terminated and the enrollee has submitted the proper application that is received within the time period stated in this subdivision and paid the required premium or fee.

Expenses incurred from the preexisting conditions of

individuals enrolled in the state plan under this subdivision must be paid by the ~~contributing member~~ health plan company canceling coverage as set forth in section 62E.11, subdivision 10.

The application must include evidence of termination of the existing policy or certificate as required in subdivision 1.

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 16. Minnesota Statutes 2004, section 290.01, subdivision 19, is amended to read:

Subd. 19. [NET INCOME.] The term "net income" means the federal taxable income, as defined in section 63 of the Internal Revenue Code of 1986, as amended through the date named in this subdivision, incorporating any elections made by the taxpayer in accordance with the Internal Revenue Code in determining federal taxable income for federal income tax purposes, and with the modifications provided in subdivisions 19a to 19f.

In the case of a regulated investment company or a fund thereof, as defined in section 851(a) or 851(g) of the Internal Revenue Code, federal taxable income means investment company taxable income as defined in section 852(b)(2) of the Internal Revenue Code, except that:

(1) the exclusion of net capital gain provided in section 852(b)(2)(A) of the Internal Revenue Code does not apply;

(2) the deduction for dividends paid under section 852(b)(2)(D) of the Internal Revenue Code must be applied by allowing a deduction for capital gain dividends and exempt-interest dividends as defined in sections 852(b)(3)(C) and 852(b)(5) of the Internal Revenue Code; and

(3) the deduction for dividends paid must also be applied in the amount of any undistributed capital gains which the regulated investment company elects to have treated as provided in section 852(b)(3)(D) of the Internal Revenue Code.

The net income of a real estate investment trust as defined and limited by section 856(a), (b), and (c) of the Internal Revenue Code means the real estate investment trust taxable income as defined in section 857(b)(2) of the Internal Revenue

Code.

The net income of a designated settlement fund as defined in section 468B(d) of the Internal Revenue Code means the gross income as defined in section 468B(b) of the Internal Revenue Code.

The provisions of sections 1113(a), 1117, 1206(a), 1313(a), 1402(a), 1403(a), 1443, 1450, 1501(a), 1605, 1611(a), 1612, 1616, 1617, 1704(l), and 1704(m) of the Small Business Job Protection Act, Public Law 104-188, the provisions of Public Law 104-117, the provisions of sections 313(a) and (b)(1), 602(a), 913(b), 941, 961, 971, 1001(a) and (b), 1002, 1003, 1012, 1013, 1014, 1061, 1062, 1081, 1084(b), 1086, 1087, 1111(a), 1131(b) and (c), 1211(b), 1213, 1530(c)(2), 1601(f)(5) and (h), and 1604(d)(1) of the Taxpayer Relief Act of 1997, Public Law 105-34, the provisions of section 6010 of the Internal Revenue Service Restructuring and Reform Act of 1998, Public Law 105-206, the provisions of section 4003 of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, Public Law 105-277, and the provisions of section 318 of the Consolidated Appropriation Act of 2001, Public Law 106-554, shall become effective at the time they become effective for federal purposes.

The Internal Revenue Code of 1986, as amended through December 31, 1996, shall be in effect for taxable years beginning after December 31, 1996.

The provisions of sections 202(a) and (b), 221(a), 225, 312, 313, 913(a), 934, 962, 1004, 1005, 1052, 1063, 1084(a) and (c), 1089, 1112, 1171, 1204, 1271(a) and (b), 1305(a), 1306, 1307, 1308, 1309, 1501(b), 1502(b), 1504(a), 1505, 1527, 1528, 1530, 1601(d), (e), (f), and (i) and 1602(a), (b), (c), and (e) of the Taxpayer Relief Act of 1997, Public Law 105-34, the provisions of sections 6004, 6005, 6012, 6013, 6015, 6016, 7002, and 7003 of the Internal Revenue Service Restructuring and Reform Act of 1998, Public Law 105-206, the provisions of section 3001 of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, Public Law 105-277, the

provisions of section 3001 of the Miscellaneous Trade and Technical Corrections Act of 1999, Public Law 106-36, and the provisions of section 316 of the Consolidated Appropriation Act of 2001, Public Law 106-554, shall become effective at the time they become effective for federal purposes.

The Internal Revenue Code of 1986, as amended through December 31, 1997, shall be in effect for taxable years beginning after December 31, 1997.

The provisions of sections 5002, 6009, 6011, and 7001 of the Internal Revenue Service Restructuring and Reform Act of 1998, Public Law 105-206, the provisions of section 9010 of the Transportation Equity Act for the 21st Century, Public Law 105-178, the provisions of sections 1004, 4002, and 5301 of the Omnibus Consolidation and Emergency Supplemental Appropriations Act, 1999, Public Law 105-277, the provision of section 303 of the Ricky Ray Hemophilia Relief Fund Act of 1998, Public Law 105-369, the provisions of sections 532, 534, 536, 537, and 538 of the Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170, the provisions of the Installment Tax Correction Act of 2000, Public Law 106-573, and the provisions of section 309 of the Consolidated Appropriation Act of 2001, Public Law 106-554, shall become effective at the time they become effective for federal purposes.

The Internal Revenue Code of 1986, as amended through December 31, 1998, shall be in effect for taxable years beginning after December 31, 1998.

The provisions of the FSC Repeal and Extraterritorial Income Exclusion Act of 2000, Public Law 106-519, and the provision of section 412 of the Job Creation and Worker Assistance Act of 2002, Public Law 107-147, shall become effective at the time it became effective for federal purposes.

The Internal Revenue Code of 1986, as amended through December 31, 1999, shall be in effect for taxable years beginning after December 31, 1999. The provisions of sections 306 and 401 of the Consolidated Appropriation Act of 2001, Public Law 106-554, and the provision of section 632(b)(2)(A) of

the Economic Growth and Tax Relief Reconciliation Act of 2001, Public Law 107-16, and provisions of sections 101 and 402 of the Job Creation and Worker Assistance Act of 2002, Public Law 107-147, shall become effective at the same time it became effective for federal purposes.

The Internal Revenue Code of 1986, as amended through December 31, 2000, shall be in effect for taxable years beginning after December 31, 2000. The provisions of sections 659a and 671 of the Economic Growth and Tax Relief Reconciliation Act of 2001, Public Law 107-16, the provisions of sections 104, 105, and 111 of the Victims of Terrorism Tax Relief Act of 2001, Public Law 107-134, and the provisions of sections 201, 403, 413, and 606 of the Job Creation and Worker Assistance Act of 2002, Public Law 107-147, shall become effective at the same time it became effective for federal purposes.

The Internal Revenue Code of 1986, as amended through March 15, 2002, shall be in effect for taxable years beginning after December 31, 2001.

The provisions of sections 101 and 102 of the Victims of Terrorism Tax Relief Act of 2001, Public Law 107-134, shall become effective at the same time it becomes effective for federal purposes.

The Internal Revenue Code of 1986, as amended through June 15, 2003, shall be in effect for taxable years beginning after December 31, 2002. The provisions of section 201 of the Jobs and Growth Tax Relief and Reconciliation Act of 2003, H.R. 2, if it is enacted into law, are effective at the same time it became effective for federal purposes.

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, relating to health savings accounts, is effective at the same time it became effective for federal purposes.

Except as otherwise provided, references to the Internal Revenue Code in subdivisions 19a to 19g mean the code in effect for purposes of determining net income for the applicable year.

[EFFECTIVE DATE.] This section is effective the day following final enactment.

Sec. 17. Minnesota Statutes 2004, section 290.01, subdivision 31, is amended to read:

Subd. 31. [INTERNAL REVENUE CODE.] Unless specifically defined otherwise, "Internal Revenue Code" means the Internal Revenue Code of 1986, as amended through June 15, 2003, and as amended by section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, relating to health savings accounts.

[EFFECTIVE DATE.] This section is effective for taxable years beginning after December 31, 2003.

Sec. 18. Minnesota Statutes 2004, section 297F.05, subdivision 1, is amended to read:

Subdivision 1. [RATES; CIGARETTES.] A tax is imposed upon the sale of cigarettes in this state, upon having cigarettes in possession in this state with intent to sell, upon any person engaged in business as a distributor, and upon the use or storage by consumers, at the following rates:

(1) on cigarettes weighing not more than three pounds per thousand, ~~24~~ 73.5 mills on each such cigarette; and

(2) on cigarettes weighing more than three pounds per thousand, ~~48~~ 147 mills on each such cigarette.

[EFFECTIVE DATE.] This section is effective December 1, 2005.

Sec. 19. Minnesota Statutes 2004, section 297F.10, subdivision 1, is amended to read:

Subdivision 1. [TAX AND USE TAX ON CIGARETTES.] Revenue received from cigarette taxes, as well as related penalties, interest, license fees, and miscellaneous sources of revenue shall be deposited by the commissioner in the state treasury and credited as follows:

(1) the revenue produced by ~~3.25~~ 3.95 mills of the tax on cigarettes weighing not more than three pounds a thousand and ~~6.5~~ 7.9 mills of the tax on cigarettes weighing more than three pounds a thousand must be credited to the Academic Health Center

special revenue fund hereby created and is annually appropriated to the Board of Regents at the University of Minnesota for Academic Health Center funding at the University of Minnesota; and

(2) the revenue produced by ~~1.25~~ 1.52 mills of the tax on cigarettes weighing not more than three pounds a thousand and ~~2.5~~ 3.04 mills of the tax on cigarettes weighing more than three pounds a thousand must be credited to the medical education and research costs account hereby created in the special revenue fund and is annually appropriated to the commissioner of health for distribution under section 62J.692, subdivision 4; and

(3) the balance of the revenues derived from taxes, penalties, and interest (under this chapter) and from license fees and miscellaneous sources of revenue shall be credited to the general fund.

[EFFECTIVE DATE.] This section is effective for revenues received for taxes subject to the rate increase in Minnesota Statutes, section 297F.05, subdivision 1, as amended by section 18, as determined by the commissioner of revenue.

Sec. 20. Minnesota Statutes 2004, section 297I.15, subdivision 4, is amended to read:

Subd. 4. [PREMIUMS PAID TO HEALTH CARRIERS ~~BY STATE~~.] A health carrier as defined in section 62A.011 is exempt from the taxes imposed under this chapter on premiums paid to it ~~by the state. Premiums paid by the state under medical assistance, general assistance medical care, and the MinnesotaCare program are not exempt under this subdivision~~ for a health plan, as defined in section 62A.011, subdivision 3, but including coverage described in clause (10) of that subdivision.

[EFFECTIVE DATE.] This section is effective for premiums received after December 31, 2005.

Sec. 21. [FLOOR STOCKS TAX.]

Subdivision 1. [TAX IMPOSED.] (a) A floor stocks tax is imposed on every person engaged in business in this state as a distributor, retailer, subjobber, vendor, manufacturer, or manufacturer's representative of cigarettes, on the stamped

cigarettes and unaffixed stamps in the person's possession or under the person's control at 12:01 a.m. on December 1, 2005. The tax is imposed at the following rates:

(1) on cigarettes weighing not more than three pounds per thousand, 49.5 mills on each cigarette; and

(2) on cigarettes weighing more than three pounds per thousand, 99 mills on each cigarette.

(b) Each distributor, by December 8, 2005, shall file a report with the commissioner of revenue, in the form the commissioner prescribes, showing the stamped cigarettes and unaffixed stamps on hand at 12:01 a.m. on December 1, 2005, and the amount of tax due on the cigarettes and unaffixed stamps. The tax imposed by this section is due and payable by January 3, 2006, and after that date bears interest as provided in Minnesota Statutes, section 270.75. Each retailer, subjobber, vendor, manufacturer, or manufacturer's representative shall file a return with the commissioner, in the form the commissioner prescribes, showing the cigarettes on hand at 12:01 a.m. on December 1, 2005, and pay the tax due on them by January 3, 2006. Tax not paid by the due date bears interest as provided in Minnesota Statutes, section 270.75.

Subd. 2. [AUDIT AND ENFORCEMENT.] The tax imposed by this section is subject to the audit, assessment, and collection provisions applicable to the taxes imposed under Minnesota Statutes, chapter 297F. The commissioner shall deposit the revenues from this tax in the general fund.

[EFFECTIVE DATE.] This section is effective December 1, 2005.

Sec. 22. [APPROPRIATION.]

(a) $210,309,000 is appropriated from the general fund to the commissioner of commerce to offset the deficit in the Minnesota Comprehensive Health Association program; $60,734,000 of this appropriation is for fiscal year 2006 and $149,575,000 for fiscal year 2007. Any amount not expended in fiscal year 2006 may be carried over to fiscal year 2007. Beginning for the 2008-2009 fiscal biennium, the commissioner of commerce shall

include estimates of the cost of the Minnesota Comprehensive Health Association deficits in its submissions under Minnesota Statutes, section 16A.10, and the governor shall include recommendations on it in the governor's budget submission to the legislature under Minnesota Statutes, section 16A.11.

(b) $41,151,000 is appropriated from the general fund for transfer to the health care access fund in fiscal year 2006 and $73,934,000 in fiscal year 2007 to offset the repeal of the insurance premiums tax on health maintenance organizations and nonprofit health service corporations.

Sec. 23. [REPEALER.]

(a) Minnesota Statutes 2004, sections 62E.02, subdivision 23; 62E.11, subdivisions 5, 6, and 13; and 62E.13, subdivision 1, are repealed.

(b) Minnesota Statutes 2004, sections 297I.01, subdivision 10; and 297I.05, subdivision 5, are repealed.

[EFFECTIVE DATE.] Paragraph (a) of this section is effective January 1, 2006. Paragraph (b) of this section is effective for premiums received after December 31, 2005.

APPENDIX
Repealed Minnesota Statutes for 05-2877

62E.02 DEFINITIONS.

Subd. 23. **Contributing member.** "Contributing member" means those companies regulated under chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance; health maintenance organizations regulated under chapter 62D; nonprofit health service plan corporations regulated under chapter 62C; community integrated service networks regulated under chapter 62N; fraternal benefit societies regulated under chapter 64B; the Minnesota employees insurance program established in section 43A.317, effective July 1, 1993; and joint self-insurance plans regulated under chapter 62H. For the purposes of determining liability of contributing members pursuant to section 62E.11 payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization or community integrated service network shall be considered to be accident and health insurance premiums.

62E.11 OPERATION OF COMPREHENSIVE PLAN.

Subd. 5. **Allocation of losses.** Each contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the contributing member's total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium, received by all contributing members from or on behalf of Minnesota residents, as determined by the commissioner. Payments made by the state to a contributing member for medical assistance, MinnesotaCare, or general assistance medical care services according to chapters 256, 256B, and 256D shall be excluded when determining a contributing member's total premium.

Subd. 6. **Member assessments.** The association shall make an annual determination of each contributing member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the contributing members whose aggregate assessments comprised a minimum of 90 percent of the most recent prior annual assessment, in the event that the association deems that methodology to be the most administratively efficient and cost-effective means of assessment, and as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment shall be due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days shall be grounds for termination of the contributing member's membership. A contributing member which ceases to do accident and health insurance business within the state shall remain

liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment, as determined herein, would not exceed ten dollars.

Subd. 13. **State funding; effect on premium rates of members.** In approving the premium rates as required in sections 62A.65, subdivision 3; and 62L.08, subdivision 8, the commissioners of health and commerce shall ensure that any appropriation to reduce the annual assessment made on the contributing members to cover the costs of the Minnesota comprehensive health insurance plan as required under this section is reflected in the premium rates charged by each contributing member.

62E.13 ADMINISTRATION OF PLAN.

Subdivision 1. **Submission of plans of coverage.** Any member of the association may submit to the commissioner the policies of accident and health insurance or the health maintenance organization contracts which are being proposed to serve in the comprehensive health insurance plan. The time and manner of the submission shall be prescribed by rule of the commissioner.

297I.01 DEFINITIONS.

Subd. 10. **Health maintenance organization.** "Health maintenance organization" has the meaning given in section 62D.02, subdivision 4.

297I.05 TAX IMPOSED.

Subd. 5. **Health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks.** (a) Health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations are exempt from the tax imposed under this section for premiums received in calendar years 2001 to 2003.

(b) For calendar years after 2003, a tax is imposed on health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations. The rate of tax is equal to one percent of gross premiums less return premiums received in the calendar year.

(c) In approving the premium rates as required in sections 62L.08, subdivision 8, and 62A.65, subdivision 3, the commissioners of health and commerce shall ensure that any exemption from tax as described in paragraph (a) is reflected in the premium rate.

(d) The commissioner shall deposit all revenues, including penalties and interest, collected under this chapter from health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations in the health care access fund. Refunds of overpayments of tax imposed by this subdivision must be paid from the health care access fund. There is annually appropriated from the health care access fund to the commissioner the amount necessary to make any refunds of the tax imposed under this subdivision.

Withdrawn 3-9-05

03/09/05 [COUNSEL] CBS SCS1164A-1

Pogemiller

Senator ..... moves to amend S.F. No. 1164 as follows:

Pages 1 to 12, delete sections 1 to 15

Page 17, delete section 20

Page 18, delete lines 30 to 36, and insert:

"$101,885,000 is appropriated from the general fund in fiscal year 2006 and $223,509,000 is appropriated from the general fund in fiscal year 2007 to increase the formula allowance under Minnesota Statutes, section 126C.10, subdivision 2, by $124 per adjusted marginal cost pupil unit in fiscal year 2006 and by $249 per adjusted marginal cost pupil unit in fiscal year 2007 and later."

Page 19, delete lines 1 to 19

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Now		Formula Now 4601	Increase	New Formula	Year to Year % Change
Proposal	FY 06	4601	124	4725	2.70%
Proposal	FY07	4601	249	4850	2.65%

Adopted. 3-9-05

03/09/05 [COUNSEL] CBS SCS1164A-2

Lourey

Senator ..... moves to amend S.F. No. 1164 as follows:

Page 19, line 12, delete "(a)"

Page 19, delete lines 15 and 16

Page 19, line 18, delete everything after the period

Page 19, delete line 19

page 19. delete lines 6-10

ROLL CALL VOTE

Date: March, 9, 2005

Senator 1164 requested a **Roll Call Vote** on:

1. ☐ **adoption** of _____ amendment

2. ☒ **passage** of S. F. No. 1164

3. ☐ **adoption** of _____ motion _____

SENATOR	YES	NO	PASS	ABSENT
Scheid	☒	☐	☐	☐
Anderson	☒	☐	☐	☐
Belanger	☒	☐	☐	☐
Gaither	☐	☐	☐	☒
Kiscaden	☒	☐	☐	☐
Larson	☐	☒	☐	☐
LeClair	☐	☒	☐	☐
Lourey	☒	☐	☐	☐
Metzen	☒	☐	☐	☐
Michel	☒	☐	☐	☐
Pappas	☐	☒	☐	☐
Pogemiller	☐	☒	☐	☐
Reiter	☐	☒	☐	☐
Rest	☐	☒	☐	☐
Sams	☒	☐	☐	☐
Sparks	☐	☒	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
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	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
TOTALS	8	7		

There being 8 *Yes* votes and 7 *No* votes the Motion:

Prevailed ☒

Did Not Prevail ☐

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

S.F. No. 1164: A bill for an act relating to health; changing the governance structure of the Minnesota Comprehensive Health Association; increasing the cigarette tax; conforming to federal law on health savings accounts; providing a health insurance exemption from the insurance premiums tax; repealing the assessment for the Minnesota Comprehensive Health Association; appropriating money; amending Minnesota Statutes 2004, sections 62A.02, by adding a subdivision; 62E.02, subdivision 23; 62E.091; 62E.10, subdivisions 1, 2, 3, 6, 7; 62E.11, subdivisions 9, 10; 62E.13, subdivisions 2, 3a, by adding a subdivision; 62E.14, subdivisions 1, 6; 290.01, subdivisions 19, 31; 297F.05, subdivision 1; 297F.10, subdivision 1; 297I.15, subdivision 4; repealing Minnesota Statutes 2004, sections 62E.02, subdivision 23; 62E.11, subdivisions 5, 6, 13; 62E.13, subdivision 1; 297I.01, subdivision 10; 297I.05, subdivision 5.

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

Page 4, line 27, before the period, insert "and at least six of whom have a working knowledge of health insurance"

Page 18, line 30, delete "(a)"

Page 19, delete lines 6 to 10

Page 19, line 12, delete "(a)"

Page 19, delete lines 15 and 16

Page 19, line 17, delete "Paragraph (a) of"

Page 19, line 18, delete everything after the period

Page 19, delete line 19

Amend the title as follows:

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

Page 1, delete line 19

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.

(Committee Chair)

March 9, 2005.....
(Date of Committee recommendation)