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Senate
State of Minnesota

S.F. No. 3573 - Geographic Rating Bands for Health Insurance Premiums (SCS3573A-2 delete-everything amendment)

Author: Senator Dan Sparks

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

Date: March 30, 2006

This bill involves "geographic rating bands" used for health insurance premiums in the individual and small employer markets. A "rating band" is the range of premiums between the highest and lowest premium charged by an insurer for an insurance product. The "index rate" is the midpoint between the highest premium and the lowest premium in a rating band. "Geographic rating bands" refers to rating bands, and therefore index rates, that vary by geographic region.

Current law permits a health insurer to have up to three geographic pricing regions in the state; forbids index rate variations of more than 20 percent between regions; and forbids the index rate in a rural area to exceed the index rate used by that insurer in the metro area. These geographic variations require approval of the commissioner, based upon inter-regional differences in costs of providing health coverage.

This bill eliminates limits on the geographic regions used. Requires that a region contain at least seven contiguous counties. Continues to forbid index rate variations of more than 20 percent between geographic areas.

CBS:cs

MINNESOTA
CHAMBER *of*
COMMERCE

April 3, 2006

Members of the Commerce Committee:

On behalf of the 2,500 members of the Minnesota Chamber of Commerce, I would like to express support for S.F. 3573. The Chamber supports efforts to improve marketplace competition and expand purchasing options for employers and individuals. This bill will help accomplish these goals.

Currently employers are limited to very few options when purchasing health care benefits, especially in greater Minnesota. S.F. 3573 allows a health insurer to create more than three separate geographic regions which will allow plans to more accurately reflect geographic cost differences in their rates and create more competition in greater Minnesota. This flexibility will attract more insurers into the market and may result in reduced premiums for many in greater Minnesota.

Thank you for your consideration of this bill.

Sincerely,

Erin Sexton

Erin Sexton
Director of Health Policy

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A-2 adopted amendments to A-2 adopted

Senators Sparks, Sams, Solon and Koering introduced–

S.F. No. 3573: Referred to the Committee on Commerce.

A bill for an act

relating to insurance; permitting reductions in premiums on small employer health insurance in greater Minnesota; amending Minnesota Statutes 2004, sections 62A.65, subdivision 3; 62L.08, subdivision 4.

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

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

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

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

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

(c) A health carrier may request approval by the commissioner to establish ~~no more than three~~ separate geographic ~~regions~~ areas determined by the health carrier and to establish separate index rates for each ~~region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers~~ such area. The commissioner ~~may~~ shall grant approval if the following conditions are met:

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

~~(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;~~

~~(3) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area; and~~

~~(4)~~ (2) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

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

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

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

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

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

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

(h) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes

in risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

EFFECTIVE DATE. This section is effective January 1, 2007, and applies to policies issued or renewed on or after that date.

Sec. 2. Minnesota Statutes 2004, section 62L.08, subdivision 4, is amended to read:

Subd. 4. **Geographic premium variations.** A health carrier may request approval by the commissioner to establish ~~no more than three~~ separate geographic ~~regions~~ areas determined by the health carrier and to establish separate index rates for each ~~region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. A health carrier may also request approval to establish one or more additional geographic regions and one or more separate index rates for premiums for employees working and residing outside of Minnesota~~ such area. The commissioner ~~may~~ shall grant approval if the following conditions are met:

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

~~(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;~~

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

~~(4)~~ (2) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

EFFECTIVE DATE. This section is effective January 1, 2007, and applies to policies issued or renewed on or after that date.

Senator Sparks moves to amend S.F. No. 3573 as follows:

Delete everything after the enacting clause and insert:

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

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

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

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

(c) A health carrier may request approval by the commissioner to establish ~~no more than three~~ separate geographic ~~regions~~ areas determined by the health carrier and to establish separate index rates for each ~~region~~ such area, provided that the index rates do not vary between any two regions by more than 20 percent. ~~Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers~~. The commissioner may grant approval if the following conditions are met:

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

~~(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;~~

~~(3) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area; and~~

(2) each geographic area must be composed of no fewer than seven counties that create a contiguous area; and

~~(4)~~ (3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, ~~2006~~ 2007, and applies to policies issued or renewed on or after that date.

Sec. 2. Minnesota Statutes 2004, section 62L.08, subdivision 4, is amended to read:

Subd. 4. **Geographic premium variations.** A health carrier may request approval by the commissioner to establish ~~no more than three~~ separate geographic ~~regions~~ areas determined by the health carrier and to establish separate index rates for each ~~region~~ such area, provided that the index rates do not vary between any two regions by more than 20 percent. ~~Health carriers that do not do business in the Minneapolis/St. Paul metropolitan~~

~~area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. A health carrier may also request approval to establish one or more additional geographic regions and one or more separate index rates for premiums for employees working and residing outside of Minnesota~~. The commissioner may grant approval if the following conditions are met:

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

~~(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;~~

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

(2) each geographic area must be composed of no fewer than seven counties that create a contiguous area; and

~~(4)~~ (3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

EFFECTIVE DATE. This section is effective January 1, 2007 ~~2008~~, and applies to policies issued or renewed on or after that date."

Amend the title accordingly

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

S.F. No. 3573: A bill for an act relating to insurance; permitting reductions in premiums on small employer health insurance in greater Minnesota; amending Minnesota Statutes 2004, sections 62A.65, subdivision 3; 62L.08, subdivision 4.

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

Delete everything after the enacting clause and insert:

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

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

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

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

(c) A health carrier may request approval by the commissioner to establish ~~no more than three~~ separate geographic ~~regions~~ areas determined by the health carrier and to establish separate index rates for each ~~region~~ such area, provided that the index rates do not vary between any two regions by more than 20 percent. ~~Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers~~. The commissioner may grant approval if the following conditions are met:

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

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~~(3) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area; and~~

(2) each geographic area must be composed of no fewer than seven counties that create a contiguous area; and

~~(4)~~ (3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2007, and applies to policies issued or renewed on or after that date.

Sec. 2. Minnesota Statutes 2004, section 62L.08, subdivision 4, is amended to read:

Subd. 4. **Geographic premium variations.** A health carrier may request approval by the commissioner to establish ~~no more than three~~ separate geographic ~~regions~~ areas determined by the health carrier and to establish separate index rates for each ~~region~~ such

area, provided that the index rates do not vary between any two regions by more than 20 percent. ~~Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. A health carrier may also request approval to establish one or more additional geographic regions and one or more separate index rates for premiums for employees working and residing outside of Minnesota~~. The commissioner may grant approval if the following conditions are met:

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

~~(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;~~

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

(2) each geographic area must be composed of no fewer than seven counties that create a contiguous area; and

~~(4)~~ (3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

EFFECTIVE DATE. This section is effective January 1, 2007, and applies to policies issued or renewed on or after that date."

Amend the title accordingly

And when so amended the bill be re-referred to the Committee on Health and Family Security without recommendation. Amendments adopted. Report adopted.

Linda Scheid
(Committee Chair)

April 3, 2006
(Date of Committee recommendation)

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 3480 - Commerce Department Insurance Bill

Author: Senator Linda Scheid

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

Date: March 28, 2006

Section 1 exempts home warranties from service contract regulation.

Section 2 includes warranties and service contracts in the Insurance Guarantee Association.

Sections 3, 13, 14, and 20 require a response by insurers or the Minnesota Comprehensive Health Association to Commerce Department inquiries within 60 days.

Section 4 states that if a group life policy contains other benefits, the election for continuation of coverage upon termination of employment will include the additional coverage.

Section 5 specifies that if an employee dies within the 60 day election period following termination of employment, but prior to making an election to continue coverage, the employee's previously selected beneficiary would be entitled to any death benefit, minus any unpaid premiums.

Section 6 clarifies that subrogation clauses would not be permitted in Medicare supplemental policies, blanket accident and sickness policies, or policies designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis.

Sections 7, 8, and 9 require insurers to permit dependents to continue to receive COBRA coverage even though the former employee does not continue coverage or if the former employee becomes covered under another group policy, contract or health plan that does not include dependent coverage. These sections also require health carriers to provide instructions which enable the dependent or the former employee to elect to receive continued coverage directly from the insurer rather than the former employer.

Section 10 specifies that notification to a health carrier is not a condition of adopted child dependent coverage but, permits a heath carrier to withhold payment of benefits until it has been compensated for premiums which would have been owed had the carrier been informed of the additional dependent immediately.

Section 11 specifies that health plan coverage of diabetes is for treatment not otherwise covered under Medicare or Medicare Part D.

Section 12 allows health carriers to offer the deductible coverage in Medicare part K & L as a basic plan rider. Medicare Part K covers fifty percent of hospital deductibles and Medicare Part B coinsurance amounts up to an out-of-pocket limit of $4,000. Medicare Part L covers seventy-five percent of hospital deductibles and Medicare Part B coinsurance amounts up to an out-of-pocket limit of $2,000.

Section 15 includes any plan established or maintained by a state, the United States government, a foreign country, or any political subdivision, as well as Minnesota's State Children's Health Insurance Program in the definition of qualifying coverage for small employers.

Section 16 adds the Minnesota Comprehensive Health Association to the list of carriers subject to the requirements of the Utilization Review Act. Utilization review evaluates the necessity, appropriateness, and efficacy of the use of health care services for the purpose of determining medical necessity of the service.

Section 17 requires a Utilization Review Organization that is not a licensed health carrier to submit an annual report to the Commissioner of Commerce.

Section 18 technical change to language requiring health care providers to submit charges to health care plans or a third party administrator within six months from the date of service.

Section 19 deletes language allowing owners of rental vehicles to be liable for damages resulting from the operation of a rental vehicle. This provision was preempted by federal law in 2005.

Sections 21 to 28 contain language that codifies provisions currently found in Minnesota Rules chapter 2781, which contains administrative rules governing the Worker's Compensation Assigned Risk Plan. The rules are outdated and in need of revision, and the Commerce Department would rather codify the changes than go through the rulemaking process.

Section 29 repeals a provision requiring the Commissioner of Commerce to develop merit rating plans for small businesses.

MSG:cs

amends:
SF 3480 delete Sec 1, 2 & 4
A3
A4
A5
A8
A9

A-6
A-10
A-12 - amend A12: page 3, line 5 after "the" insert "legal"
A-11

A-13
delete Sec. 9

Senator Scheid introduced–

S.F. No. 3480: Referred to the Committee on Commerce.

A bill for an act

relating to insurance; regulating certain form approvals, coverages, filings, utilization reviews, and claims; amending Minnesota Statutes 2004, sections 60C.02, subdivision 1; 61A.02, subdivision 3; 61A.092, subdivisions 1, 3; 62A.095, subdivision 1; 62A.17, subdivisions 1, 2, 5; 62A.27; 62A.3093; 62C.14, subdivisions 9, 10; 62L.02, subdivision 24; 62M.01, subdivision 2; 62M.09, subdivision 9; 72C.10, subdivision 1; 79.01, by adding subdivisions; 79.251, by adding a subdivision; 79.252, by adding subdivisions; 79A.23, subdivision 3; Minnesota Statutes 2005 Supplement, sections 59B.01; 62A.316; 62Q.75, subdivision 3; 65B.49, subdivision 5a; 79A.04, subdivision 2; repealing Minnesota Statutes 2004, section 79.251, subdivision 2; Minnesota Rules, parts 2781.0400; 2781.0500; 2781.0600.

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

DELETE sec. 1

"Section 1. Minnesota Statutes 2005 Supplement, section 59B.01, is amended to read:

59B.01 SCOPE AND PURPOSE.

(a) The purpose of this chapter is to create a legal framework within which service contracts may be sold in this state.

(b) The following are exempt from this chapter:

(1) warranties;

(2) maintenance agreements;

(3) warranties, service contracts, or maintenance agreements offered by public utilities, as defined in section 216B.02, subdivision 4, or an entity or operating unit owned by or under common control with a public utility;

(4) service contracts sold or offered for sale to persons other than consumers;

(5) service contracts on tangible property where the tangible property for which the service contract is sold has a purchase price of $250 or less, exclusive of sales tax;

(6) motor vehicle service contracts as defined in section 65B.29, subdivision 1, paragraph (1);

(7) service contracts for home security equipment installed by a licensed technology systems contractor; ~~and~~

(8) motor club membership contracts that typically provide roadside assistance services to motorists stranded for reasons that include, but are not limited to, mechanical breakdown or adverse road conditions; and

(9) home warranties.

(c) The types of agreements referred to in paragraph (b) are not subject to chapters 60A to 79A, except as otherwise specifically provided by law.

DELETE SEC 2. "

Sec. 2. Minnesota Statutes 2004, section 60C.02, subdivision 1, is amended to read:

Subdivision 1. **Scope.** This chapter applies to all kinds of direct insurance, except:

(1) life;

(2) annuity;

(3) title;

(4) accident and sickness;

(5) credit;

(6) vendor's single interest or collateral protection or any similar insurance protecting the interests of a creditor arising out of a creditor debtor transaction;

(7) mortgage guaranty;

(8) financial guaranty or other forms of insurance offering protection against investment risks;

(9) ocean marine;

(10) a transaction or combination of transactions between a person, including affiliates of the person, and an insurer, including affiliates of the insurer, that involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or

(11) insurance provided by or guaranteed by government; ~~or~~.

~~(12) insurance of warranties or service contracts, including insurance that provides for the repair, replacement, or services of goods or property, or indemnification for repair, replacement or service, for the operation or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability insured by the user of agreement or service contracts that provide these benefits.~~

Sec. 3. Minnesota Statutes 2004, section 61A.02, subdivision 3, is amended to read:

Subd. 3. **Disapproval.** (a) The commissioner shall, within 60 days after the filing of any form, disapprove the form:

(1) if the benefits provided are unreasonable in relation to the premium charged;

(2) if the safety and soundness of the company would be threatened by the offering of an excess rate of interest on the policy or contract;

(3) if it contains a provision or provisions which are unlawful, unfair, inequitable, misleading, or encourages misrepresentation of the policy; or

(4) if the form, or its provisions, is otherwise not in the public interest. It shall be unlawful for the company to issue any policy in the form so disapproved. If the commissioner does not within 60 days after the filing of any form, disapprove or otherwise object, the form shall be deemed approved.

(b) When an insurer or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission.

(c) For purposes of paragraph (a), clause (2), an excess rate of interest is a rate of interest exceeding the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available.

DELETE SEC. 4

Sec. 4. Minnesota Statutes 2004, section 61A.092, subdivision 1, is amended to read:

Subdivision 1. **Continuation of coverage.** Every group insurance policy issued or renewed within this state after August 1, 1987, providing coverage for life insurance benefits shall contain a provision that permits covered employees who are voluntarily or involuntarily terminated or laid off from their employment, if the policy remains in force for any active employee of the employer, to elect to continue the coverage for themselves and their dependents. If the policy includes other benefits, the election provided by this section extends to those other benefits.

An employee is considered to be laid off from employment if there is a reduction in hours to the point where the employee is no longer eligible for coverage under the group life insurance policy. Termination does not include discharge for gross misconduct.

Sec. 5. Minnesota Statutes 2004, section 61A.092, subdivision 3, is amended to read:

Subd. 3. **Notice of options.** Upon termination of or layoff from employment of a covered employee, the employer shall inform the employee of:

(1) the employee's right to elect to continue the coverage;

(2) the amount the employee must pay monthly to the employer to retain the coverage;

(3) the manner in which and the office of the employer to which the payment to the employer must be made; and

(4) the time by which the payments to the employer must be made to retain coverage.

The employee has 60 days within which to elect coverage. The 60-day period shall begin to run on the date coverage would otherwise terminate or on the date upon which notice of the right to coverage is received, whichever is later.

If the covered employee or covered dependent dies during the 60-day election period and before the covered employee makes an election to continue or reject continuation, then the covered employee will be considered to have elected continuation of coverage. The ~~estate of~~ beneficiary previously selected by the former employee or covered dependent would then be entitled to a death benefit equal to the amount of insurance that could have been continued less any unpaid premium owing as of the date of death.

Notice must be in writing and sent by first class mail to the employee's last known address which the employee has provided to the employer.

A notice in substantially the following form is sufficient: "As a terminated or laid off employee, the law authorizes you to maintain your group insurance benefits, in an amount equal to the amount of insurance in effect on the date you terminated or were laid off from employment, for a period of up to 18 months. To do so, you must notify your former employer within 60 days of your receipt of this notice that you intend to retain this coverage and must make a monthly payment of $..... at ..... by the ..... of each month."

Sec. 6. Minnesota Statutes 2004, section 62A.095, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) No health plan shall be offered, sold, or issued to a resident of this state, or to cover a resident of this state, unless the health plan complies with subdivision 2.

(b) Health plans providing benefits under health care programs administered by the commissioner of human services are not subject to the limits described in subdivision 2 but are subject to the right of subrogation provisions under section 256B.37 and the lien provisions under section 256.015; 256B.042; 256D.03, subdivision 8; or 256L.03, subdivision 6.

For purposes of this section, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clauses (4), (7), and (10).

Sec. 7. Minnesota Statutes 2004, section 62A.17, subdivision 1, is amended to read:

Subdivision 1. **Continuation of coverage.** Every group insurance policy, group subscriber contract, and health care plan included within the provisions of section 62A.16, except policies, contracts, or health care plans covering employees of an agency of the federal government, shall contain a provision which permits every covered employee who is voluntarily or involuntarily terminated or laid off from employment and every covered dependent of the covered employee, if the policy, contract, or health care plan remains in force for active employees of the employer, to elect to continue the coverage ~~for the employee and dependents~~.

An employee shall be considered to be laid off from employment if there is a reduction in hours to the point where the employee is no longer eligible under the policy, contract, or health care plan. Termination shall not include discharge for gross misconduct.

Upon request by the terminated or laid off employee or any covered dependent, a health carrier must provide the instructions necessary to enable the employee or dependent to elect and receive continuation of coverage through the insurer in place of the former employer.

Sec. 8. Minnesota Statutes 2004, section 62A.17, subdivision 2, is amended to read:

Subd. 2. **Responsibility of employee.** Every covered employee or dependent electing to continue coverage shall pay the former employer, on a monthly basis, the cost of the continued coverage. The policy, contract, or plan must require the group policyholder or contract holder to, upon request, provide the employee or dependent with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. If the policy, contract, or health care plan is administered by a trust, every covered employee or dependent electing to continue coverage shall pay the trust the cost of continued coverage according to the eligibility rules established by the trust. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for similarly situated employees with respect to whom neither termination nor layoff has occurred, without regard to whether such cost is paid by the employer or employee. The employee and every covered dependent shall be eligible to continue the coverage until the employee becomes covered under another group health plan, or for a period of 18 months after the termination of or lay off from employment, whichever is shorter. If the employee becomes covered under another group policy, contract, or health plan that does not include dependent coverage, every covered dependent remains eligible to continue coverage with the former employer subject to the conditions specified in this

subdivision. If the employee or any covered dependent becomes covered under another group policy, contract, or health plan and the new group policy, contract, or health plan contains any preexisting condition limitations, the employee or dependent may, subject to the 18-month maximum continuation limit, continue coverage with the former employer until the preexisting condition limitations have been satisfied. The new policy, contract, or health plan is primary except as to the preexisting condition. In the case of a newborn child who is a dependent of the employee, the new policy, contract, or health plan is primary upon the date of birth of the child, regardless of which policy, contract, or health plan coverage is deemed primary for the mother of the child.

Sec. 9. Minnesota Statutes 2004, section 62A.17, subdivision 5, is amended to read:

Subd. 5. **Notice of options.** Upon the termination of or lay off from employment of an eligible employee, the employer shall inform the employee within ten days after termination or lay off of:

(a) the right to elect to continue the coverage;

(b) the amount the employee must pay monthly to the employer or health carrier to retain the coverage;

(c) the manner in which and the office of the employer or health carrier to which the payment to the employer or health carrier must be made; and

(d) the time by which the payments to the employer or health carrier must be made to retain coverage.

If the policy, contract, or health care plan is administered by a trust, the employer is relieved of the obligation imposed by clauses (a) to (d). The trust shall inform the employee of the information required by clauses (a) to (d).

The employee shall have 60 days within which to elect coverage. The 60-day period shall begin to run on the date plan coverage would otherwise terminate or on the date upon which notice of the right to coverage is received, whichever is later.

Notice must be in writing and sent by first class mail to the employee's last known address which the employee has provided the employer or trust.

A notice in substantially the following form shall be sufficient: "As a terminated or laid off employee, the law authorizes you to maintain your group medical insurance for a period of up to 18 months. To do so you must notify your former employer or health carrier within 60 days of your receipt of this notice that you intend to retain this coverage and must make a monthly payment of $..... to ..... at ..... by the ..... of each month."

Sec. 10. Minnesota Statutes 2004, section 62A.27, is amended to read:

62A.27 COVERAGE OF ADOPTED CHILDREN.

(a) A health plan that provides coverage to a Minnesota resident must cover adopted children of the insured, subscriber, participant, or enrollee on the same basis as other dependents. Consequently, the plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning children placed for adoption with the participant.

(b) The coverage required by this section is effective from the date of placement for adoption. For purposes of this section, placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation for total or partial support.

(c) For the purpose of this section, health plan includes:

(1) coverage offered by community integrated service networks;

(2) coverage that is designed solely to provide dental or vision care; and

(3) any plan under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461.

(d) No policy or contract covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy or contract mandates an additional premium for each dependent, the health carrier is entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may withhold payment of any health benefits for the new dependent until it has been compensated with the applicable premium which would have been owed if the health carrier had been informed of the additional dependent immediately.

Sec. 11. Minnesota Statutes 2004, section 62A.3093, is amended to read:

62A.3093 COVERAGE FOR DIABETES.

A health plan, including a plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), must provide coverage for: (1) all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes not otherwise covered under Medicare or Medicare Part D; and (2) diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage must include

persons with gestational, type I or type II diabetes. Coverage required under this section is subject to the same deductible or coinsurance provisions applicable to the plan's hospital, medical expense, medical equipment, or prescription drug benefits. A health carrier may not reduce or eliminate coverage due to this requirement.

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

Sec. 12. Minnesota Statutes 2005 Supplement, section 62A.316, is amended to read:

62A.316 BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.

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

(1) coverage for all of the Medicare Part A inpatient hospital coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare, 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 not otherwise covered under Part D of the Medicare program 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 not otherwise covered under Part D of the Medicare program. 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) preventive medical care benefit coverage for the following preventative health services not covered by Medicare:

(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) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically 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~~.~~;

(8)(i) Medicare Part A Deductible: coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (vii);

(ii) Skilled Nursing Facility Care: coverage for 50 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period

for posthospital skilled nursing care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (vii);

(iii) Hospice Care: coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (vii);

(iv) coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in clause (vii);

(v) except for coverage provided in this clause, coverage for the 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in clause (vii);

(vi) coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(vii) coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment by the Secretary of the United States Department of Health and Human Services; and

(9)(i) the benefits described in clause (8)(vi);

(ii) the benefit described in clause (8)(i), (ii), (iii), (iv), and (v), but substituting 75 percent for 50 percent; and

(iii) the benefit described in clause (8)(vii), but substituting $2,000 for $4,000.

Sec. 13. Minnesota Statutes 2004, section 62C.14, subdivision 9, is amended to read:

Subd. 9. **Required filing.** No service plan corporation shall deliver or issue for delivery in this state any subscriber contract, endorsement, rider, amendment or application until a copy of the form thereof has been filed with the commissioner, subject to disapproval by the commissioner. Any such form issued or in use on August 1, 1971, if filed with the commissioner within 60 days after August 1, 1971, shall be deemed filed upon receipt by the commissioner. When an insurer, service plan corporation, or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission. The commissioner also may by regulation exempt

from filing those subscriber contracts issued to a group of not less than 300 subscribers, or to other groups upon such reasonable conditions and restrictions as the commissioner may require.

Sec. 14. Minnesota Statutes 2004, section 62C.14, subdivision 10, is amended to read:

Subd. 10. **Filing or disapproval.** Except as otherwise provided in subdivision 9, all forms received by the commissioner shall be deemed filed 60 days after received unless disapproved by order transmitted to the corporation stating that the form used in a specified respect is contrary to law, contains a provision or provisions which are unfair, inequitable, misleading, inconsistent or ambiguous, or is in part illegible. It shall be unlawful to issue or use a document disapproved by the commissioner. When an insurer, service plan corporation, or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission.

Sec. 15. Minnesota Statutes 2004, section 62L.02, subdivision 24, is amended to read:

Subd. 24. **Qualifying coverage.** "Qualifying coverage" means health benefits or health coverage provided under:

(1) a health benefit plan, as defined in this section, but without regard to whether it is issued to a small employer and including blanket accident and sickness insurance, other than accident-only coverage, as defined in section 62A.11;

(2) part A or part B of Medicare;

(3) medical assistance under chapter 256B;

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

(5) MCHA;

(6) a self-insured health plan;

(7) the MinnesotaCare program established under section 256L.02;

(8) a plan provided under section 43A.316, 43A.317, or 471.617;

(9) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or other coverage provided under United States Code, title 10, chapter 55;

(10) coverage provided by a health care network cooperative under chapter 62R;

(11) a medical care program of the Indian Health Service or of a tribal organization;

(12) the federal Employees Health Benefits Plan, or other coverage provided under United States Code, title 5, chapter 89;

(13) a health benefit plan under section 5(e) of the Peace Corps Act, codified as United States Code, title 22, section 2504(e);

(14) a health plan; ~~or~~

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

(16) any plan established or maintained by a state, the United States government, or a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan; or

(17) the State Children's Health Insurance Program (SCHIP).

Sec. 16. Minnesota Statutes 2004, section 62M.01, subdivision 2, is amended to read:

Subd. 2. **Jurisdiction.** Sections 62M.01 to 62M.16 apply to any insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; the Minnesota Comprehensive Health Association created under chapter 62E; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, that provides utilization review services for the administration of benefits under a health benefit plan as defined in section 62M.02; or any entity performing utilization review on behalf of a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

Sec. 17. Minnesota Statutes 2004, section 62M.09, subdivision 9, is amended to read:

Subd. 9. **Annual report.** A utilization review organization shall file an annual report with the annual financial statement it submits to the commissioner of commerce that includes:

(1) per 1,000 ~~claims~~ utilization reviews, the number and rate of ~~claims denied~~ determinations not to certify based on medical necessity for each procedure or service; and

(2) the number and rate of denials overturned on appeal.

A utilization review organization that is not a licensed health carrier must submit the annual report required by this subdivision on April 1 of each year.

Sec. 18. Minnesota Statutes 2005 Supplement, section 62Q.75, subdivision 3, is amended to read:

Subd. 3. **Claims filing.** Unless otherwise provided ~~by contract,~~ by section 16A.124, subdivision 4a, ~~or~~ by federal law, or unless the contract provides for a shorter time period, the health care providers and facilities specified in subdivision 2 must submit their charges to a health plan company or third-party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later. A health care provider or facility that does not make an initial submission of charges within the six-month period shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer. The six-month submission requirement may be extended to 12 months in cases where a health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. This subdivision also applies to all health care providers and facilities that submit charges to workers' compensation payers for treatment of a workers' compensation injury compensable under chapter 176, or to reparation obligors for treatment of an injury compensable under chapter 65B.

Sec. 19. Minnesota Statutes 2005 Supplement, section 65B.49, subdivision 5a, is amended to read:

Subd. 5a. **Rental vehicles.** (a) Every plan of reparation security insuring a natural person as named insured, covering private passenger vehicles as defined under section 65B.001, subdivision 3, and pickup trucks and vans as defined under section 168.011 must provide that all of the obligation for damage and loss of use to a rented private passenger vehicle, including pickup trucks and vans as defined under section 168.011, and rented trucks with a registered gross vehicle weight of 26,000 pounds or less would be covered by the property damage liability portion of the plan. This subdivision does not apply to plans of reparation security covering only motor vehicles registered under section 168.10, subdivision 1a, 1b, 1c, or 1d, or recreational equipment as defined under section 168.011. The obligation of the plan must not be contingent on fault or negligence. In all cases where the plan's property damage liability coverage is less than $35,000, the coverage available under the subdivision must be $35,000. Other than as described in this paragraph or in paragraph (j), nothing in this section amends or alters the provisions of the plan of reparation security as to primacy of the coverages in this section.

(b) A vehicle is rented for purposes of this subdivision:

(1) if the rate for the use of the vehicle is determined on a monthly, weekly, or daily basis; or

(2) during the time that a vehicle is loaned as a replacement for a vehicle being serviced or repaired regardless of whether the customer is charged a fee for the use of the vehicle.

A vehicle is not rented for the purposes of this subdivision if the rate for the vehicle's use is determined on a period longer than one month or if the term of the rental agreement is longer than one month. A vehicle is not rented for purposes of this subdivision if the rental agreement has a purchase or buyout option or otherwise functions as a substitute for purchase of the vehicle.

(c) The policy or certificate issued by the plan must inform the insured of the application of the plan to private passenger rental vehicles, including pickup trucks and vans as defined under section 168.011, and that the insured may not need to purchase additional coverage from the rental company.

(d) Where an insured has two or more vehicles covered by a plan or plans of reparation security containing the rented motor vehicle coverage required under paragraph (a), the insured may select the plan the insured wishes to collect from and that plan is entitled to a pro rata contribution from the other plan or plans based upon the property damage limits of liability. If the person renting the motor vehicle is also covered by the person's employer's insurance policy or the employer's automobile self-insurance plan, the reparation obligor under the employer's policy or self-insurance plan has primary responsibility to pay claims arising from use of the rented vehicle.

(e) A notice advising the insured of rental vehicle coverage must be given by the reparation obligor to each current insured with the first renewal notice after January 1, 1989. The notice must be approved by the commissioner of commerce. The commissioner may specify the form of the notice.

(f) When a motor vehicle is rented in this state, there must be attached to the rental contract a separate form containing a written notice in at least 10-point bold type, if printed, or in capital letters, if typewritten, which states:

Under Minnesota law, a personal automobile insurance policy issued in Minnesota must cover the rental of this motor vehicle against damage to the vehicle and against loss of use of the vehicle. Therefore, purchase of any collision damage waiver or similar insurance affected in this rental contract is not necessary if your policy was issued in Minnesota.

No collision damage waiver or other insurance offered as part of or in conjunction with a rental of a motor vehicle may be sold unless the person renting the vehicle provides a written acknowledgment that the above consumer protection notice has been read and understood.

(g) When damage to a rented vehicle is covered by a plan of reparation security as provided under paragraph (a), the rental contract must state that payment by the reparation obligor within the time limits of section 72A.201 is acceptable, and prior payment by the renter is not required.

(h) Compensation for the loss of use of a damaged rented motor vehicle is limited to a period no longer than 14 days.

(i)(1) For purposes of this paragraph, "rented motor vehicle" means a rented vehicle described in paragraph (a), using the definition of "rented" provided in paragraph (b).

~~(2) Notwithstanding section 169.09, subdivision 5a, an owner of a rented motor vehicle is not vicariously liable for legal damages resulting from the operation of the rented motor vehicle in an amount greater than $100,000 because of bodily injury to one person in any one accident and, subject to the limit for one person, $300,000 because of injury to two or more persons in any one accident, and $50,000 because of injury to or destruction of property of others in any one accident, if the owner of the rented motor vehicle has in effect, at the time of the accident, a policy of insurance or self-insurance, as provided in section 65B.48, subdivision 3, covering losses up to at least the amounts set forth in this paragraph. Nothing in this paragraph alters or affects the obligations of an owner of a rented motor vehicle to comply with the requirements of compulsory insurance through a policy of insurance as provided in section 65B.48, subdivision 2, or through self-insurance as provided in section 65B.48, subdivision 3; or with the obligations arising from section 72A.125 for products sold in conjunction with the rental of a motor vehicle. Nothing in this paragraph alters or affects liability, other than vicarious liability, of an owner of a rented motor vehicle.~~

~~(3)~~ (2) The dollar amounts stated in this paragraph shall be adjusted for inflation based upon the Consumer Price Index for all urban consumers, known as the CPI-U, published by the United States Bureau of Labor Statistics. The dollar amounts stated in this paragraph are based upon the value of that index for July 1995, which is the reference base index for purposes of this paragraph. The dollar amounts in this paragraph shall change effective January 1 of each odd-numbered year based upon the percentage difference between the index for July of the preceding year and the reference base index, calculated to the nearest whole percentage point. The commissioner shall announce and publish, on or before September 30 of the preceding year, the changes in the dollar

amounts required by this paragraph to take effect on January 1 of each odd-numbered year. The commissioner shall use the most recent revision of the July index available as of September 1. Changes in the dollar amounts must be in increments of $5,000, and no change shall be made in a dollar amount until the change in the index requires at least a $5,000 change. If the United States Bureau of Labor Statistics changes the base year upon which the CPI-U is based, the commissioner shall make the calculations necessary to convert from the old base year to the new base year. If the CPI-U is discontinued, the commissioner shall use the available index that is most similar to the CPI-U.

(j) The plan of reparation security covering the owner of a rented motor vehicle is excess of any residual liability coverage insuring an operator of a rented motor vehicle if the vehicle is loaned as a replacement for a vehicle being serviced or repaired, regardless of whether a fee is charged for use of the vehicle, provided that the vehicle so loaned is owned by the service or repair business.

Sec. 20. Minnesota Statutes 2004, section 72C.10, subdivision 1, is amended to read:

Subdivision 1. **Readability compliance; filing and approval.** No insurer shall make, issue, amend, or renew any policy or contract after the dates specified in section 72C.11 for the applicable type of policy unless the contract is in compliance with the requirements of sections 72C.06 to 72C.09 and unless the contract is filed with the commissioner for approval. The contract shall be deemed approved ~~90~~ 60 days after filing unless disapproved by the commissioner within the ~~90-day~~ 60-day period. When an insurer, service plan corporation, or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission. The commissioner shall not unreasonably withhold approval. Any disapproval shall be delivered to the insurer in writing, stating the grounds therefor. Any policy filed with the commissioner shall be accompanied by a Flesch scale readability analysis and test score and by the insurer's certification that the policy or contract is in its judgment readable based on the factors specified in sections 72C.06 to 72C.08.

Sec. 21. Minnesota Statutes 2004, section 79.01, is amended by adding a subdivision to read:

Subd. 1a. **Assigned risk plan.** "Assigned risk plan" means:

(1) the method to provide workers' compensation coverage to employers unable to obtain coverage through licensed workers' compensation companies; and

Subd. 2. **Minimum deposit.** The minimum deposit is 110 percent of the private self-insurer's estimated future liability. The deposit may be used to secure payment of all administrative and legal costs, and unpaid assessments required by section 79A.12, subdivision 2, relating to or arising from its or other employers' self-insuring. As used in this section, "private self-insurer" includes both current and former members of the self-insurers' security fund; and "private self-insurers' estimated future liability" means the private self-insurers' total of estimated future liability as determined by an Associate or Fellow of the Casualty Actuarial Society every year for group member private self-insurers and, for a nongroup member private self-insurer's authority to self-insure, every year for the first five years. After the first five years, the nongroup member's total shall be as determined by an Associate or Fellow of the Casualty Actuarial Society at least every two years, and each such actuarial study shall include a projection of future losses during the period until the next scheduled actuarial study, less payments anticipated to be made during that time.

All data and information furnished by a private self-insurer to an Associate or Fellow of the Casualty Actuarial Society for purposes of determining private self-insurers' estimated future liability must be certified by an officer of the private self-insurer to be true and correct with respect to payroll and paid losses, and must be certified, upon information and belief, to be true and correct with respect to reserves. The certification must be made by sworn affidavit. In addition to any other remedies provided by law, the certification of false data or information pursuant to this subdivision may result in a fine imposed by the commissioner of commerce on the private self-insurer up to the amount of $5,000, and termination of the private self-insurers' authority to self-insure. The determination of private self-insurers' estimated future liability by an Associate or Fellow of the Casualty Actuarial Society shall be conducted in accordance with standards and principles for establishing loss and loss adjustment expense reserves by the Actuarial Standards Board, an affiliate of the American Academy of Actuaries. The commissioner may reject an actuarial report that does not meet the standards and principles of the Actuarial Standards Board, and may further disqualify the actuary who prepared the report from submitting any future actuarial reports pursuant to this chapter. Within 30 days after the actuary has been served by the commissioner with a notice of disqualification, an actuary who is aggrieved by the disqualification may request a hearing to be conducted in accordance with chapter 14. Based on a review of the actuarial report, the commissioner of commerce may require an increase in the minimum security deposit in an amount the commissioner considers sufficient.

In addition, the Minnesota self-insurers' security fund may, at its sole discretion and cost, undertake an independent actuarial review or an actuarial study of a private self-insurers' estimated future liability as defined herein. The review or study must be conducted by an associate or fellow of the Casualty Actuarial Society. The actuary has the right to receive and review data and information of the self-insurer necessary for the actuary to complete its review or study. A copy of this report must be filed with the commissioner and a copy must be furnished to the self-insurer.

Estimated future liability is determined by first taking the total amount of the self-insured's future liability of workers' compensation claims and then deducting the total amount which is estimated to be returned to the self-insurer from any specific excess insurance coverage, aggregate excess insurance coverage, and any supplementary benefits or second injury benefits which are estimated to be reimbursed by the special compensation fund. However, in the determination of estimated future liability, the actuary for the self-insurer shall not take a credit for any excess insurance or reinsurance which is provided by a captive insurance company which is wholly owned by the self-insurer. Supplementary benefits or second injury benefits will not be reimbursed by the special compensation fund unless the special compensation fund assessment pursuant to section 176.129 is paid and the reports required thereunder are filed with the special compensation fund. In the case of surety bonds, bonds shall secure administrative and legal costs in addition to the liability for payment of compensation reflected on the face of the bond. In no event shall the security be less than the last retention limit selected by the self-insurer with the Workers' Compensation Reinsurance Association, provided that the commissioner may allow former members to post less than the Workers' Compensation Reinsurance Association retention level if that amount is adequate to secure payment of the self-insurers' estimated future liability, as defined in this subdivision, including payment of claims, administrative and legal costs, and unpaid assessments required by section 79A.12, subdivision 2. The posting or depositing of security pursuant to this section shall release all previously posted or deposited security from any obligations under the posting or depositing and any surety bond so released shall be returned to the surety. Any other security shall be returned to the depositor or the person posting the bond.

As a condition for the granting or renewing of a certificate to self-insure, the commissioner may require a private self-insurer to furnish any additional security the commissioner considers sufficient to insure payment of all claims under chapter 176.

Sec. 28. Minnesota Statutes 2004, section 79A.23, subdivision 3, is amended to read:

Subd. 3. **Operational audit.** (a) The commissioner~~, prior to authorizing surplus distribution of a commercial self-insurance group's first fund year or no later than after the third anniversary of the group's authority to self-insure,~~ may conduct an operational audit of the commercial self-insurance group's claim handling and reserve practices as well as its underwriting procedures to determine if they adhere to the group's business plan and sound business practices. The commissioner may select outside consultants to assist in conducting the audit. After completion of the audit, the commissioner shall either renew or revoke the commercial self-insurance group's authority to self-insure. The commissioner may also order any changes deemed necessary in the claims handling, reserving practices, or underwriting procedures of the group.

(b) The cost of the operational audit shall be borne by the commercial self-insurance group.

Sec. 29. **REPEALER.**

(a) Minnesota Statutes 2004, section 79.251, subdivision 2, is repealed.

(b) Minnesota Rules, parts 2781.0400; 2781.0500; and 2781.0600, are repealed.

79.251 ADMINISTRATION OF ASSIGNED RISK PLAN.

Subd. 2. **Merit rating plan.** To assist small businesses with good safety records, the commissioner shall develop a merit rating plan applicable to all employers holding policies issued pursuant to subdivision 4. The plan shall provide that nonexperience rated employers, with no lost time claims for the last three policy years, shall receive 33 percent credit. The credit must be applied directly to the premium charged for the policy. Nonexperience rated employers with two or more lost time claims for the last three policy years may receive a debit. Experience rated employers shall receive a maximum credit or debit of ten percent of premium. The merit rating plan shall be subject to adjustment by the commissioner as necessary to fulfill the commissioner's assigned risk plan responsibilities.

Not Moved

Senator ..... moves to amend S.F. No. 3480 as follows:

Page 11, after line 24, insert:

"Sec. 13. Minnesota Statutes 2004, section 62A.65, subdivision 3, is amended to read:

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

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

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

(c) A health carrier may request approval by the commissioner to establish ~~no more than three~~ separate geographic ~~regions~~ areas determined by the health carrier and to establish separate index rates for each ~~region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers~~ such area. The commissioner ~~may~~ shall grant approval if the following conditions are met:

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

~~(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;~~

~~(3) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area; and~~

~~(4)~~ (2) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2007, and applies to policies issued or renewed on or after that date."

Page 13, after line 9, insert:

"Sec. 17. Minnesota Statutes 2004, section 62L.08, subdivision 4, is amended to read:

Subd. 4. **Geographic premium variations.** A health carrier may request approval by the commissioner to establish ~~no more than three~~ separate geographic ~~regions~~ areas determined by the health carrier and to establish separate index rates for each ~~region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan~~

~~area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. A health carrier may also request approval to establish one or more additional geographic regions and one or more separate index rates for premiums for employees working and residing outside of Minnesota~~ such area. The commissioner ~~may~~ shall grant approval if the following conditions are met:

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

~~(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;~~

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

~~(4)~~ (2) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

EFFECTIVE DATE. This section is effective January 1, 2007, and applies to policies issued or renewed on or after that date."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator Pogemiller moves to amend S.F. No. 3480 as follows:

Page 12, after line 14, insert:

"Sec. 15. Minnesota Statutes 2004, section 62J.60, subdivision 2, is amended to read:

Subd. 2. **General characteristics.** (a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements ~~left justified in the following top to bottom sequence~~: card issuer name, electronic transaction routing information, card issuer identification number, cardholder (insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements. ~~The window must be left justified.~~

(c) Standardized labels are required next to human readable data elements ~~and must come before the human readable data elements~~.

Sec. 16. Minnesota Statutes 2004, section 62J.60, subdivision 3, is amended to read:

Subd. 3. **Human readable data elements.** (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota uniform health care identification card:

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to

electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be "Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;

(3) ~~card issuer identification number. The standardized label for this element is "Issuer";~~

~~(4)~~ cardholder (insured) identification number, which is the unique identification number of the individual card holder established and defined under this section. The standardized label for the data element is "ID";

~~(5)~~ (4) cardholder (insured) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

~~(6)~~ (5) care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

~~(7)~~ (6) service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health. ~~The standard label for this data element is "Svc Type"~~; and

~~(8)~~ (7) provider/clinic name, which is the name of the primary care clinic the card holder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the card holder.

(b) The following human readable data elements shall be present on the back side of the Minnesota uniform health care identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

(1) claims submission names and addresses, which are the names and addresses of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;

(2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies

or other providers with assistance or with the telephone numbers and names of contacts for assistance; and

(3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

(1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and

(2) one of the following:

(i) telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section 256B.69, 256D.03, or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 and the address to appeal to the commissioner of human services. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

adopted

Senator Rosenilier moves to amend S.F. No. 3480 as follows:

Page 14, line 19, after the period, insert "This section may be implemented as the contracts for health care providers and facilities renew as long as it is fully implemented by January 1, 2008."

adopted

Senator Lechair moves to amend S.F. No. 3480 as follows:

Page 8, delete section 12, and insert:

"Sec. 12. **[62A.3161] MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT COVERAGE.**

The Medicare supplement plan with 50 percent coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (8);

(3) coverage for 50 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (8);

(4) coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (8);

(5) coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations, until the out-of-pocket limitation is met as described in clause (8);

(6) except for coverage provided in this clause, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B, after the policyholder pays the Medicare Part B deductible, until the out-of-pocket limitation is met as described in clause (8);

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible; and

(8) coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment by the secretary of the United States Department of Health and Human Services.

Sec. 13. **[62A.3162] MEDICARE SUPPLEMENT PLAN WITH 75 PERCENT COVERAGE.**

The basic Medicare supplement plan with 75 percent coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 75 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (8);

(3) coverage for 75 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (8);

(4) coverage for 75 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (8);

(5) coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations until the out-of-pocket limitation is met as described in clause (8);

(6) except for coverage provided in this clause, coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in clause (8);

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible; and

(8) coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2,000 in 2006, indexed each year by the appropriate inflation adjustment by the Secretary of the United States Department of Health and Human Services."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

adopted

Senator Belanger moves to amend S.F. No. 3480 as follows:

Page 1, after line 13, insert:

"Section 1. Minnesota Statutes 2005 Supplement, section 45.22, is amended to read:

45.22 LICENSE EDUCATION APPROVAL.

(a) License education courses must be approved in advance by the commissioner. Each sponsor who offers a license education course must ~~have at least one coordinator, approved by the commissioner,~~ be approved by the commissioner. Each approved sponsor must have at least one coordinator who meets the criteria specified in Minnesota Rules, chapter 2809, and who is responsible for supervising the educational program and assuring compliance with all laws and rules. "Sponsor" means any person or entity offering approved education.

~~(b) For coordinators with an initial approval date before August 1, 2005, approval will expire on December 31, 2005.~~ For courses with an initial approval date on or before December 31, 2000, approval will expire on April 30, 2006. For courses with an initial approval date after January 1, 2001, but before August 1, 2005, approval will expire on April 30, 2007.

Sec. 2. Minnesota Statutes 2005 Supplement, section 45.23, is amended to read:

45.23 LICENSE EDUCATION FEES.

The following fees must be paid to the commissioner:

(1) initial course approval, $10 for each hour or fraction of one hour of education course approval sought. Initial course approval expires on the last day of the 24th month after the course is approved;

(2) renewal of course approval, $10 per course. Renewal of course approval expires on the last day of the 24th month after the course is renewed;

(3) initial ~~coordinator~~ sponsor approval, $100. ~~Initial coordinator approval expires on the last day of the 24th month after the coordinator is approved;~~ Initial sponsor approval issued under this section is valid for a period not to exceed 24 months and expires on January 31 of the renewal year assigned by the commissioner. Active sponsors who have at least one approved coordinator as of the effective date of this section are deemed to be approved sponsors and are not required to submit an initial application for sponsor approval; and

(4) renewal of ~~coordinator~~ sponsor approval, $10. ~~Renewal of coordinator approval expires on the last day of the 24th month after the coordinator is renewed.~~ Each renewal of sponsor approval is valid for a period of 24 months. Active sponsors who have at least one approved coordinator as of the effective date of this section will have an expiration date of January 31, 2008.

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

Page 4, after line 23, insert:

"Sec. 8. Minnesota Statutes 2004, section 62A.02, subdivision 3, is amended to read:

Subd. 3. **Standards for disapproval.** (a) The commissioner shall, within 60 days after the filing of any form or rate, disapprove the form or rate:

(1) if the benefits provided are not reasonable in relation to the premium charged;

(2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A;

(3) if the proposed premium rate is excessive or not adequate; or

(4) the actuarial reasons and data submitted do not justify the rate.

The party proposing a rate has the burden of proving by a preponderance of the evidence that it does not violate this subdivision.

In determining the reasonableness of a rate, the commissioner shall also review all administrative contracts, service contracts, and other agreements to determine the reasonableness of the cost of the contracts or agreement and effect of the contracts on the rate. If the commissioner determines that a contract or agreement is not reasonable, the commissioner shall disapprove any rate that reflects any unreasonable cost arising out of the contract or agreement. The commissioner may require any information that the commissioner deems necessary to determine the reasonableness of the cost.

For the purposes of this subdivision, the commissioner shall establish by rule a schedule of minimum anticipated loss ratios which shall be based on (i) the type or types of coverage provided, (ii) whether the policy is for group or individual coverage, and (iii) the size of the group for group policies. Except for individual policies of disability or income protection insurance, the minimum anticipated loss ratio shall not be less than 50 percent after the first year that a policy is in force. All applicants for a policy shall be informed in writing at the time of application of the anticipated loss ratio of the policy. "Anticipated loss ratio" means the ratio at the time of filing, at the time of notice of withdrawal under subdivision 4a, or at the time of subsequent rate revision of the present value of all expected future benefits, excluding dividends, to the present value of all expected future premiums.

If the commissioner notifies a health carrier that has filed any form or rate that it does not comply with this chapter, chapter 62L, or chapter 72A, it shall be unlawful for the health carrier to issue or use the form or rate. In the notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the health carrier.

The 60-day period within which the commissioner is to approve or disapprove the form or rate does not begin to run until a complete filing of all data and materials required by statute or requested by the commissioner has been submitted.

However, if the supporting data is not filed within 30 days after a request by the commissioner, the rate is not effective and is presumed to be an excessive rate.

(b) When an insurer or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission."

Page 18, after line 6, insert:

"Sec. 25. Minnesota Statutes 2004, section 79.251, subdivision 1, is amended to read:

Subdivision 1. **General duties of commissioner.** (a)(1) The commissioner shall have all the usual powers and authorities necessary for the discharge of the commissioner's duties under this section and may contract with individuals in discharge of those duties. The commissioner shall audit the reserves established (a) for individual cases arising under policies and contracts of coverage issued under subdivision 4 and (b) for the total book of business issued under subdivision 4. If the commissioner determines on the basis of an audit that there is an excess surplus in the assigned risk plan, the commissioner must notify the commissioner of finance who shall transfer assets of the plan equal to the excess surplus to the budget reserve account in the general fund.

(2) The commissioner shall monitor the operations of section 79.252 and this section and shall periodically make recommendations to the governor and legislature when appropriate, for improvement in the operation of those sections.

(3) All insurers and self-insurance administrators issuing policies or contracts under subdivision 4 shall pay to the commissioner a .25 percent assessment on premiums for policies and contracts of coverage issued under subdivision 4 for the purpose of defraying the costs of performing the duties under clauses (1) and (2). Proceeds of the assessment shall be deposited in the state treasury and credited to the general fund.

(4) The assigned risk plan shall not be deemed a state agency.

(5) The commissioner shall monitor and have jurisdiction over all reserves maintained for assigned risk plan losses.

(b) As used in this subdivision, "excess surplus" means the amount of assigned risk plan assets in excess of the amount needed to pay all current liabilities of the plan, including, but not limited to:

(1) administrative expenses;

(2) benefit claims; and

(3) if the assigned risk plan is dissolved under subdivision 8, the amounts that would be due insurers who have paid assessments to the plan."

Page 18, delete section 23 and insert:

"Sec. 26. Minnesota Statutes 2004, section 79.251, is amended by adding a subdivision to read:

Subd. 2a. **Assigned risk rating plan.** (a) Employers insured through the assigned risk plan are subject to paragraphs (b) and (c).

(b) Classifications must be assigned according to a uniform classification system approved by the commissioner.

(c) Rates must be modified according to an experience rating plan approved by the commissioner. Any experience rating plan is subject to Minnesota Rules, parts 2700.2800 and 2700.2900."

Page 19, line 18, delete "30" and insert "60"

Page 19, delete line 19 and insert "notice to the employer pursuant to section 176.185, subdivision 1."

Page 22, delete lines 14 and 15 and insert:

"Minnesota Rules, parts 2781.0100; 2781.0200; 2781.0300; 2781.0400; 2781.0500; and 2781.0600, are repealed."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

adopted

Senator Pappas moves to amend S.F. No. 3480 as follows:

Page 12, after line 14, insert:

"Sec. 15. Minnesota Statutes 2004, section 62E.14, subdivision 5, is amended to read:

Subd. 5. **Terminated employees.** An employee who is voluntarily or involuntarily terminated or laid off from employment and unable to exercise the option to continue coverage under section 62A.17, and who is a Minnesota resident and who is otherwise eligible, may enroll in the comprehensive health insurance plan, by submitting an application that is received by the writing carrier no later than 90 days after termination or layoff, with a waiver of the preexisting condition limitation set forth in subdivision 3 ~~and a waiver of the evidence of rejection set forth in subdivision 1, paragraph (c)~~.

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

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

adopted

Senator Scheid moves to amend S.F. No. 3480 as follows:

Page 12, after line 14, insert:

"Sec. 15. Minnesota Statutes 2004, section 62E.13, subdivision 3, is amended to read:

Subd. 3. **Duties of writing carrier.** The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of ~~three~~ five years, unless a request to terminate is approved by the commissioner. The commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. Six months prior to the expiration of each ~~three-year~~ five-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of subdivision 2 in selecting a writing carrier for the subsequent ~~three-year~~ five-year period."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

adopted

Senator Lourey moves to amend S.F. No. 3480 as follows:

Page 17, after line 13, insert:

"Sec. 20. Minnesota Statutes 2004, section 70A.07, is amended to read:

70A.07 RATES AND FORMS OPEN TO INSPECTION.

All rates, supplementary rate information, and forms furnished to the commissioner under this chapter shall, ~~as soon as the commissioner's review has been completed~~ within ten days of their effective date, be open to public inspection at any reasonable time."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

adopt

Senator Michel moves to amend S.F. No. 3480 as follows:

Page 22, after line 12, insert:

"Sec. 29. Minnesota Statutes 2004, section 79A.32, is amended to read:

79A.32 REPORTING TO ~~MINNESOTA WORKERS' COMPENSATION INSURERS' ASSOCIATION~~ LICENSED DATA SERVICE ORGANIZATIONS.

~~Subdivision 1. **Required activity.** Each self-insurer shall perform the following activities:~~

~~(1) maintain membership in and report loss experience data to the Minnesota Workers' Compensation Insurers Association, or a licensed data service organization, in accordance with the statistical plan and rules of the organization as approved by the commissioner;~~

~~(2) establish a plan for merit rating which shall be consistently applied to all insureds, provided that members of a data service organization may use merit rating plans developed by that data service organization;~~

~~(3) provide an annual report to the commissioner containing the information and prepared in the form required by the commissioner; and~~

~~(4) keep a record of the losses paid by the self-insurers and premiums for the group self-insurers.~~

Subd. 2. **Permitted activity.** ~~In addition to any other activities not prohibited by this chapter, self-insurers may~~ Through data service organizations licensed under chapter 79, self insurers may:

(1) ~~through licensed data service organizations,~~ individually, or with self-insurers commonly owned, managed, or controlled, conduct research and collect statistics to investigate, identify, and classify information relating to causes or prevention of losses; and

(2) at the request of a private self insurer or self insurer group, submit and collect data, including payroll and loss data; and perform calculations, including calculations of experience modifications of individual self-insured employers.

~~(2) develop and use classification plans and rates based upon any reasonable factors; and~~

~~(3) develop rules for the assignment of risks to classifications.~~

~~Subd. 3. **Delayed reporting.** Private self-insurers established under sections 79A.01 to 79A.18 prior to August 1, 1995, need not begin filing the reports required under subdivision 1 until January 1, 1998.~~"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

adopted

Senator Rieter moves to amend S.F. No. 3480 as follows:

Page 17, after line 13, insert:

"Sec. 20. Minnesota Statutes 2005 Supplement, section 72A.201, subdivision 6, is amended to read:

Subd. 6. **Standards for automobile insurance claims handling, settlement offers, and agreements.** In addition to the acts specified in subdivisions 4, 5, 7, 8, and 9, the following acts by an insurer, adjuster, or a self-insured or self-insurance administrator constitute unfair settlement practices:

(1) if an automobile insurance policy provides for the adjustment and settlement of an automobile total loss on the basis of actual cash value or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) comparable and available replacement automobile, with all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to the transfer or evidence of ownership of the automobile paid, at no cost to the insured other than the deductible amount as provided in the policy;

(b) a cash settlement based upon the actual cost of purchase of a comparable automobile, including all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to transfer of evidence of ownership, less the deductible amount as provided in the policy. The costs must be determined by:

(i) the cost of a comparable automobile, adjusted for mileage, condition, and options, in the local market area of the insured, if such an automobile is available in that area; or

(ii) one of two or more quotations obtained from two or more qualified sources located within the local market area when a comparable automobile is not available in the local market area. The insured shall be provided the information contained in all quotations prior to settlement; or

(iii) any settlement or offer of settlement which deviates from the procedure above must be documented and justified in detail. The basis for the settlement or offer of settlement must be explained to the insured;

(2) if an automobile insurance policy provides for the adjustment and settlement of an automobile partial loss on the basis of repair or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) to assume all costs, including reasonable towing costs, for the satisfactory repair of the motor vehicle. Satisfactory repair includes repair of both obvious and hidden

damage as caused by the claim incident. This assumption of cost may be reduced by applicable policy provision; or

(b) to offer a cash settlement sufficient to pay for satisfactory repair of the vehicle. Satisfactory repair includes repair of obvious and hidden damage caused by the claim incident, and includes reasonable towing costs;

(3) regardless of whether the loss was total or partial, in the event that a damaged vehicle of an insured cannot be safely driven, failing to exercise the right to inspect automobile damage prior to repair within five business days following receipt of notification of claim. In other cases the inspection must be made in 15 days;

(4) regardless of whether the loss was total or partial, requiring unreasonable travel of a claimant or insured to inspect a replacement automobile, to obtain a repair estimate, to allow an insurer to inspect a repair estimate, to allow an insurer to inspect repairs made pursuant to policy requirements, or to have the automobile repaired;

(5) regardless of whether the loss was total or partial, if loss of use coverage exists under the insurance policy, failing to notify an insured at the time of the insurer's acknowledgment of claim, or sooner if inquiry is made, of the fact of the coverage, including the policy terms and conditions affecting the coverage and the manner in which the insured can apply for this coverage;

(6) regardless of whether the loss was total or partial, failing to include the insured's deductible in the insurer's demands under its subrogation rights. Subrogation recovery must be shared at least on a proportionate basis with the insured, unless the deductible amount has been otherwise recovered by the insured, except that when an insurer is recovering directly from an uninsured third party by means of installments, the insured must receive the full deductible share as soon as that amount is collected and before any part of the total recovery is applied to any other use. No deduction for expenses may be made from the deductible recovery unless an attorney is retained to collect the recovery, in which case deduction may be made only for a pro rata share of the cost of retaining the attorney. An insured is not bound by any settlement of its insurer's subrogation claim with respect to the deductible amount, unless the insured receives, as a result of the subrogation settlement, the full amount of the deductible. Recovery by the insurer and receipt by the insured of less than all of the insured's deductible amount does not affect the insured's rights to recover any unreimbursed portion of the deductible from parties liable for the loss;

(7) requiring as a condition of payment of a claim that repairs to any damaged vehicle must be made by a particular contractor or repair shop or that parts, other than window glass, must be replaced with parts other than original equipment parts or engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or

against an insured to use a particular contractor or repair shop. Consumer benefits included within preferred vendor programs must not be considered an incentive or inducement. At the time a claim is reported, the insurer must provide the following advisory to the insured or claimant:

"~~Minnesota law gives~~ You have the legal right to choose a repair shop to fix your vehicle. Your policy will cover the reasonable costs of repairing your vehicle to its pre-accident condition no matter where you have repairs made. Have you selected a repair shop or would you like a referral?"

After an insured has indicated that the insured has selected a repair shop, the insurer must cease all efforts to influence the insured's or claimant's choice of repair shop;

(8) where liability is reasonably clear, failing to inform the claimant in an automobile property damage liability claim that the claimant may have a claim for loss of use of the vehicle;

(9) failing to make a good faith assignment of comparative negligence percentages in ascertaining the issue of liability;

(10) failing to pay any interest required by statute on overdue payment for an automobile personal injury protection claim;

(11) if an automobile insurance policy contains either or both of the time limitation provisions as permitted by section 65B.55, subdivisions 1 and 2, failing to notify the insured in writing of those limitations at least 60 days prior to the expiration of that time limitation;

(12) if an insurer chooses to have an insured examined as permitted by section 65B.56, subdivision 1, failing to notify the insured of all of the insured's rights and obligations under that statute, including the right to request, in writing, and to receive a copy of the report of the examination;

(13) failing to provide, to an insured who has submitted a claim for benefits described in section 65B.44, a complete copy of the insurer's claim file on the insured, excluding internal company memoranda, all materials that relate to any insurance fraud investigation, materials that constitute attorney work-product or that qualify for the attorney-client privilege, and medical reviews that are subject to section 145.64, within ten business days of receiving a written request from the insured. The insurer may charge the insured a reasonable copying fee. This clause supersedes any inconsistent provisions of sections 72A.49 to 72A.505;

(14) if an automobile policy provides for the adjustment or settlement of an automobile loss due to damaged window glass, failing to provide payment to the insured's

chosen vendor based on a competitive price that is fair and reasonable within the local industry at large.

Where facts establish that a different rate in a specific geographic area actually served by the vendor is required by that market, that geographic area must be considered. This clause does not prohibit an insurer from recommending a vendor to the insured or from agreeing with a vendor to perform work at an agreed-upon price, provided, however, that before recommending a vendor, the insurer shall offer its insured the opportunity to choose the vendor. If the insurer recommends a vendor, the insurer must also provide the following advisory:

"Minnesota law gives you the right to go to any glass vendor you choose, and prohibits me from pressuring you to choose a particular vendor.";

(15) requiring that the repair or replacement of motor vehicle glass and related products and services be made in a particular place or shop or by a particular entity, or by otherwise limiting the ability of the insured to select the place, shop, or entity to repair or replace the motor vehicle glass and related products and services; or

(16) engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an insured to use a particular company or location to provide the motor vehicle glass repair or replacement services or products. For purposes of this section, a warranty shall not be considered an inducement or incentive."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

adopted

Senator Sparks moves to amend S.F. No. 3480 as follows:

Page 14, delete section 19 and insert:

"Sec. 19. Minnesota Statutes 2005 Supplement, section 65B.49, subdivision 5a, is amended to read:

Subd. 5a. **Rental vehicles.** (a) Every plan of reparation security, wherever issued, insuring a natural person as named insured, covering private passenger vehicles as defined under section 65B.001, subdivision 3, and pickup trucks and vans as defined under section 168.011 must: (1) provide that all of the obligation for damage and loss of use to a rented private passenger vehicle, including pickup trucks and vans as defined under section 168.011, and rented trucks with a registered gross vehicle weight of 26,000 pounds or less would be covered by the property damage liability portion of the plan; and (2) extend the plan's basic economic loss benefits, residual liability insurance, and uninsured and underinsured motorist coverages to the operation or use of the rented motor vehicle. This subdivision does not apply to plans of reparation security covering only motor vehicles registered under section 168.10, subdivision 1a, 1b, 1c, or 1d, or recreational equipment as defined under section 168.011. The obligation of the plan must not be contingent on fault or negligence. In all cases where the plan's property damage liability coverage is less than $35,000, the coverage available under the subdivision must be $35,000. Other than as described in this paragraph ~~or in~~; paragraph (i), clause (2); or paragraph (j), nothing in this section amends or alters the provisions of the plan of reparation security as to primacy of the coverages in this section.

(b) A vehicle is rented for purposes of this subdivision:

(1) if the rate for the use of the vehicle is determined on a monthly, weekly, or daily basis; or

(2) during the time that a vehicle is loaned as a replacement for a vehicle being serviced or repaired regardless of whether the customer is charged a fee for the use of the vehicle.

A vehicle is not rented for the purposes of this subdivision if the rate for the vehicle's use is determined on a period longer than one month or if the term of the rental agreement is longer than one month. A vehicle is not rented for purposes of this subdivision if the rental agreement has a purchase or buyout option or otherwise functions as a substitute for purchase of the vehicle.

(c) The policy or certificate issued by the plan must inform the insured of the application of the plan to private passenger rental vehicles, including pickup trucks and vans as defined under section 168.011, and that the insured may not need to purchase additional coverage from the rental company.

(d) Where an insured has two or more vehicles covered by a plan or plans of reparation security containing the rented motor vehicle coverage required under paragraph (a), the insured may select the plan the insured wishes to collect from and that plan is entitled to a pro rata contribution from the other plan or plans based upon the property damage limits of liability. If the person renting the motor vehicle is also covered by the person's employer's insurance policy or the employer's automobile self-insurance plan, the reparation obligor under the employer's policy or self-insurance plan has primary responsibility to pay claims arising from use of the rented vehicle.

(e) A notice advising the insured of rental vehicle coverage must be given by the reparation obligor to each current insured with the first renewal notice after January 1, 1989. The notice must be approved by the commissioner of commerce. The commissioner may specify the form of the notice.

(f) When a motor vehicle is rented in this state, ~~there must be attached to~~ the rental contract ~~a separate form containing~~ must contain a written notice in at least 10-point bold type, if printed, or in capital letters, if typewritten, which states:

Under Minnesota law, a personal automobile insurance policy ~~issued in Minnesota~~ must : (1) cover the rental of this motor vehicle against damage to the vehicle and against loss of use of the vehicle; and (2) extend the policy's basic economic loss benefits, residual liability insurance, and uninsured and underinsured motorist coverages to the operation or use of a rented motor vehicle. Therefore, purchase of any collision damage waiver or similar insurance affected in this rental contract is not necessary ~~if your policy was issued in Minnesota~~. In addition, purchase of any additional liability insurance is not necessary if your policy was issued in Minnesota unless you wish to have coverage for liability that exceeds the amount specified in your personal automobile insurance policy.

No collision damage waiver or other insurance offered as part of or in conjunction with a rental of a motor vehicle may be sold unless the person renting the vehicle provides a written acknowledgment that the above consumer protection notice has been read and understood.

(g) When damage to a rented vehicle is covered by a plan of reparation security as provided under paragraph (a), the rental contract must state that payment by the reparation obligor within the time limits of section 72A.201 is acceptable, and prior payment by the renter is not required.

(h) Compensation for the loss of use of a damaged rented motor vehicle is limited to a period no longer than 14 days.

(i)(1) For purposes of this ~~paragraph~~ subdivision, "rented motor vehicle" means a rented vehicle described in paragraph (a), using the definition of "rented" provided in paragraph (b).

(2) Notwithstanding section 169.09, subdivision 5a, an owner of a rented motor vehicle is not vicariously liable for legal damages resulting from the operation of the rented motor vehicle in an amount greater than $100,000 because of bodily injury to one person in any one accident and, subject to the limit for one person, $300,000 because of injury to two or more persons in any one accident, and $50,000 because of injury to or destruction of property of others in any one accident, if the owner of the rented motor vehicle has in effect, at the time of the accident, a policy of insurance or self-insurance, as provided in section 65B.48, subdivision 3, covering losses up to at least the amounts set forth in this paragraph. Nothing in this paragraph alters or affects the obligations of an owner of a rented motor vehicle to comply with the requirements of compulsory insurance through a policy of insurance as provided in section 65B.48, subdivision 2, or through self-insurance as provided in section 65B.48, subdivision 3, which policy of insurance or self-insurance must apply whenever the operator is not covered by a plan of reparation security as provided under paragraph (a); or with the obligations arising from section 72A.125 for products sold in conjunction with the rental of a motor vehicle. Nothing in this paragraph alters or affects liability, other than vicarious liability, of an owner of a rented motor vehicle.

(3) The dollar amounts stated in this paragraph shall be adjusted for inflation based upon the Consumer Price Index for all urban consumers, known as the CPI-U, published by the United States Bureau of Labor Statistics. The dollar amounts stated in this paragraph are based upon the value of that index for July 1995, which is the reference base index for purposes of this paragraph. The dollar amounts in this paragraph shall change effective January 1 of each odd-numbered year based upon the percentage difference between the index for July of the preceding year and the reference base index, calculated to the nearest whole percentage point. The commissioner shall announce and publish, on or before September 30 of the preceding year, the changes in the dollar amounts required by this paragraph to take effect on January 1 of each odd-numbered year. The commissioner shall use the most recent revision of the July index available as of September 1. Changes in the dollar amounts must be in increments of $5,000, and no change shall be made in a dollar amount until the change in the index requires at least a $5,000 change. If the United States Bureau of Labor Statistics changes the base year upon which the CPI-U is based, the commissioner shall make the calculations necessary

to convert from the old base year to the new base year. If the CPI-U is discontinued, the commissioner shall use the available index that is most similar to the CPI-U.

(j) The plan of reparation security covering the owner of a rented motor vehicle is excess of any residual liability coverage insuring an operator of a rented motor vehicle ~~if the vehicle is loaned as a replacement for a vehicle being serviced or repaired, regardless of whether a fee is charged for use of the vehicle, provided that the vehicle so loaned is owned by the service or repair business~~.

(k) Notwithstanding any other law to the contrary, the owner of a rented private passenger vehicle is responsible for all damages and loss of use to a rented private passenger vehicle, which is caused directly by weather-related natural phenomena."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

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

S.F. No. 3480: A bill for an act relating to insurance; regulating certain form approvals, coverages, filings, utilization reviews, and claims; amending Minnesota Statutes 2004, sections 60C.02, subdivision 1; 61A.02, subdivision 3; 61A.092, subdivisions 1, 3; 62A.095, subdivision 1; 62A.17, subdivisions 1, 2, 5; 62A.27; 62A.3093; 62C.14, subdivisions 9, 10; 62L.02, subdivision 24; 62M.01, subdivision 2; 62M.09, subdivision 9; 72C.10, subdivision 1; 79.01, by adding subdivisions; 79.251, by adding a subdivision; 79.252, by adding subdivisions; 79A.23, subdivision 3; Minnesota Statutes 2005 Supplement, sections 59B.01; 62A.316; 62Q.75, subdivision 3; 65B.49, subdivision 5a; 79A.04, subdivision 2; repealing Minnesota Statutes 2004, section 79.251, subdivision 2; Minnesota Rules, parts 2781.0400; 2781.0500; 2781.0600.

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

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

"Section 1. Minnesota Statutes 2005 Supplement, section 45.22, is amended to read:

45.22 LICENSE EDUCATION APPROVAL.

(a) License education courses must be approved in advance by the commissioner. Each sponsor who offers a license education course must ~~have at least one coordinator, approved by the commissioner,~~ be approved by the commissioner. Each approved sponsor must have at least one coordinator who meets the criteria specified in Minnesota Rules, chapter 2809, and who is responsible for supervising the educational program and assuring compliance with all laws and rules. "Sponsor" means any person or entity offering approved education.

~~(b) For coordinators with an initial approval date before August 1, 2005, approval will expire on December 31, 2005.~~ For courses with an initial approval date on or before December 31, 2000, approval will expire on April 30, 2006. For courses with an initial approval date after January 1, 2001, but before August 1, 2005, approval will expire on April 30, 2007.

Sec. 2. Minnesota Statutes 2005 Supplement, section 45.23, is amended to read:

45.23 LICENSE EDUCATION FEES.

The following fees must be paid to the commissioner:

(1) initial course approval, $10 for each hour or fraction of one hour of education course approval sought. Initial course approval expires on the last day of the 24th month after the course is approved;

(2) renewal of course approval, $10 per course. Renewal of course approval expires on the last day of the 24th month after the course is renewed;

(3) initial ~~coordinator~~ sponsor approval, $100. ~~Initial coordinator approval expires on the last day of the 24th month after the coordinator is approved;~~ Initial sponsor approval issued under this section is valid for a period not to exceed 24 months and expires on January 31 of the renewal year assigned by the commissioner. Active sponsors

who have at least one approved coordinator as of the effective date of this section are deemed to be approved sponsors and are not required to submit an initial application for sponsor approval; and

(4) renewal of ~~coordinator~~ sponsor approval, $10. ~~Renewal of coordinator approval expires on the last day of the 24th month after the coordinator is renewed.~~ Each renewal of sponsor approval is valid for a period of 24 months. Active sponsors who have at least one approved coordinator as of the effective date of this section will have an expiration date of January 31, 2008.

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

Page 3, delete section 4

Page 4, after line 23, insert:

"Sec. 5. Minnesota Statutes 2004, section 62A.02, subdivision 3, is amended to read:

Subd. 3. **Standards for disapproval.** (a) The commissioner shall, within 60 days after the filing of any form or rate, disapprove the form or rate:

(1) if the benefits provided are not reasonable in relation to the premium charged;

(2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A;

(3) if the proposed premium rate is excessive or not adequate; or

(4) the actuarial reasons and data submitted do not justify the rate.

The party proposing a rate has the burden of proving by a preponderance of the evidence that it does not violate this subdivision.

In determining the reasonableness of a rate, the commissioner shall also review all administrative contracts, service contracts, and other agreements to determine the reasonableness of the cost of the contracts or agreement and effect of the contracts on the rate. If the commissioner determines that a contract or agreement is not reasonable, the commissioner shall disapprove any rate that reflects any unreasonable cost arising out of the contract or agreement. The commissioner may require any information that the commissioner deems necessary to determine the reasonableness of the cost.

For the purposes of this subdivision, the commissioner shall establish by rule a schedule of minimum anticipated loss ratios which shall be based on (i) the type or types of coverage provided, (ii) whether the policy is for group or individual coverage, and (iii) the size of the group for group policies. Except for individual policies of disability or income protection insurance, the minimum anticipated loss ratio shall not be less than 50 percent after the first year that a policy is in force. All applicants for a policy shall be informed in writing at the time of application of the anticipated loss ratio of the

policy. "Anticipated loss ratio" means the ratio at the time of filing, at the time of notice of withdrawal under subdivision 4a, or at the time of subsequent rate revision of the present value of all expected future benefits, excluding dividends, to the present value of all expected future premiums.

If the commissioner notifies a health carrier that has filed any form or rate that it does not comply with this chapter, chapter 62L, or chapter 72A, it shall be unlawful for the health carrier to issue or use the form or rate. In the notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the health carrier.

The 60-day period within which the commissioner is to approve or disapprove the form or rate does not begin to run until a complete filing of all data and materials required by statute or requested by the commissioner has been submitted.

However, if the supporting data is not filed within 30 days after a request by the commissioner, the rate is not effective and is presumed to be an excessive rate.

(b) When an insurer or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission."

Page 6, delete section 9

Pages 8 to 11, delete section 12 and insert:

"Sec. 11. **[62A.3161] MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT COVERAGE.**

The Medicare supplement plan with 50 percent coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (8);

(3) coverage for 50 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (8);

(4) coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (8);

(5) coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations, until the out-of-pocket limitation is met as described in clause (8);

(6) except for coverage provided in this clause, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B, after the policyholder pays the Medicare Part B deductible, until the out-of-pocket limitation is met as described in clause (8);

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible; and

(8) coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment by the secretary of the United States Department of Health and Human Services.

Sec. 12. **[62A.3162] MEDICARE SUPPLEMENT PLAN WITH 75 PERCENT COVERAGE.**

The basic Medicare supplement plan with 75 percent coverage must have a level of coverage that will provide:

(1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end;

(2) coverage for 75 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (8);

(3) coverage for 75 percent of the coinsurance amount for each day used from the 21st through the 100th day in a Medicare benefit period for posthospital skilled nursing care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (8);

(4) coverage for 75 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (8);

(5) coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced according to federal regulations until the out-of-pocket limitation is met as described in clause (8);

(6) except for coverage provided in this clause, coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in clause (8);

(7) coverage of 100 percent of the cost sharing for Medicare Part B preventive services and diagnostic procedures for cancer screening described in section 62A.30 after the policyholder pays the Medicare Part B deductible; and

(8) coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2,000 in 2006, indexed each year by the appropriate inflation adjustment by the Secretary of the United States Department of Health and Human Services."

Page 12, after line 14, insert:

"Sec. 15. Minnesota Statutes 2004, section 62E.13, subdivision 3, is amended to read:

Subd. 3. **Duties of writing carrier.** The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of ~~three~~ five years, unless a request to terminate is approved by the commissioner. The commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. Six months prior to the expiration of each ~~three-year~~ five-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of subdivision 2 in selecting a writing carrier for the subsequent ~~three-year~~ five-year period.

Sec. 16. Minnesota Statutes 2004, section 62E.14, subdivision 5, is amended to read:

Subd. 5. **Terminated employees.** An employee who is voluntarily or involuntarily terminated or laid off from employment and unable to exercise the option to continue coverage under section 62A.17, and who is a Minnesota resident and who is otherwise eligible, may enroll in the comprehensive health insurance plan, by submitting an application that is received by the writing carrier no later than 90 days after termination or layoff, with a waiver of the preexisting condition limitation set forth in subdivision 3 ~~and a waiver of the evidence of rejection set forth in subdivision 1, paragraph (c)~~.

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

Sec. 17. Minnesota Statutes 2004, section 62J.60, subdivision 2, is amended to read:

Subd. 2. **General characteristics.** (a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements ~~left justified in the following top to bottom sequence~~: card issuer name, electronic transaction routing information, card issuer identification number, cardholder (insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements. ~~The window must be left justified.~~

(c) Standardized labels are required next to human readable data elements ~~and must come before the human readable data elements~~.

Sec. 18. Minnesota Statutes 2004, section 62J.60, subdivision 3, is amended to read:

Subd. 3. **Human readable data elements.** (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota uniform health care identification card:

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be

"Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;

(3) ~~card issuer identification number. The standardized label for this element is "Issuer";~~

~~(4)~~ cardholder (insured) identification number, which is the unique identification number of the individual card holder established and defined under this section. The standardized label for the data element is "ID";

~~(5)~~ (4) cardholder (insured) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

~~(6)~~ (5) care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

~~(7)~~ (6) service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health. ~~The standard label for this data element is "Svc Type"~~; and

~~(8)~~ (7) provider/clinic name, which is the name of the primary care clinic the card holder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the card holder.

(b) The following human readable data elements shall be present on the back side of the Minnesota uniform health care identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

(1) claims submission names and addresses, which are the names and addresses of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;

(2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies or other providers with assistance or with the telephone numbers and names of contacts for assistance; and

(3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

(1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and

(2) one of the following:

(i) telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section 256B.69, 256D.03, or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 and the address to appeal to the commissioner of human services. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion."

Page 14, line 19, after the period, insert "This section may be implemented as the contracts for health care providers and facilities renew as long as it is fully implemented by January 1, 2008."

Pages 14 to 17, delete section 19 and insert:

"Sec. 23. Minnesota Statutes 2005 Supplement, section 65B.49, subdivision 5a, is amended to read:

Subd. 5a. **Rental vehicles.** (a) Every plan of reparation security, wherever issued, insuring a natural person as named insured, covering private passenger vehicles as defined under section 65B.001, subdivision 3, and pickup trucks and vans as defined under section 168.011 must: (1) provide that all of the obligation for damage and loss of use to a rented private passenger vehicle, including pickup trucks and vans as defined under section 168.011, and rented trucks with a registered gross vehicle weight of 26,000 pounds or less would be covered by the property damage liability portion of the plan; and (2) extend the plan's basic economic loss benefits, residual liability insurance, and uninsured and underinsured motorist coverages to the operation or use of the rented motor vehicle. This subdivision does not apply to plans of reparation security covering only motor vehicles registered under section 168.10, subdivision 1a, 1b, 1c, or 1d, or recreational equipment as defined under section 168.011. The obligation of the plan must not be contingent on

fault or negligence. In all cases where the plan's property damage liability coverage is less than $35,000, the coverage available under the subdivision must be $35,000. Other than as described in this paragraph ~~or in~~; paragraph (i), clause (2); or paragraph (j), nothing in this section amends or alters the provisions of the plan of reparation security as to primacy of the coverages in this section.

(b) A vehicle is rented for purposes of this subdivision:

(1) if the rate for the use of the vehicle is determined on a monthly, weekly, or daily basis; or

(2) during the time that a vehicle is loaned as a replacement for a vehicle being serviced or repaired regardless of whether the customer is charged a fee for the use of the vehicle.

A vehicle is not rented for the purposes of this subdivision if the rate for the vehicle's use is determined on a period longer than one month or if the term of the rental agreement is longer than one month. A vehicle is not rented for purposes of this subdivision if the rental agreement has a purchase or buyout option or otherwise functions as a substitute for purchase of the vehicle.

(c) The policy or certificate issued by the plan must inform the insured of the application of the plan to private passenger rental vehicles, including pickup trucks and vans as defined under section 168.011, and that the insured may not need to purchase additional coverage from the rental company.

(d) Where an insured has two or more vehicles covered by a plan or plans of reparation security containing the rented motor vehicle coverage required under paragraph (a), the insured may select the plan the insured wishes to collect from and that plan is entitled to a pro rata contribution from the other plan or plans based upon the property damage limits of liability. If the person renting the motor vehicle is also covered by the person's employer's insurance policy or the employer's automobile self-insurance plan, the reparation obligor under the employer's policy or self-insurance plan has primary responsibility to pay claims arising from use of the rented vehicle.

(e) A notice advising the insured of rental vehicle coverage must be given by the reparation obligor to each current insured with the first renewal notice after January 1, 1989. The notice must be approved by the commissioner of commerce. The commissioner may specify the form of the notice.

(f) When a motor vehicle is rented in this state, ~~there must be attached to~~ the rental contract ~~a separate form containing~~ must contain a written notice in at least 10-point bold type, if printed, or in capital letters, if typewritten, which states:

Under Minnesota law, a personal automobile insurance policy ~~issued in Minnesota~~ must : (1) cover the rental of this motor vehicle against damage to the vehicle and against loss of use of the vehicle; and (2) extend the policy's basic economic loss benefits, residual liability insurance, and uninsured and underinsured motorist coverages to the operation or use of a rented motor vehicle. Therefore, purchase of any collision damage waiver or similar insurance affected in this rental contract is not necessary ~~if your policy was issued in Minnesota~~. In addition, purchase of any additional liability insurance is not necessary if your policy was issued in Minnesota unless you wish to have coverage for liability that exceeds the amount specified in your personal automobile insurance policy.

No collision damage waiver or other insurance offered as part of or in conjunction with a rental of a motor vehicle may be sold unless the person renting the vehicle provides a written acknowledgment that the above consumer protection notice has been read and understood.

(g) When damage to a rented vehicle is covered by a plan of reparation security as provided under paragraph (a), the rental contract must state that payment by the reparation obligor within the time limits of section 72A.201 is acceptable, and prior payment by the renter is not required.

(h) Compensation for the loss of use of a damaged rented motor vehicle is limited to a period no longer than 14 days.

(i)(1) For purposes of this ~~paragraph~~ subdivision, "rented motor vehicle" means a rented vehicle described in paragraph (a), using the definition of "rented" provided in paragraph (b).

(2) Notwithstanding section 169.09, subdivision 5a, an owner of a rented motor vehicle is not vicariously liable for legal damages resulting from the operation of the rented motor vehicle in an amount greater than $100,000 because of bodily injury to one person in any one accident and, subject to the limit for one person, $300,000 because of injury to two or more persons in any one accident, and $50,000 because of injury to or destruction of property of others in any one accident, if the owner of the rented motor vehicle has in effect, at the time of the accident, a policy of insurance or self-insurance, as provided in section 65B.48, subdivision 3, covering losses up to at least the amounts set forth in this paragraph. Nothing in this paragraph alters or affects the obligations of an owner of a rented motor vehicle to comply with the requirements of compulsory insurance through a policy of insurance as provided in section 65B.48, subdivision 2, or through self-insurance as provided in section 65B.48, subdivision 3, which policy of insurance or self-insurance must apply whenever the operator is not covered by a plan of reparation

security as provided under paragraph (a); or with the obligations arising from section 72A.125 for products sold in conjunction with the rental of a motor vehicle. Nothing in this paragraph alters or affects liability, other than vicarious liability, of an owner of a rented motor vehicle.

(3) The dollar amounts stated in this paragraph shall be adjusted for inflation based upon the Consumer Price Index for all urban consumers, known as the CPI-U, published by the United States Bureau of Labor Statistics. The dollar amounts stated in this paragraph are based upon the value of that index for July 1995, which is the reference base index for purposes of this paragraph. The dollar amounts in this paragraph shall change effective January 1 of each odd-numbered year based upon the percentage difference between the index for July of the preceding year and the reference base index, calculated to the nearest whole percentage point. The commissioner shall announce and publish, on or before September 30 of the preceding year, the changes in the dollar amounts required by this paragraph to take effect on January 1 of each odd-numbered year. The commissioner shall use the most recent revision of the July index available as of September 1. Changes in the dollar amounts must be in increments of $5,000, and no change shall be made in a dollar amount until the change in the index requires at least a $5,000 change. If the United States Bureau of Labor Statistics changes the base year upon which the CPI-U is based, the commissioner shall make the calculations necessary to convert from the old base year to the new base year. If the CPI-U is discontinued, the commissioner shall use the available index that is most similar to the CPI-U.

(j) The plan of reparation security covering the owner of a rented motor vehicle is excess of any residual liability coverage insuring an operator of a rented motor vehicle ~~if the vehicle is loaned as a replacement for a vehicle being serviced or repaired, regardless of whether a fee is charged for use of the vehicle, provided that the vehicle so loaned is owned by the service or repair business~~.

(k) Notwithstanding any other law to the contrary, the owner of a rented private passenger vehicle is responsible for all damages and loss of use to a rented private passenger vehicle, which is caused directly by weather-related natural phenomena.

Sec. 24. Minnesota Statutes 2004, section 70A.07, is amended to read:

70A.07 RATES AND FORMS OPEN TO INSPECTION.

All rates, supplementary rate information, and forms furnished to the commissioner under this chapter shall, ~~as soon as the commissioner's review has been completed~~ within ten days of their effective date, be open to public inspection at any reasonable time.

Sec. 25. Minnesota Statutes 2005 Supplement, section 72A.201, subdivision 6, is amended to read:

Subd. 6. **Standards for automobile insurance claims handling, settlement offers, and agreements.** In addition to the acts specified in subdivisions 4, 5, 7, 8, and 9, the following acts by an insurer, adjuster, or a self-insured or self-insurance administrator constitute unfair settlement practices:

(1) if an automobile insurance policy provides for the adjustment and settlement of an automobile total loss on the basis of actual cash value or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) comparable and available replacement automobile, with all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to the transfer or evidence of ownership of the automobile paid, at no cost to the insured other than the deductible amount as provided in the policy;

(b) a cash settlement based upon the actual cost of purchase of a comparable automobile, including all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to transfer of evidence of ownership, less the deductible amount as provided in the policy. The costs must be determined by:

(i) the cost of a comparable automobile, adjusted for mileage, condition, and options, in the local market area of the insured, if such an automobile is available in that area; or

(ii) one of two or more quotations obtained from two or more qualified sources located within the local market area when a comparable automobile is not available in the local market area. The insured shall be provided the information contained in all quotations prior to settlement; or

(iii) any settlement or offer of settlement which deviates from the procedure above must be documented and justified in detail. The basis for the settlement or offer of settlement must be explained to the insured;

(2) if an automobile insurance policy provides for the adjustment and settlement of an automobile partial loss on the basis of repair or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) to assume all costs, including reasonable towing costs, for the satisfactory repair of the motor vehicle. Satisfactory repair includes repair of both obvious and hidden damage as caused by the claim incident. This assumption of cost may be reduced by applicable policy provision; or

(b) to offer a cash settlement sufficient to pay for satisfactory repair of the vehicle. Satisfactory repair includes repair of obvious and hidden damage caused by the claim incident, and includes reasonable towing costs;

(3) regardless of whether the loss was total or partial, in the event that a damaged vehicle of an insured cannot be safely driven, failing to exercise the right to inspect automobile damage prior to repair within five business days following receipt of notification of claim. In other cases the inspection must be made in 15 days;

(4) regardless of whether the loss was total or partial, requiring unreasonable travel of a claimant or insured to inspect a replacement automobile, to obtain a repair estimate, to allow an insurer to inspect a repair estimate, to allow an insurer to inspect repairs made pursuant to policy requirements, or to have the automobile repaired;

(5) regardless of whether the loss was total or partial, if loss of use coverage exists under the insurance policy, failing to notify an insured at the time of the insurer's acknowledgment of claim, or sooner if inquiry is made, of the fact of the coverage, including the policy terms and conditions affecting the coverage and the manner in which the insured can apply for this coverage;

(6) regardless of whether the loss was total or partial, failing to include the insured's deductible in the insurer's demands under its subrogation rights. Subrogation recovery must be shared at least on a proportionate basis with the insured, unless the deductible amount has been otherwise recovered by the insured, except that when an insurer is recovering directly from an uninsured third party by means of installments, the insured must receive the full deductible share as soon as that amount is collected and before any part of the total recovery is applied to any other use. No deduction for expenses may be made from the deductible recovery unless an attorney is retained to collect the recovery, in which case deduction may be made only for a pro rata share of the cost of retaining the attorney. An insured is not bound by any settlement of its insurer's subrogation claim with respect to the deductible amount, unless the insured receives, as a result of the subrogation settlement, the full amount of the deductible. Recovery by the insurer and receipt by the insured of less than all of the insured's deductible amount does not affect the insured's rights to recover any unreimbursed portion of the deductible from parties liable for the loss;

(7) requiring as a condition of payment of a claim that repairs to any damaged vehicle must be made by a particular contractor or repair shop or that parts, other than window glass, must be replaced with parts other than original equipment parts or engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an insured to use a particular contractor or repair shop. Consumer benefits included within preferred vendor programs must not be considered an incentive or inducement.

At the time a claim is reported, the insurer must provide the following advisory to the insured or claimant:

"~~Minnesota law gives~~ You have the legal right to choose a repair shop to fix your vehicle. Your policy will cover the reasonable costs of repairing your vehicle to its pre-accident condition no matter where you have repairs made. Have you selected a repair shop or would you like a referral?"

After an insured has indicated that the insured has selected a repair shop, the insurer must cease all efforts to influence the insured's or claimant's choice of repair shop;

(8) where liability is reasonably clear, failing to inform the claimant in an automobile property damage liability claim that the claimant may have a claim for loss of use of the vehicle;

(9) failing to make a good faith assignment of comparative negligence percentages in ascertaining the issue of liability;

(10) failing to pay any interest required by statute on overdue payment for an automobile personal injury protection claim;

(11) if an automobile insurance policy contains either or both of the time limitation provisions as permitted by section 65B.55, subdivisions 1 and 2, failing to notify the insured in writing of those limitations at least 60 days prior to the expiration of that time limitation;

(12) if an insurer chooses to have an insured examined as permitted by section 65B.56, subdivision 1, failing to notify the insured of all of the insured's rights and obligations under that statute, including the right to request, in writing, and to receive a copy of the report of the examination;

(13) failing to provide, to an insured who has submitted a claim for benefits described in section 65B.44, a complete copy of the insurer's claim file on the insured, excluding internal company memoranda, all materials that relate to any insurance fraud investigation, materials that constitute attorney work-product or that qualify for the attorney-client privilege, and medical reviews that are subject to section 145.64, within ten business days of receiving a written request from the insured. The insurer may charge the insured a reasonable copying fee. This clause supersedes any inconsistent provisions of sections 72A.49 to 72A.505;

(14) if an automobile policy provides for the adjustment or settlement of an automobile loss due to damaged window glass, failing to provide payment to the insured's chosen vendor based on a competitive price that is fair and reasonable within the local industry at large.

Where facts establish that a different rate in a specific geographic area actually served by the vendor is required by that market, that geographic area must be considered. This clause does not prohibit an insurer from recommending a vendor to the insured or from agreeing with a vendor to perform work at an agreed-upon price, provided, however, that before recommending a vendor, the insurer shall offer its insured the opportunity to choose the vendor. If the insurer recommends a vendor, the insurer must also provide the following advisory:

"Minnesota law gives you the right to go to any glass vendor you choose, and prohibits me from pressuring you to choose a particular vendor.";

(15) requiring that the repair or replacement of motor vehicle glass and related products and services be made in a particular place or shop or by a particular entity, or by otherwise limiting the ability of the insured to select the place, shop, or entity to repair or replace the motor vehicle glass and related products and services; or

(16) engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an insured to use a particular company or location to provide the motor vehicle glass repair or replacement services or products. For purposes of this section, a warranty shall not be considered an inducement or incentive."

Page 18, delete section 23 and insert:

"Sec. 29. Minnesota Statutes 2004, section 79.251, subdivision 1, is amended to read:

Subdivision 1. **General duties of commissioner.** (a)(1) The commissioner shall have all the usual powers and authorities necessary for the discharge of the commissioner's duties under this section and may contract with individuals in discharge of those duties. The commissioner shall audit the reserves established (a) for individual cases arising under policies and contracts of coverage issued under subdivision 4 and (b) for the total book of business issued under subdivision 4. If the commissioner determines on the basis of an audit that there is an excess surplus in the assigned risk plan, the commissioner must notify the commissioner of finance who shall transfer assets of the plan equal to the excess surplus to the budget reserve account in the general fund.

(2) The commissioner shall monitor the operations of section 79.252 and this section and shall periodically make recommendations to the governor and legislature when appropriate, for improvement in the operation of those sections.

(3) All insurers and self-insurance administrators issuing policies or contracts under subdivision 4 shall pay to the commissioner a .25 percent assessment on premiums for policies and contracts of coverage issued under subdivision 4 for the purpose of defraying

the costs of performing the duties under clauses (1) and (2). Proceeds of the assessment shall be deposited in the state treasury and credited to the general fund.

(4) The assigned risk plan shall not be deemed a state agency.

(5) The commissioner shall monitor and have jurisdiction over all reserves maintained for assigned risk plan losses.

(b) As used in this subdivision, "excess surplus" means the amount of assigned risk plan assets in excess of the amount needed to pay all current liabilities of the plan, including, but not limited to:

(1) administrative expenses;

(2) benefit claims; and

(3) if the assigned risk plan is dissolved under subdivision 8, the amounts that would be due insurers who have paid assessments to the plan.

Sec. 30. Minnesota Statutes 2004, section 79.251, is amended by adding a subdivision to read:

Subd. 2a. **Assigned risk rating plan.** (a) Employers insured through the assigned risk plan are subject to paragraphs (b) and (c).

(b) Classifications must be assigned according to a uniform classification system approved by the commissioner.

(c) Rates must be modified according to an experience rating plan approved by the commissioner. Any experience rating plan is subject to Minnesota Rules, parts 2700.2800 and 2700.2900."

Page 19, line 18, delete "30" and insert "60"

Page 19, delete line 19 and insert "notice to the employer pursuant to section 176.185, subdivision 1."

Page 22, after line 12, insert:

"Sec. 36. Minnesota Statutes 2004, section 79A.32, is amended to read:

79A.32 REPORTING TO ~~MINNESOTA WORKERS' COMPENSATION INSURERS' ASSOCIATION~~ LICENSED DATA SERVICE ORGANIZATIONS.

~~Subdivision 1. **Required activity.** Each self-insurer shall perform the following activities:~~

~~(1) maintain membership in and report loss experience data to the Minnesota Workers' Compensation Insurers Association, or a licensed data service organization, in accordance with the statistical plan and rules of the organization as approved by the commissioner;~~

~~(2) establish a plan for merit rating which shall be consistently applied to all insureds, provided that members of a data service organization may use merit rating plans developed by that data service organization;~~

~~(3) provide an annual report to the commissioner containing the information and prepared in the form required by the commissioner; and~~

~~(4) keep a record of the losses paid by the self-insurers and premiums for the group self-insurers.~~

Subd. 2. **Permitted activity.** ~~In addition to any other activities not prohibited by this chapter, self-insurers may~~ Through data service organizations licensed under chapter 79, self insurers may:

(1) ~~through licensed data service organizations,~~ individually, or with self-insurers commonly owned, managed, or controlled, conduct research and collect statistics to investigate, identify, and classify information relating to causes or prevention of losses; and

(2) at the request of a private self insurer or self insurer group, submit and collect data, including payroll and loss data; and perform calculations, including calculations of experience modifications of individual self-insured employers.

~~(2) develop and use classification plans and rates based upon any reasonable factors; and~~

~~(3) develop rules for the assignment of risks to classifications.~~

~~Subd. 3. **Delayed reporting.** Private self-insurers established under sections 79A.01 to 79A.18 prior to August 1, 1995, need not begin filing the reports required under subdivision 1 until January 1, 1998.~~"

Page 22, delete lines 14 and 15 and insert:

"Minnesota Rules, parts 2781.0100; 2781.0200; 2781.0300; 2781.0400; 2781.0500; and 2781.0600, are repealed."

Renumber the sections in sequence

Amend the title accordingly

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

Linda Scheid .....
(Committee Chair)

April 3, 2006 .....
(Date of Committee recommendation)