STATE OF MINNESOTA
DEPARTMENT OF COMMERCE

In the Matter of the Proposed Rules Governing Employee Health and Disability Joint Self-Insurance Plans Minnesota Rules, Parts 2765.0100 to 2765.1500

STATEMENT OF NEED AND REASONABLENESS OF PROPOSED RULES

STATEMENT OF AUTHORITY

Minnesota Statutes, section 62H.06 (Laws of 1983, chapter 241, section 6) requires the Commissioner of Commerce to adopt rules to insure the solvency and operation of all self-insured plans subject to chapter 62H. These rules are proposed pursuant to that authority. The rules' purpose is to ensure that the financial integrity of these plans is maintained, and that they are administered competently and equitably. The rules govern the formation, operation, and dissolution of multiple employer plans for joint self-insurance of employee health, dental, or short-term disability benefits.

FACTS ESTABLISHING NEED AND REASONABLENESS

As more specifically stated below, the proposed rules are necessary to insure the solvency and operation of employee health and disability joint self-insurance plans.

Part 2765.0100 Definitions.

Part 2765.0100 defines 20 key words and phrases used in the rules. Most of the meanings are straightforward clarifications of commonly used terms. The following commentary is provided for the minority of definitions with less obvious meanings and necessity.

Subpart 7 defines "covered employee." Covered employee is a key term in the statute authorizing joint self-insurance plans. Specifically, Minnesota Statutes, section 62H.01, states in part that "(j)oint plans must have a minimum of 250 covered employees and meet all conditions and terms of sections 62H.01 to 62H.08." This requirement establishes a basic financial minimum size for joint self-insurance plans, since a typical group of 250 employees would require annual premiums in excess of $250,000. This presumes that such a group includes at least 250 "units," made up of a mixture of single and family units. If each covered employee's dependents were also counted toward the 250 minimum, the financial minimum size would be substantially reduced. As defined, the minimum size requirement is similar to the minimum annual premium requirement for workers' compensation self-insurance pools ($300,000, Minnesota Rules, part 2780.2400), which are similar to employee health and disability joint self-insurance plans.

Subpart 9 defines "financial administrator." It establishes minimum standards of staff and organizational experience for entities to be eligible to administer a plan's funds. The standard of five years experience for the organization and current employment of experienced staff are reasonable criteria for precluding inexperienced organizations from assuming responsibility for a plan's finances. This requirement is necessary, because competent financial management is essential to a plan's stability and financial integrity.

Subpart 10 defines "fund year" as the calendar year. This requirement is necessary because Minnesota Statutes, section 62H.05 requires plans to file their annual report within 30 days immediately following the end of each calendar year.

Subpart 19 defines "separate employer." In addition to the 250 covered employees requirement, plans are required by Minnesota Statutes, section 62H.01, to include three or more employers. Having multiple employers increases a plan's stability and financial integrity, since it is unlikely that all members would incur financial difficulties or choose to withdraw from the plan at the same time. This definition is necessary to preserve the benefit of having multiple employers, by requiring that to be considered "separate," employers must not be the parent, subsidiary, or affiliate of one another.

Part 2765.0200 Purpose.

Part 2765.0200 describes the rules' purpose. This part is necessary to describe the rules' regulatory intent as a guide to the rules' users. The statement of purpose is consistent with their statutory authority.

Part 2765.0300 Scope.

Part 2765.0300 describes the rules' scope in terms of the entities and organizations that are directly affected. This part is necessary to identify the entities with rights and responsibilities under the rules as a guide to the rules' users.

Part 2765.0400 ByLaws.

Part 2765.0400 states minimum requirements for the content of a plan's bylaws, and procedures for adoption and change of the bylaws.

Subpart 1 specifies the content requirements. The requirements range from basic matters such as the plan's name, to important procedural issues such as the method for distributing dividends. It is necessary and reasonable that a plan decide in advance how important matters are to be resolved, such as membership rights, the relative powers of the various governing parties, access to money, and similar issues. Statements concerning these matters are necessary to the regulator to obtain a complete picture of the plan's method of governance. They are also necessary to enable prospective plan members to ascertain their rights and responsibilities within the plan's structure. Failure to clarify these important matters in advance could harm a plan's stability, because "mid-stream" decisions would be likely to harm some members' interests while benefitting others'. One of the principal elements of a plan's stability and financial integrity is the presence of long-term members. Maintenance of long-term members is enhanced by settling potentially divisive issues before they can disrupt a plan's unity.

Subpart 2 contains the requirements for adopting and changing the bylaws. It is necessary and reasonable that authority over the bylaws reside solely with the plan membership or with a representative board, because the membership is ultimately responsible for the plan's financial integrity. Under part 2765.1400, subpart 6, a plan's members may be assessed to maintain the plan's financial integrity. Accordingly, although the plan's contractors may play a major role in day-to-day administration, final responsibility for the plan's solvency and governance must reside with the membership or the board.

Part 2765.0500 Board.

Part 2765.0500 states minimum requirements for the structure and duties of a plan's board of trustees.

Subpart 1 contains the requirements concerning board structure. The most important requirement is that the board members be officials or employees of the employers participating in the plan. This is a necessary and reasonable requirement because the plan's member employers are ultimately responsible for the plan's financial integrity. The plan's contractors, such as the service company, financial administrator, or stop-loss insurer, could have conflicts of interest in serving on the plan's board. The requirement that the board meet at least four times annually is necessary and reasonable to guarantee that the board will keep appraised of the plan's status, notwithstanding that day-to-day operations may be delegated to the contractors.

Subpart 2 defines the board's overall rights and responsibilities, and states the board's minimum responsibilities. Because the board represents the membership, and because the membership is assessable in the event the plan's financial integrity deteriorates, it is reasonable that the board is responsible for the plan's operation. It is specifically necessary to define the board's minimum responsibilities, lest a board abdicate its responsibilities to the service company or other contractors. This subpart establishes the basis for a plan's contractors reporting to the board, and bringing major decisions and policy issues to the board for its approval.

Part 2765.0600 Application.

Part 2765.0600 establishes the procedures for submission and review of applications for licensure as an employee health and disability joint self-insurance plan.

Subpart 1 defines the initial application procedure. The basic 60 day period established for application review is reasonable and necessary to permit a thorough and orderly staff analysis. A shorter period could result in application rejections solely on the basis of inadequate time for analysis.

Subpart 2 defines the renewal application procedure. It is a reasonable convenience that renewal applications consist of the plan's annual status report, since the report contains most of the same information as the initial application. This streamlines the renewal procedure.

Subpart 3 indicates that multiple employer self-insurance plans qualified under federal ERISA law are exempt from these rules upon filing notice of such qualification. Qualified plans are most likely to be established under collective bargaining agreements or through trade association sponsorship. It is necessary and reasonable that ERISA qualified plans be required to file notice of their qualification to be considered exempt from the rules. Without such a requirement there would be no basis for determining whether a plan claiming to be outside state authority was legitimate.

Subpart 4 requires that two or more existing plans proposing to merge must assume all obligations of the prior plans. This requirement is necessary to guarantee continuity of coverage to employees of participating employers.

Subpart 5 establishes the period of licensure, and the criteria for approving or disapproving joint self-insurance plan applications. The approval criteria are reasonable, consisting of adherence to the various rules and statutes governing such plans. No further criteria are necessary.

Part 2765.0700 Ending self-insurance, runoff period, and plan dissolution.

Part 2765.0700 establishes the procedures that apply at the end of a plan's life-cycle.

Subpart 1 states how a plan may voluntarily end its self-insurance authority. The three major requirements are that ending self-insurance coincide with the end of the fund year, that the commissioner is notified, and that a plan cannot end self-insurance when less than 45 days remain in a fund year. These requirements are reasonable and necessary to protect the continuity of coverage for covered employees, and to allow participating employers time to arrange alternative coverage.

Subpart 2 establishes standards for the revocation of a plan's self-insurance authority. The revocation standards parallel the criteria for evaluation of a plan's application for self-insurance authority. An additional standard is added concerning a deterioration of a plan's financial integrity. This standard is necessary and reasonable because notwithstanding the various financial safeguards built into the rules, it is possible that a plan's overall financial situation could deteriorate before any specific rules violation could be ascertained. In such circumstances, it would be necessary for the commissioner to be able to act before a plan's situation worsened to a point where it could not conduct an orderly runoff period.

Subpart 3 requires a plan to continue to exist after its self-insurance authority is ended to handle its "runoff" obligations, both regulatory and regarding coverage. This requirement is necessary, given the time-delayed nature of coverage obligations.

Subpart 4 establishes standards and procedures for a plan's final dissolution. In order to dissolve, a plan must demonstrate that it has no further outstanding liabilities, or that it has contracted with an insurance company to assume all outstanding liabilities. These requirements are necessary to preserve the coverage rights of covered employees, lest a plan dissolve prematurely with open claims remaining.

Part 2765.0800 Administration.

Part 2765.0800 establishes requirements concerning a plan's operations and administration.

Subpart 1 requires plans to contract with a service company for handling most day-to-day operations. It is necessary and reasonable that a licensed service company be assigned responsibility for daily operations, since they are required to demonstrate expertise and their own financial integrity to be licensed. Since joint self-insurance plans are not insurance companies, the services customarily provided by insurers must be secured from another source.

Subpart 2 requires plans to contract with a financial administrator for handling investments and for other financial services. The financial administrator cannot be affiliated with the service company. Because joint self-insurance plans are not insurance companies, financial services must be secured from an outside source. The minimum requirements for financial administrators are contained in the definition, part 2765.0100, subpart 9. It is reasonable

that responsibility for financial services and daily operations is segregated, because service companies are not licensed on the basis of financial expertise, and because segregation reduces the potential for a single contractor assuming near-total control over a plan. Since the service company is likely to be responsible for a plan's underwriting and marketing, conflicts of interest could arise if the service company had full access to a plan's reserves.

Subpart 3 requires a plan to maintain all records necessary to verify its reports to the commissioner. This requirement is necessary and reasonable to prudent operation, as a basis for financial audits and examinations, and in the event of plan dissolution to provide a basis for allocating remaining assets.

Part 2765.0900 Membership.

Part 2765.0900 establishes procedures for joining a plan, leaving a plan, and monitoring membership size.

Subpart 1 limits plan membership to Minnesota-domiciled employers, and establishes that a plan may exercise reasonable, nondiscriminatory underwriting criteria. The Minnesota domicile requirement is necessary because joint self-insurance plans represent a new self-insurance concept not recognized by other states. It is not the rules' intent to permit formation of a nationwide self-insurance plan under chapter 62H licensure, nor would other states acknowledge the legitimacy of a multi-state entity. The underwriting criteria standard is reasonable and necessary to maintaining a plan's financial integrity. If a plan could not reject employers with poor loss experience, it would eventually be unable to sustain itself.

Subpart 2 states that membership is not effective until the employer signs a membership agreement, which must disclose the possibility of assessment. This requirement is reasonable and necessary because plan membership is likely to be marketed like insurance, but differs from conventional insurance in the possibility of assessment. If employers are not made aware of this possibility, and do not acknowledge their responsibilities upon joining the plan, it would be difficult to levy an assessment should that become necessary.

Subpart 3 requires employers to give at least 30 days notice before leaving a plan, and prohibits withdrawal unless a minimum membership term has been served and any outstanding debts to the plan have been paid. Subpart 3 also requires the plan to notify the commissioner if a member's withdrawal would cause the plan to fall below the minimum employer and employee requirements. The minimum membership term is necessary to preserving a plan's stability. Unlike an insurance company, a joint self-insurance plan has no capital or surplus to cushion itself in the event of poor loss experience. As such, it is particularly vulnerable to a rapid loss of business, because its members constitute its primary base of financial support. Although the minimum membership term is not long, its presence requires new members to establish a basic commitment to the plan exceeding the commitment to a commercial insurance policy.

Subpart 4 requires a plan to review its members at least annually to determine whether any warrant expulsion. This requirement is necessary for the same reason that underwriting criteria are specifically sanctioned. Not having capital or surlus, a plan must be able to protect itself against members with extraordinarily poor loss experience, members that do not pay their debts, or members failing to meet other reasonable membership criteria.

Subpart 5 requires plans to monitor the number of employers and employees it covers. If the statutory minimum number of covered employees is approached, the plan must begin monthly reporting to the commissioner. If the minimums are not met, the plan must end its self-insurance authority or submit a feasible proposal for restoring compliance. These requirements are necessary for the commissioner to learn promptly of a plan's shrinkage. As stated above, a plan's members are its principal asset. If the members are departing to a point where the statutory minimums cannot be met, a plan must seriously consider terminating self-insurance. The 90-day grace period for plans with feasible proposals for restoring compliance provides a window for rehabilitation, if a plan can demonstrate the likelihood of restoring compliance. If possible, it is in the regulator's interest to rehabilitate a plan rather than force unnecessary termination.

Subpart 6 states that after self-insurance authority is ended, plan membership is frozen. This requirement is necessary to guarantee that the members at the time of self-insurance ending will remain available to sustain the plan while it fulfills its runoff responsibilities. The requirement also precludes any new members from joining should it appear likely that assets will remain upon plan dissolution.

Part 2765.1000 Coverage.

Part 2765.1000 establishes standards for a plan's coverage documents, and procedural requirements for initiating coverages.

Subpart 1 imposes on a plan's coverage content, administration, rates, underwriting, and related matters, the same requirements that apply to comparable insurance policies provided by licensed insurance companies. These

requirements are necessary and reasonable to guarantee a "level playing field" in the marketing of insurance policies and self-insurance plan memberships. These requirements are also reasonable in that they tie directly into the long-established and refined procedures and requirements applicable to policies of insurance. These include requirements concerning clarity of language, continuation and conversion coverage, mandated benefits, employee notice, and related matters. The purpose of Minnesota Statutes, chapter 62H, was to permit formation of alternative financial arrangements for providing employee health and disability benefits. The purpose was not to exempt such alternative arrangements from the basic coverage requirements applicable to comparable insurance.

Subpart 2 prohibits plans from offering coverage to individuals other than members' employees and their dependents. Conversion coverage must be provided through licensed insurers. These requirements are reasonable and necessary to prevent joint self-insurance plans from extending coverage beyond their "base" of employer members. As stated previously, employers' commitment to the plan substitutes in part for an insurer's capital and surplus. Were a plan to extend coverage to individuals not employed by a plan member (or an employee's dependent), the plan would be operating like a commercial insurance company. If a group of employers wish to enter the insurance business, they would be obliged to follow the same procedures that apply to other investors.

Subpart 3 explicitly permits a plan to arrange for health maintenance organization coverage for members obliged or desiring to provide such coverage to their employees. This is a reasonable function for a plan to be allowed to perform, since it may be able to make such arrangements more efficiently than

individual employers could on their own. However, for the reasons stated in the previous paragraph concerning insurance companies, a plan cannot itself function as an HMO, but must make such arrangements through a duly licensed HMO.

Subpart 4 requires plans to apply the same underwriting standards to all employees of all members. This requirement is necessary to guarantee equitable treatment of all covered employees. Specifically, this prohibits a plan from applying inconsistent underwriting standards for marketing purposes.

Subpart 5 prohibits a plan from committing itself to coverage extending beyond the term of required stop-loss insurance policies. The required stop-loss insurance policies provide another basic financial support for joint self-insurance plans. (The other most important supports are membership continuity and assessability, and financial reserving requirements.) Since stop-loss insurance policies must be in force for a plan to maintain its licensure, it would be unreasonable to permit a plan to obligate itself to provide coverage into a period when the availability of required stop-loss coverage is uncertain. For example, this would prohibit a plan from entering into a three-year coverage agreement with an employer, if its required stop-loss insurance policies extended for only 18 months. The required stop-loss policies are sufficiently unusual and the joint self-insurance plan concept is new enough that long-term availability of stop-loss insurance is by no means assured.

Subpart 6 states that a plan retains indefinitely the responibilities associated with coverage previously in force. That is, a plan cannot avoid its responsibilities to covered employees through ending self-insurance authority, expelling an employer from the plan, or ceasing to offer a particular coverage. This requirement is necessary to guarantee the integrity of coverage provided through a plan.

Part 2765.1100 Premiums and dividends.

Part 2765.1100 establishes standards and procedures for premiums paid to a plan and dividends paid from a plan.

Subpart 1 requires premium to be calculated on a fund year basis; permits installment payments if paid before premium is earned; requires prompt collection of delinquencies; and requires delinquent employers to pay collection costs. These requirements are reasonable and necessary to guarantee a plan's prudent and conscientious operation and protection of its financial integrity.

Subpart 2 permits a plan to pay a dividend only if the dividend would not cause the plan to have an overall deficit, if the plan does not have an outstanding loan from its stop-loss insurer, and if the dividend is fairly apportioned according to premium paid by members and covered employees. The deficit requirement is self-explanatory: if a dividend would cause or worsen a deficit, it cannot be consistent with preservation of the plan's financial integrity. Furthermore, if a plan has obtained a loan ("aggregate advancement") from its stop-loss insurer due to financial difficulties, it is reasonable that the loan be repaid before members receive any benefits from good loss experience. Finally, it is reasonable that dividends be required to be apportioned on the basis of premium paid by members and employees. This requirement ensures that dividends will not be paid unfairly only to the employer members, when employees may have contributed a significant amount to creation of the surplus. (Employers and employees commonly share premium payments.) This requirement is also conducive to preserving plan unity. Just as all members share in the risk of assessments should experience be poor, all members will benefit equitably should experience be good. In practice, loss experience will be reflected most directly in premium levels.

Part 2765.1200 Reserves.

Part 2765.1200 requires plans to establish reserves for losses, unearned premiums, and potential stop-loss insurance liability. This part also requires a plan to maintain a minimal surplus, or to require the stop-loss insurer to advance the plan funds against its potential stop-loss obligation, to protect the plan should it encounter financial difficulties.

Subpart 1 establishes standards for maintaining loss and unearned premium reserves. The standards require prudence and conservatism in setting reserve amounts, with precise accounting instructions contained in the financial statement forms. The establishment of conservative reserves is reasonable and necessary to maintenance of a plan's financial integrity. Reserves are fundamental to the operation of an insurance entity. Failure to establish reserves, or setting reserves too low, may cause a plan to overestimate its financial resources or operating success. A plan may not realize it is in financial trouble until it is too late.

Subpart 2 establishes standards for maintaining the stop-loss insurance full funding reserves, with precise accounting instructions contained in the financial statement forms. Minnesota Statutes, section 62H.02 requires that reserves be maintained up to the point that a plan's stop-loss insurer would assume liability for losses. This requirement is necessary to prevent a plan from paying dividends from a particular fund year's premiums until the liability of the stop-loss insurer for that fund year, if any, has been established. The full funding reserve constitutes a temporary cushion against poor loss experience. Slightly different full funding requirements apply depending on whether a plan's stop-loss insurance is on a paid or an incurred basis.

Subpart 3 requires a plan to protect itself against cash flow difficulties by either establishing a surplus equal to the greater of three months' premium or $100,000; or by obtaining a commitment from its stop-loss insurer to advance or loan money to the plan if the plan judges it will suffer cash flow difficulties. Despite a plan's best intentions and planning, it is possible that poor losses, poor investment results, membership declines, and other misfortunes may impose temporary financial hardship on a plan. A plan's revenues may not be timed correctly with its expenses, or the overall levels of expenses and revenues may be worse than a plan estimated. To protect its financial integrity, it is necessary for a plan to have the ability to handle such circumstances without delaying or defaulting on its obligations. The requirements of this subpart provide a reasonable method for handling cash flow difficulties. A plan may choose to pay-in an initial surplus or to retain a portion of earnings to provide a surplus reserve. Alternatively, if the stop-loss insurer has committed to the arrangement, a plan may obtain an advance on potential obligations of the stop-loss insurer. Such an advance would fulfill the same purpose as a surplus reserve.

Part 2765.1300 Stop-loss insurance.

Part 2765.1300 establishes standards and requirements for a plan's stop-loss insurance policies. As stated previously, the stop-loss policies constitute one of the primary financial safeguards of a plan.

Subpart 1 requires 90-day notice to the commissioner of whether or not a stop-loss policy will be renewed; prohibits mid-term changes in the policies that would reduce coverage; and requires that stoploss policies must be non-cancellable for at least two years, even for non-payment of premium. All of

these requirements are reasonable and necessary to maintain the integrity of the stop-loss insurance policies, which in turn are necessary to maintaining a plan's financial integrity. If losses are very high, a known phenomenon among insurance and self-insurance entities, the stop-loss insurer will be called upon to pay the excess losses. Although a plan's members may be assessed if a deficit is incurred, assessments are complex, cumbersome, and better avoided if possible. Stop-loss insurance is a simpler and quicker remedy for extraordinary losses, and can preserve members' confidence better than assessments. The importance of stoploss insurance to the financial integrity of joint self-insurance plans is reflected in the requirements of Minnesota Statutes, section 62H.02. Those general requirements are given specific meaning in part 2765.1300.

The 90-day notice requirement is necessary to permit the commissioner to order a timely revocation of a plan's self-insurance authority, if it appears they will be unable to renew their stop-loss policies. The mid-term change prohibition is necessary to maintain the basic scope and integrity of the policies while they remain in force. The same reasoning applies to the two-year noncancellable requirement, which is in the statute, and the requirement that this include cancellation for non-payment of premium. It is precisely at times when a plan may have difficulty in making premium payments that it would stand most in need of the stop-loss insurance. In practice, it is likely this requirement would cause stop-loss insurers to require payment in advance.

Subpart 2 requires individual excess stop-loss insurance for all liability in excess of $25,000 per person per year. A plan may apply for a higher limit, up to $50,000, if it can demonstrate that this would not be detrimental to its solvency and stability. Minnesota Statutes, section 62H.02, requires this type of stop-loss insurance. Establishing a $25,000 per case

limit is necessary to give specific meaning to this requirement. This is a common limit in individual excess stop-loss insurance policies. Its reasonableness is also demonstrated by the fact that $25,000 represents approximately ten percent of the annual premium that a minimum-size plan would have. A ten percent limit on the maximum possible loss a plan could have on any one risk is comparable to the requirement placed on insurers that they limit their risk on any one case to ten percent of their total surplus. This is a less stringent requirement for plans than the requirement for insurers, because surplus is a smaller figure than annual premium. However, a less stringent individual excess requirement is justified because the aggregate excess stop-loss insurance requirement for plans is more important. Any losses not covered by the individual excess coverage may be counted toward the aggregate excess coverage limit. In this sense, the aggregate excess coverage supersedes the individual excess coverage.

Subpart 3 requires plans to maintain aggregate excess stop-loss insurance. Essentially, this means that after a plan's total losses exceed a certain point, the stop-loss insurer is obligated to reimburse the plan for additional losses. A plan may obtain aggregate excess insurance on a paid or an incurred basis, provided that a paid basis policy must include a runoff provision upon policy nonrenewal. Aggregate excess coverage is also required by Minnesota Statutes, section 62H.02. Subpart 3 does not prescribe a specific percentage of premium or dollar amount at which the stop-loss insurer's liability would begin, because under the full-funding reserve requirement a plan is obligated to maintain a reserve up to the point that the stop-loss insurer's liability begins. If a plan chose a very high aggregate attachment point, they would also be requiring themselves to maintain a very large full-funding reserve.

Subpart 4 requires a plan to obtain a clause in its stop-loss insurance policy requiring the insurer to reimburse the plan for any premium delinquencies on the part of its members. This provision is required by Minnesota Statutes, section 62H.02, and is helpful to maintenance of a plan's financial integrity.

Subpart 5 requires a plan to obtain a clause in its stop-loss insurance policy requiring the insurer to assume direct responsibility for a plan's operations if the plan becomes insolvent or otherwise fails to fulfill its responsibilities. This provision is also required by Minnesota Statutes, section 62H.02, and is necessary to guarantee fulfillment of a plan's responsibilities to covered persons if the plan fails to do so. As a licensed insurer for health and disability coverages, the stop-loss insurer is qualified to assume these responsibilities.

Subpart 6 prohibits a plan, its member employers, or their affiliates, from making an arrangement with the stop-loss insurer whereby the liability assumed by the stop-loss insurer under these rules is returned to the plan and its participants. This prohibition is reasonable and necessary to prevent a "fronting" arrangement, whereby an insurer agrees to provide the appearance of insurance, although in fact liability is passed back to the original parties. Such an arrangement could harm a plan's financial integrity, by circumventing the purpose of the required stop-loss insurance.

Part 2765.1400 Financial integrity.

Part 2765.1400 establishes several requirements affecting various aspects of a plan's financial integrity.

Subpart 1 requires all persons with access to plan funds to be covered by a fidelity bond of at least $300,000. This requirement is reasonable and necessary to protect a plan from losses by dishonesty, robbery, or related causes. Such coverage is commonly required in commercial transactions involving funds-handling. Under rules governing service companies, fidelity bonds of greater amount must be secured.

Subpart 2 prohibits a plan's assets from being used for purposes other than those for which the plan was established. Specifically, plan assets cannot be commingled with member employer's assets, cannot be loaned, and cannot be considered the property of any other person, except as specifically permitted in the rules. These requirements are reasonable and necessary to guarantee that a plan's assets will be segregated, and that no party will use its affiliation with the plan and access to plan funds for their own ends.

Subpart 3 delineates the sources and uses of funds appropriate for a plan. A plan may expend funds for expenses consistent with its purpose. A plan can obtain funds from the usual sources available to an insurance company, but cannot borrow money except as permitted from the stop-loss insurer, and cannot obtain funds through subrogation of the rights of covered employees. These requirements are reasonable and necessary to circumscribe a plan's financial activity to the activities considered prudent, appropriate, and equitable for insurance entities. This would preclude a plan from engaging in business or transactions unrelated to its self-insurance purposes, and not generally permitted to comparable insurance companies. The restriction on borrowing money is reasonable, because a more appropriate and secure source of funds in times of financial difficulty is through a surplus reserve or aggregate advancement, as

provided in part 2765.1200, subpart 3. The restriction on the use of subrogation is reasonable, because the same restriction applies to comparable insurance companies.

Subpart 4 permits a plan to establish separate monetary accounts for the use of various contractors, provided their use and size is subject to reasonable controls. This requirement is reasonable and necessary to prevent any contractor other than the financial administrator from having more access than necessary to a plan's funds.

Subpart 5 restricts a plan's investments according to the standards of Minnesota Statutes, section 475.66, as required by Minnesota Statutes, section 62H.05. This subpart also prohibits a plan from investing in securities or debt of its members or contractors. This requirement is reasonable and necessary to prevent conflicts of interest in handling of the plan's funds, and to prevent the possibility of a plan member or contractor defaulting and the plan's investments failing at the same time.

Subpart 6 requires the plan's board to monitor the plan's financial condition, and to take corrective action if necessary. The commissioner is empowered to take corrective action if the board is not doing so when required. Standards are established for how assessments may be levied. In part 2765.0500, subpart 2, the board is assigned fiduciary responsibility for the plan's financial condition. This subpart is a necessary complement to that mandate, stating in detail what the board must do to monitor and maintain the plan's financial integrity. It is further reasonable and necessary that if the board does not take action to maintain the plan's financial integrity, that the commissioner be empowered to order changes to restore the plan's sound financial condition. This power is comparable to the commissioner's power to direct the rehabilitation of a financially impaired insurance company.

Part 2765.1500 Reporting.

Part 2765.1500 establishes various reporting requirements and standards necessary for the commissioner's monitoring of plans' status, operations, and financial integrity.

Subpart 1 requires plans to file annual financial reports, and that the reports be audited by an independent certified public accountant and reviewed by a qualified actuary. This requirement is reasonable and necessary to the commissioner's monitoring of a plan's financial condition. The requirement is also necessary to the proper application of various financial requirements in the rules, particularly the reserving requirements and the requirements that necessitate determining whether a surplus or deficit exists. Comparable but more complex financial reporting requirements exist for insurance companies. As a quasi-insurance entity, it is necessary for joint self-insurance plans to report on a basis similar to insurance entities.

Subpart 2 requires that plans file quarterly statements summarizing key data from the full financial statements, and other key operating data such as the current total members and covered employees. This requirement is reasonable and necessary to the commissioner's monitoring of a plan's stability and financial integrity. Because plans do not have the financial safeguards available to insurance companies, primarily surplus and membership in guaranty associations, it is important for the commissioner to monitor their performance at more frequent intervals than annually. Although adequate safeguards exist, joint self-insurance plans are a new concept with a limited track record. Particu-

larly in the early years of operation, it is possible that if reports were only received annually the commissioner might not learn of important financial or operational developments until it was too late to take corrective action.

Subpart 3 authorizes the commissioner to order investigations into a plan's finances and operations if warranted by irregularities in a plan's reports. The commissioner may order changes in a plan's operations if warranted by the investigation's findings. This power is reasonable and necessary to allow the commissioner to correct deficiencies in a plan's reserving, accounting, or recordkeeping practices. The commissioner's ability to monitor adequately a plan's financial integrity and compliance with the rules depends on the accuracy of the plan's reports. If there is any possibility that the reports may not be reliable, it is essential that the commissioner be able to investigate and order corrections.

Subpart 4 requires plans to file annual status reports, containing updated information from the initial application. This requirement is reasonable and necessary to monitor a plan's continuing compliance with the rules, and for practical administrative purposes such as maintaining accurate addresses, contact persons, membership lists, etc. The annual status report also serves the function of a renewal application in those years when self-insurance authority expires (see part 2765.0600, subpart 2).

Subpart 5 states that plans' financial statements, status reports, and other reports required by these rules are subject to the same standards as apply to comparable reports required of licensed insurance companies. Various penalties may be levied upon insurance companies if they fail to submit required reports. This requirement is reasonable and necessary as an enforcement tool, to compel timely compliance with reporting requirements. Without such a tool the only recourse for non-compliance available to the commissioner, besides

persuasion, is revocation of self-insurance authority. This is an excessive power to bring to bear on every minor reporting infraction. It is important that the commissioner have some direct enforcement power over a plan besides the ultimate authority over licensure. Reporting is the most common source of compliance problems with other insurance and self-insurance entities, but monetary penalties have proven effective in causing reporting requirements to be taken seriously.

Subpart 6 establishes procedures and standards for submission of the revenue fee required of plans by Minnesota Statutes, section 62H.07. The standards are necessary to clarify the statutory term, "paid claims level for the most recently completed calendar year." This is defined to mean the total amount of claims paid during the fund year, with no deduction for claims subject to stop-loss insurance. This definition is reasonable because the level and terms of stop-loss insurance are a matter for each plan's discretion, subject to the basic requirements of these rules. If stop-loss insurance could affect the extent of a plan's revenue fee liability, an incentive would exist to structure stop-loss insurance to minimize that liability.

IMPACT ON SMALL BUSINESSES

Qualitative impact.

In drafting these rules, their effect on small businesses has been considered as required by Minnesota Statutes, section 14.115.

The primary effect of these rules on small businesses will be in providing small businesses with an additional safe and competitive alternative for financing their employee health and disability benefits. As stated in part 2765.0200, the purpose of these rules is to ensure that the financial solvency

of these plans is maintained, and that they are administered competently and equitably. In general, these are the same objectives as in the regulation of other insurance and group self-insurance entities. Regulation provides consumers a measure of safety and reliability in the marketplace. In this case, small businesses will be the probable "consumers" of joint self-insurance plan membership. The "product" is a financing mechanism for employee benefits.

In this sense, the primary effect of the rules is a direct benefit to small businesses: ensuring the safety and reliability of a product small businesses buy. In considering other effects of the rules on small businesses, the importance of maintaining this primary effect and benefit has been weighed against the possible benefits of reducing, simplifying, or eliminating the rules' requirements for small businesses.

As stated in part 2765.0300, the rules affect employers seeking to join self-insurance plans, service companies administering plans, and insurance companies providing stop-loss insurance to plans. Insurance companies would not meet the definition of small business contained in Minnesota Statutes, section 14.115, subdivision 1. This leaves employer members and service companies as the small businesses affected by the rules.

The major responsibilities of the service company and other plan contractors are outlined in part 2765.0800. Other responsibilities may be assigned to the service company depending on each plan's bylaws and board resolutions. Although the rules assign specific responsibilities to the service company, most requirements apply to the plan as such. It is the service company's role to fulfill operating requirements of the plan, and to conduct its day-to-day activities. This is the business that service companies are in; they are licensed on the basis of their competence in these areas, and they are paid by their clients to do it. For these reasons, it is not appropriate to lessen

requirements imposed on the service company or other contractors in the interests of making life easier for small businesses. The operating requirements are intended to ensure a plan's competent and equitable administration, and that its financial integrity is maintained. Service companies are licensed and paid to do this work. If the requirements were lessened or eliminated, it would actually harm service company small businesses by lessening the market for their services.

The only direct responsibilities of employers that belong to a joint self-insurance plan are contained in part 2765.0900, subparts 2 and 3; part 2765.1100, subpart 1; and part 2765.1400, subpart 6. All other requirements of the rules that affect employers indirectly are, in fact, requirements of the plan, and would be implemented by the service company or other contractors on the plan's behalf.

Part 2765.0900, subparts 2 and 3, govern employers' joining and leaving a plan. Subpart 2 states that a member may not join a plan until they have signed an agreement affirming their commitment to comply with the rules and the bylaws. The agreement must also specifically acknowledge the possibility of assessment if necessary to maintain the plan's sound financial condition.

The alternatives to this requirement are to eliminate it, or to allow the agreement to be completed after having joined a plan. These alternatives were considered, but were judged to be contrary to the purpose of the proposed rule. Joint self-insurance plan membership is fundamentally different from a conventional insurance policy, because members are assessable for plan deficits under certain circumstances. Members also have a much more direct role in a plan's administration than a policyholder has in an insurance company's administration. If an employer is unaware that assessments are possible, it would be a rude awakening to learn of it first upon being presented with an assessment. The

collection of an assessment in the face of such ignorance could be considerably complicated. However, the capacity to assess is a fundamental component of a plan's financial integrity. It would not benefit employers to hide their major responsibilities from them, particularly for assessments and in plan governance, until after they had already joined. These facts should be understood ahead of time, so the employer can judge whether joint self-insurance plan membership is appropriate to their needs.

Part 2765.0900, subpart 3, states that a member must notify the plan at least 30 days before withdrawing from the plan. Members also cannot withdraw until fulfilling a minimum term of membership which could range from three to fifteen months, and until any outstanding debts had been paid.

The alternatives to these requirements are to eliminate some or all of them, or to establish shorter reporting periods or terms of membership. These alternatives were considered, but were judged to be contrary to the purpose of the proposed rule. The 30-day notice requirement is essential if a plan is to have advance notice that it may be dropping below the statutory minimum plan size. The 30-day period allows a plan sufficient time to seek new members and prevent a violation of the minimum size requirement, if possible. Longer periods were also considered, but 30 days was judged to be long enough to seek out new members if, indeed, they could be found at all. The minimum term of membership was longer in earlier drafts of the rule. But after discussions with parties interested in the rule, it was judged that the three to fifteen month period would be long enough to prevent excessive membership turnover and thereby preserve plan stability, but not so long as to bind an employer to a plan for an excessive period. Finally, the requirement to pay all debts to the plan before ending membership is a basic requirement to enforce the payment of debts and preserve the plan's financial integrity. The only alternative is to permit

withdrawal with debts outstanding. However, a plan has more leverage over an employer if they can compel continuing membership if the debt is not paid. Elimination of this requirement would not be in the interests of the plan, nor would it be an appropriate concession to small businesses.

Part 2765.1100, subpart 1, requires employers to be responsible for that portion of the premium to be paid to the plan that their employees contribute. The alternative is to eliminate this requirement, making the plan responsible in the event employees default on their portion of the premium payment. In practice, an employee default is unlikely because the employer typically deducts such contributions directly from payroll. But if for any reason an employee should default, it would be unreasonable to expect the plan to seek reimbursement directly from the employee. The plan's financial agreements run between it and the employer, not to any individual employees. The plan also has no control over the portion of premium to be paid by any particular employer and its employees. The plan charges an overall premium, and the employer is responsible to collect it in whatever way it finds appropriate. For these reasons, it would be inappropriate to make the plan directly responsible for employee defaults.

This part also states that if a plan must undertake special costs to collect money from a member, the costs are also the member's obligation. This requirement was also judged necessary to preserve a plan's financial integrity. Because a plan is not an independent company like an insurer, but consists of its collective members and their pooled funds, defaulting to the plan is a more serious matter than defaulting to a wholly separate for-profit business.

And finally, part 2765.1400, subpart 6, states that the commissioner may assess a plan's member employers if necessary to maintain or restore a plan's sound financial condition. This is only one of several options available to the commissioner, none of which would be invoked unless the board had first failed in its responsibility to take corrective action.

The alternative to retaining the assessment possibility is to rely wholly on the other financial safeguards contained in the rules. The most important of these are the reserving requirements, the stop-loss insurance requirements, the requirement that rates be adequate, and the various provisions of part 2765.1400 (fidelity bonds, separate accounts, investment restrictions, etc.).

The necessity of each of these requirements was carefully weighed before inclusion in the final proposed rules. It was judged that each requirement, including the assessment possibility, was necessary to insuring the stability and financial integrity of joint self-insurance plans. As stated previously, unlike insurance companies, joint self-insurance plans have no investors who have paid-in capital to finance the venture, or who will bail the company out if loss experience is poor. Plans also do not participate in the collective insurance industry arrangements, such as the guaranty associations, which will assume outstanding claims in the event a company goes bankrupt. These differences make joint self-insurance plans less financially sound than insurance companies, unless substitute financial guarantees are required.

The requirements concerning reserves, stop-loss insurance, rates, and related matters should be adequate to protect a plan in all but the most extreme circumstances. Nevertheless, there are scenarios that could occur in which these safeguards would prove inadequate, as occasionally happens with insurance companies. In such cases, there must be some other source to turn to, and it is appropriate that that should be the entities responsible for the plan's exis-

tence and direction. In this respect, a plan's members have a role much like the investors of a business. The rules contain sufficient safeguards to reduce the possibility of extreme cases of financial hardship arising. But to fulfill their purpose and the statutory mandate, the rules must contain some provision for handling a worst-case scenario. And for that reason, the assessability of the members must be established.

Quantitative impact.

The quantitative impact of the rules on small businesses depends on the efforts put forth to establish and market joint self-insurance plans. Two plans have applied for joint self-insurance authority through August, 1984. They contain over 50 separate employers, and many hundred employees. If more plans are formed, and if the present plans grow, they could constitute a significant new participant in the competitive environment for health care plans. The formation and rapid growth of the existing plans indicates that the temporary rules have not been an impediment to the use of Minnesota Statutes, chapter 62H. The proposed permanent rules do not contain extensive changes from the temporary rules, and are not expected to constitute any more of an impediment than the temporary rules. On the contrary, it is likely that the state oversight of these plans, which the rules represent, is a major factor favoring these plans' growth.

CONCLUSION

For the reasons stated above, the commissioner believes that the proposed rules governing employee health and disability joint self-insurance plans are necessary to ensure that the financial integrity of these plans is maintained, and that they are administered competently and equitably. For the reasons stated above, the commissioner believes that the proposed rules reasonably address that need, and accomodate the interests of small businesses to the extent permitted by the statutory objectives of the proposed rules.