

Minnesota Attorney General: Administrative Rules Proceedings

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DEPARTMENT OF COMMERCE

INSURANCE DIVISION

Adopted Rules Governing the Minnesota Comprehensive Health Insurance Act of 1976, as Amended.

March 2, 1979

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4 MCAR § 1.3200 - Authority, Scope and Purpose

These rules are promulgated pursuant to Minn. Stat. § 62E.09(i) relating to qualified comprehensive health insurance plans and the operations of the Minnesota Comprehensive Health Association ~~in particular, and MINN. STAT. §§ 15.0411 to 15.0421, as amended, relating generally to the promulgation of administrative rules and regulations.~~ These rules and all future changes herein apply to all insurers, (including non-profit health service plan corporations), self-insurers, fraternals, health maintenance organizations and other organizations which are at the time of adoption of these rules, or at any time in the future, licensed or authorized to do business in or otherwise doing business in this state and thereby ~~are~~ subject to the provisions of the Minnesota comprehensive health insurance act of 1976. as amended. These rules are promulgated to carry out the act, as amended, and to facilitate its full and uniform implementation, ~~and~~ enforcement~~.~~ and application to all persons affected thereby.

4 MCAR § 1.3201 - Definitions

All terms used herein which are defined in Minn. Stat. ch. 62E shall have the meanings attributed to them therein. For the purpose of Minn. Stat. Ch. 62E and these rules ~~REGULATIONS~~, the terms defined herein shall have the meanings given to them.

A. Accident only coverage. "Accident only coverage" means a policy designed to provide coverage solely upon the occurrence of an accidental injury or death.

B. Act. "Act" means Minn. Stat. §§ 62E.01 to 62E.17, as amended, which shall be cited as the Minnesota comprehensive health insurance act of 1976.

C. ~~ACTUARIAL EQUIVALENCE~~ Actuarial Equivalent. "Actuarial equivalent" or "an actuarially equivalent benefit" means a benefit, the expected value of which when substituted for another benefit or benefits in a plan of health coverage will be the same as the benefit or benefits for which it was substituted, and which will result in the plan of health coverage after substitution of the actuarially equivalent benefit, being the actuarial equivalence of the original plan of health coverage. "Actuarial equivalence" shall be recognized for two plans where, employing the same set of assumptions for the same population, the expected value of benefits provided by the plans is equal. Expected value of benefits shall ~~WILL~~ be measured by the probability of the claim for each benefit multiplied by the average expected amount of each of those benefits.

D. Administrative expenses of the pool. "Administrative expenses of the pool" means the actual operating and administrative expenses of the Association incurred directly in the operation of the reinsurance plan including fees to a reinsurance administrator.

E. Association. "Association" means the Minnesota Comprehensive Health Association.

F. Board. "Board" means the board of directors of the Association.

G. Calendar year. "Calendar year" means a twelve month period from January 1, to and including December 31.

H. Certificate of eligibility. "Certificate of eligibility" or "certificate of eligibility and enrollment form" means the document entitled "certificate of eligibility and enrollment form" or any other document which is used to apply for coverage under the state plan.

I. Claims expenses. "Claims expenses" or "payment of benefits" means all payments to covered persons or providers including payments for hospital, surgical and medical care, and reasonable estimates (as determined by the Association and approved by the commissioner) of the incurred but not reported claims of the state plan.

J. Close relative. "Close relative" means the insured person's spouse, brother, sister, parent or child.

K. Commercial reinsurance. "Commercial reinsurance" or "excess of loss reinsurance" means reinsurance arranged by the Association under which the pool pays premiums to a reinsurer which assumes part of the risk of the reinsurance plan.

L. Covered expenses. "Covered expenses" means the usual and customary charges for the services and articles listed in Minn. Stat. § 62E.06, or the actuarial equivalence thereof, when prescribed for a covered person by a physician and when such expenses are incurred during a period in which the state plan policy or contract is in effect.

M. Covered person. "Covered person" means the insured person or an insured dependent.

N. Dental care. "Dental care" means those services which a person licensed to practice dentistry may provide as defined in Minn. Stat. § ~~105.05~~ 150A.05 subd. 1. → by Jan E. Shurig per agency memo of 3-28-79 filed in this matter w/ Office of Atty Gen.

O. Disabled child. "Disabled child" or a "dependent child of any age who is disabled" means a child, married or unmarried, who is and has been continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap and is financially dependent upon the insured, provided proof of such incapacity and dependency is furnished to the insurer or to the Association within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or the Association but not more frequently than annually after the two year period following the child's attainment of the limiting age.

P. Employee welfare benefit plan. "Employee welfare benefit plan" means any plan, fund, or program through which an employer provides, directly or indirectly, accident and health benefits to its employees through a trust, through the purchase of insurance, or through the provision of benefits for medical, surgical or hospital care.

Q. Financially dependent. A person shall be considered "financially dependent" if that person is chiefly dependent upon the insured person for support and maintenance.

R. Free standing ambulatory surgical center. "Free standing ambulatory surgical center" or "free standing ambulatory medical

center" means a surgical or medical center approved as such by the state of Minnesota.

S. Home health agency. "Home health agency" means a public or private agency that specializes in giving nursing service and other therapeutic services in the insured person's home and is approved as such by the state of Minnesota.

T. Hospital. "Hospital" means:

1. An institution which is operated pursuant to law and which is primarily engaged in providing on an inpatient basis for the medical care and treatment of sick and injured persons through medical, diagnostic, and surgical facilities, under the supervision of a staff of physicians and with twenty-four hour a day nursing service, or

2. An institution not meeting all the requirements of (1), but which is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.

3. In no event shall the term "hospital" include a nursing home or any institution or part thereof which is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

U. Hospital indemnity coverage. "Hospital indemnity coverage" means coverage which provides a fixed dollar benefit on the occurrence of the condition precedent that the covered person was confined in a hospital.

V. Illness. "Illness" means disease, injury, or a condition involving bodily or mental disorder of any kind, and including pregnancy.

W. Independent contractor. "Independent contractor" means a person who exercises an independent employment and contracts to do certain work without being subject to the control of his employer except as to the results of the work.

X. Individual insured. "Individual insured" means the covered employee or surviving spouse or surviving dependent of a covered employee as those terms are used in Minn. Stat. § 62A.17, subd. 6.

Y. Insured dependent. "Insured dependent" means an eligible dependent originally named in the policy or contract schedule or otherwise insured subsequent to the effective date of the policy or contract.

Z. Insured person. "Insured person" means the person named in the policy or contract schedule.

AA. Interim reinsurance assessment. "Interim reinsurance assessment" means an assessment at any time other than at the end of a calendar year (or other fiscal year end as determined by the Association) of participating members when pooling payments and payments by reinsurers for the year are not sufficient to fund paid and estimated obligations of the pool and administrative expenses of the pool.

BB. Licensed and tested insurance agent or solicitor. "Licensed and tested insurance agent or solicitor" means an agent or solicitor as defined in Minn. Stat. § 60A.02 subd. 7 or 8 and licensed by the commissioner under Minn. Stat. § 60A.17 to act as an agent or solicitor for accident and health insurance as defined in Minn. Stat. § 60A.06 subd. 1(5)(a).

CC. Losses. "Losses" means all claims expenses.

DD. Major medical expenses. "Major medical expenses" as used in Minn. Stat. § 62E.04 means the covered expenses for services and articles listed in Minn. Stat. § 62E.06, subd. 1 or the actuarial equivalence thereof, provided that the maximum lifetime benefit limit shall not be less than $250,000.

EE. Net gains. "Net gains" means the excess of premiums or contract charges over claims expenses, after the writing carrier's expenses and agent referral fees (not to exceed 12½% of premiums or contract charges) have been paid as provided in 4 MCAR § 1.3233.B.4.

FF. Non-qualified policy. "A non-qualified policy" or "unqualified policy" or "unqualified plan" means a policy, contract, or plan which has not been certified by the commissioner as qualified pursuant to the terms of the act.

GG. Nursing home. "Nursing home" means an institution meeting the following requirements: (1) it is operated pursuant to law and is primarily engaged in providing the following services for persons convalescing from illness: room, board, and twenty-four hour a day nursing service by one or more professional nurses and such other nursing personnel as are needed to provide adequate medical care; (2) it provides such services under the full-time supervision of a proprietor or employee who is a physician or a registered nurse; and (3) it maintains adequate medical records and has available the services of a physician under an established agreement if not supervised by a physician.

HH. Operating and administrative expenses of the Association. "Operating and administrative expenses of the Association" means expenditures reasonably necessary to the operation and administration of the Association including but not limited to rents, stationery, telegraph and telephone charges, salaries and expenses of office employees, investigators or adjusters, and legal expenses, as well as expenses of directors of the board of the Association relating to the conduct of or attendance at meetings. The operating and administrative expenses of the Association do not include the operating and administrative expenses of the writing carrier.

II. Out-of-pocket expenses. "Out-of-pocket expenses" means any cost or charge in a calendar year for a health service or article which is included in the list of covered services and articles under the qualified plan, qualified medicare supplement plan, policy or contract of major medical coverage, or state plan policy or contract under which the person is a covered person, and which is not paid or payable if claim were made under any plan of health coverage, medicare, or other governmental program.

JJ. Participating members. "Participating members" means insurer and fraternal members of the Association which elect to reinsure risks of issuing certain coverages required under the act through the Association under its reinsurance plan.

KK. Per diem policies. "Designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis" means policies which provide benefits upon the occurrence or existence

of a condition precedent, without reference to expenses incurred or services provided, for hospital, surgical or medical care.

LL. Policies or contracts of accident and health insurance. "Policies or contracts of accident and health insurance" means accident and health insurance policies as defined by Minn. Stat. § 62E.02, subd. 11.

MM. Pooling payment. "Pooling payment" means the amount each participating member pays the Association or its reinsurance administrator during a given period of time as determined by the Association or its reinsurance administrator based on pooling rates and volume of policies and contracts reinsured by the participating member in each category.

NN. Pooling rates. "Pooling rates" means unit rates approved by the Association and used as the basis for pooling payments.

OO. Pre-existing condition. "Pre-existing condition" means an injury, illness or other physical or mental condition of a covered person which existed prior to the issuance of the covered person's policy or contract.

PP. Pre-existing conditions limitation. "Pre-existing conditions limitation" means a limitation excluding coverage for an injury, illness or other physical or mental condition of an applicant which existed prior to the issuance of the applicant's policy or contract.

QQ. Professional services. "Professional services" means only services rendered by a physician or at the physician's direction by a private duty, licensed, registered nurse or an allied health professional. Professional services shall not include a service rendered by a close relative.

RR. Reasonable benefits in relation to the cost of covered services. "Reasonable benefits in relation to the cost of covered services" means reasonable benefits in relation to premium charged for coverage under a policy as determined by the minimum anticipated loss ratio requirement of Minn. Stat. § 62A.02, subd. 3.

SS. Reimbursable services. "Reimbursable services" means eligible services under medicare.

TT. Reinsurance administrator. "Reinsurance administrator" means an entity with which the Association contracts for administration of its reinsurance plan.

UU. Reinsurance assessment. "Reinsurance assessment" means a calendar year end (or other fiscal year end as determined by the Association) assessment of participating members when pooling payments and payments by reinsurers for the year are not sufficient to fund paid and estimated obligations of the pool and administrative expenses of the pool.

VV. Reinsurance plan. "Reinsurance plan" means any mechanism by which the Association undertakes to reinsure the risks which Minn. Stat. § 62E.10, subd. 7 authorizes the Association to reinsure.

WW. Reinsurance pool. "Reinsurance pool" or "pool" means the pool or fund into which the Association or the reinsurance administrator deposits pooling payments, interim reinsurance assessments and reinsurance assessments paid to the Association or its reinsurance administrator by insurer or fraternal members wishing to reinsure certain risks, as well as claims paid by reinsurers

under contract for commercial reinsurance with the Association, and other receipts, and from which the Association or its reinsurance administrator pays premiums for commercial reinsurance, administrative expenses of the pool, and reimbursement for claims paid by insurer or fraternal members which have reinsured all or any portion of risks covered under policies or contracts which have been reinsured pursuant to a reinsurance pooling agreement with the Association.

XX. Reinsurance pooling agreement. "Reinsurance pooling agreement" means the agreement between the Association and participating members which establishes a reinsurance plan.

YY. Reinsurer. "Reinsurer" means the commercial reinsurance company which contracts with the Association to provide excess of loss coverage for the risks which participating members reinsure through the Association.

ZZ. Rejection. "Rejection" means refusal by any Association member to issue a qualified plan to a person who completes an application for coverage under such qualified plan, as determined by the board.

AAA. Renewal date. "Renewal date" means the date specified in a policy or contract on which renewal occurs. In the absence of a specified renewal date in a policy or contract renewal date shall be determined in reference to the anniversary date specified in the policy or contract and shall occur in intervals of no greater than 12 months duration as determined in reference to the date on which the policy or contract became effective. Renewal of a

policy or contract shall be deemed to occur upon the expiration of a renewal date if coverage under the policy or contract is continued.

BBB. Resident of Minnesota. "Resident of Minnesota" means a person who is an actual resident of Minnesota, having there his or her principal and permanent abode.

CCC. Restrictive rider. "Restrictive rider" means a document or contractual provision adding certain conditions to the policy's or contract's coverage, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk.

DDD. Student. "Student" means any unmarried child under the age of 25 who during the calendar year is enrolled in and attends an educational institution as a full-time student and who is financially dependent upon an insured person.

EEE. Total cost of self insurance. "Total cost of self insurance" includes any direct and indirect administrative expenses incurred which are related to the operation of a plan of self-insurance, plus the sum of any payment made to or on behalf of Minnesota residents for costs or charges for health benefits by an employer which is a self-insurer under a plan of health coverage, regardless of the amount incurred or relationship of the cost to an insured or partially insured plan of health coverage, which is not counted as premium by an insurer, except to the extent of such payments made for coverage of the types described in clauses 1 through 8 of Minn. Stat. § 62E.02, subd. 11.

FFF. Usual and customary charge. "Usual and customary charge" for the purpose of the state plan means the normal charge, in absence of insurance, of the provider for a service or article ſupply, but not more than the prevailing charge in the area for a like service or article ſupply. A "like service" is of the same nature and duration, requires the same skill and is performed by a provider of similar training and experience. A "like article ſupply" is one which is identical or substantially equivalent. "Area" means the municipality (or, in the case of a large city, a subdivision thereof) in which the service or article ſupply is actually provided or such greater area as is necessary to obtain a representative cross-section of charges for a like service or article ſupply.

Part I - Qualified Comprehensive Health Insurance Plan

4 MCAR § 1.3202 - Duties of Employers

A. Duty to make available a qualified plan. An employer shall be deemed to have made available a qualified plan to its employees as required in Minn. Stat. § 62E.03, subd. 1 when participation under a number 2 or number 3 qualified plan or a health maintenance plan is offered to the employee directly or through an insurer or health maintenance organization and without regard to whether the cost of such participation is paid directly or indirectly by the employer or by the employee or by their joint payment.

B. Effect of collective bargaining on duty to make available a qualified plan. An employer whose employees are represented by one or more exclusive bargaining representatives shall be deemed to have complied with the provisions of Minn. Stat. § 62E.03, subd. 1 with respect to all employees within each unit for collective bargaining if the employer makes available qualified plans of health coverage to the exclusive bargaining representatives.

1. Such employers shall be deemed to have complied with requirements of Minn. Stat. § 62E.03, subd. 1 for each accounting period utilized by the employer for Minnesota income tax purposes during the entire term of any collective bargaining agreement executed after an offer of qualified health coverage has been made.

2. Nothing in this section shall require the employer to renegotiate any collectively bargained agreement solely for the purposes of compliance with this act.

C. Frequency of required offer. Except as provided in 4 MCAR § 1.3202 B., an employer shall be deemed to have complied with the requirements of Minn. Stat. § 62E.03, subd. 1 of the act if he makes available to his employees a plan of health coverage which is certified as a number 2 or number 3 qualified plan or a health maintenance plan at least once during each accounting period utilized by the employer for Minnesota income tax purposes.

4 MCAR 1.3203 - Duties of Insurers and Fraternals

A. Exception to definition of "accident and health insurance policy." The exception provided by Minn. Stat. § 62E.02, subd. 11(4), shall apply with respect to hospital indemnity coverage sold by an insurer to an applicant who is, at the time of application for hospital indemnity coverage, covered by a qualified plan, notwithstanding the possibility that the applicant may subsequently terminate coverage under a qualified plan.

1. The exclusion of Minn. Stat. § 62E.02, subd. 11(4) shall also apply to a hospital indemnity coverage which is sold by an insurer to an applicant who is then currently covered by a health maintenance plan.

2. Insurers shall be entitled to conclusively rely upon the written statement of an applicant for hospital indemnity coverage that such applicant is, at the time of the application, covered by a qualified plan or a health maintenance plan.

B. Timing of required offer of a qualified plan or qualified medicare supplement plan.

1. The offer of each type of qualified plan (that is a number 1, number 2, and number 3 qualified plan) which is required when an insurer or fraternal is offering an individual policy of accident and health insurance shall occur no later than the date of delivery of such policy to the applicant.

2. The offer of a qualified medicare supplement plan which is required when an insurer or fraternal is offering a medicare supplement policy shall occur no later than the date of delivery of such policy to the applicant.

3. The offer of each type of qualified plan (that is a number 1, number 2, or number 3 qualified plan) required when an insurer or fraternal is offering a group policy of accident and health insurance shall occur no later than the date of delivery of such policy to the applicant.

4. "Each person who applies" and "applicant" for the purposes of Minn. Stat. § 62E.04 and this section of the rules shall be deemed to be only the individual making an initial application for an individual policy or in the case of a group policy, the corporation,partnership, proprietorship, association or other qualified entity making application for a group policy.

5. Minn. Stat. § 62E.04, subds. 1, 2 and 3 shall not be deemed to require an insurer or fraternal to offer a qualified plan or qualified medicare supplement plan at the time a policy is subject to renewal.

C. No duty to offer a particular category of insurance. For the purposes of the act, individual accident and health insurance, group accident and health insurance, individual medicare supplement plans and group medicare supplement plans are recognized as separate and distinct categories of insurance. Nothing in Minn. Stat. § 62E.04, subds. 1, 2 and 3 shall be construed as requiring an insurer or fraternal to engage in the business of offering or issuing a particular category of accident and

health insurance policy or medicare supplement plan which it does not otherwise offer or issue in this state.

D. Duty to offer major medical coverage. Each insurer and fraternal shall affirmatively offer, subject to its underwriting standards, coverage of major medical expenses to every applicant for a new unqualified policy at the time of application and annually thereafter to every holder of an unqualified policy of accident and health insurance as required by Minn. Stat. § 62E.04, subd. 4. "Affirmatively offer" shall mean written advice to the applicant for, or the holder of, an unqualified policy of accident and health insurance, of the availability of coverage for major medical expenses. Such written advice of the availability of the coverage for major medical expenses may be satisfied by a contractual provision in the unqualified policy which gives the insured the contractual right to apply to the insurer or fraternal for a policy or rider which provides coverage for 80% of the covered expenses for services listed in Minn. Stat. § 62E.06, subd. 1 or the actuarial equivalence thereof subject to a $5,000 deductible for out-of-pocket expenses, subject to the insurer's or fraternal's underwriting requirements.

E. Effect on foreign contracts. No provision of the act shall be construed to require any insurer or fraternal to alter or amend any policy or contract issued outside the state of Minnesota.

F. Exclusion of certain foreign conversion policies.

The issuance of individual group conversion policies or contracts in Minnesota pursuant to Minn. Stat. § 62A.17 or Minn. Stat. § 62E.16 shall not, in and of itself, constitute the transaction of accident and health insurance business by an insurer or fraternal which has relinquished prior authority to transact such business in Minnesota and which is not otherwise currently issuing policies or contracts in Minnesota.

G. Exceptions to duties for certain policies and contracts.

1. The continuation in force of a policy or contract under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend or change the terms, conditions or premium rate of the policy or contract in any way, shall not be considered a renewal for the purposes of Minn. Stat. § 62E.04 and 4 MCAR § 1.3225 A.1. if the policy or contract:

   a. was issued prior to July 1, 1976, or

   b. was designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis and was issued prior to June 3, 1977.

2. The issuance or renewal by an insurer or fraternal on or after June 3, 1977, of a policy or contract which is designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis, shall not be subject to Minn. Stat. § 62E.04, except for policies and contracts sold by an insurer to provide payments on

a hospital indemnity basis if such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue.

H. Sanction for failure to comply with duties of insurers and fraternals. Any insurer or fraternal not in compliance with Minn. Stat. § 62E.04 shall cease and desist from transacting accident and health insurance business in the state of Minnesota. Nothing in this section shall prohibit such an insurer or fraternal no longer meeting the definition of insurer in Minn. Stat. § 62E.02, subd. 10 or fraternal in Minn. Stat. § 62E.02, subd. 19 from continuing to maintain in force any policies or contracts described in 4 MCAR § 1.3203 G.1.

4 MCAR § 1.3204 - Qualified Plan Pre-existing conditions.

A qualified plan may include provisions consistent with generally accepted underwriting practices which provide that any pre-existing condition for any person covered under the policy which was diagnosed prior to the effective date of the policy, and for which medical care or treatment was rendered or prescribed during the 90 days immediately prior to the application for such policy, shall not be covered or eligible for the payment of any benefits for care or treatment rendered during a period of time beginning on the effective date of the policy and ending 24 months after the policy has been continuously in force.

4 MCAR § 1.3205 - Minimum Benefits of Qualified Medicare Supplement Plans

The minimum benefits of qualified medicare supplement plans shall be as provided in Minn. Stat. § 62E.07 and as described for the purposes of the state plan in 4 MCAR § 1.3230 C.

4 MCAR § 1.3206- Certification of Qualified Plans

A. Application for certification. The application of an insurer, fraternal, or employer for certification by the commissioner of a plan of health coverage as a qualified plan or a qualified medicare supplement plan under Minn. Stat. § 62E.05 shall include the qualification number of the plan for which certification is sought pursuant to the procedures specified in the actuarial equivalence tables set forth in Appendix I of these rules.

B. Certification by the commissioner. An accident and health insurance policy or plan is deemed certified as a qualified plan or qualified medicare supplement plan for the purposes of Minn. Stat. § 62E.05 if it meets the requirements of these rules ~~regulations~~ and other relevant laws of this state upon the expiration of 90 days after receipt of the request for certification by the commissioner, unless earlier rejected or certified by the commissioner. In the event the commissioner rejects such request, he shall give written notice of the grounds for rejection to the person submitting the plan, and the insurer, fraternal or employer has the same rights in the event of such rejection as provided in Minn. Stat. § 62A.02.

C. Required Benefits under the act. On or after June 3, 1977, each plan of health coverage in order to be certified as a number 1, number 2 or number 3 qualified plan, shall provide a limitation of $3,000 per person on total annual out-of-pocket

expenses and a maximum lifetime benefit of not less than $250,000, and shall provide all other benefits required under the act which are not subject to substitution of actuarially equivalent benefits, under Minn. Stat. § 62E.06.

D. Certification of an employer's plan of health coverage. For purposes of certification of an employer's plan of health coverage pursuant to Minn. Stat. § 62E.03, any plan of health coverage which constitutes a qualified plan at the time of issue shall continue to be a qualified plan until the later of the next renewal date of the plan of health coverage or the expiration of an applicable collective bargaining agreement, if any.

4 MCAR § 1.3207 - Termination of Coverage: Conversion Privileges

A. Eligibility for conversion upon termination. A person whose employment has terminated may elect to exercise the right provided by Minn. Stat. § 62A.17 for continued coverage under the group insurance policy, group subscriber contract, health maintenance contract, or plan of health coverage which is self insured or, at the employee's option, may exercise the right provided by Minn. Stat. § 62E.16, to convert to an individual coverage qualified plan. If the employee elects to continue coverage under Minn. Stat. § 62A.17, such employee may not exercise the right of conversion under Minn. Stat. § 62E.16 until the continuation coverage obtained pursuant to Minn. Stat. § 62A.17 is terminated, and if the employee elects to convert to an individual qualified plan, the employee may not elect to continue group coverage pursuant to Minn. Stat. § 62A.17.

B. Duty to offer conversion policy or contract.

1. For the purposes of Minn. Stat. § 62E.16 and Minn. Stat. § 62A.17, an insurer, health maintenance organization, or self insurer shall not be required to offer a conversion policy or contract to a person who is then covered by a qualified plan or eligible for medicare.

2. An insurer, health maintenance organization, or self insurer shall not be required to renew a conversion policy or contract issued to a person who, during the prior policy or contract year, became covered by a qualified plan or became eligible for medicare.

3. An insurer, health maintenance organization or self insurer which is required to offer conversion coverage to a terminated employee must offer, at the employee's option, a number 1, number 2 or number 3 qualified plan. A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, spouse or a dependent in lieu of the optional coverage otherwise required by Minn. Stat. §§ 62A.17, subd. 6 and 62E.16.

C. Due notice of cancellation or termination.

An insurer, health maintenance organization or self insurer shall be deemed to have provided "due notice of cancellation or termination" as required in Minn. Stat. § 62E.16 if the insurer, health maintenance organization or self insurer notifies in writing those employees at their respective addresses as provided the insurer, health maintenance organization or self insurer by the employer pursuant to the terms of Minn. Stat. § 62E.16.

4 MCAR § 1.3208 Revision of Actuarial Equivalence Tables

The commissioner shall periodically, no less frequently than biennially, review the actuarial equivalence tables set forth in Appendix I of these rules, and shall require that the relative point values set forth therein be actuarially updated when required to more accurately reflect changes in the relative values of benefits (including copayments). Any revision of relative point values which the commissioner shall make shall be promulgated pursuant to the rulemaking requirements of the Administrative Procedures Act (Minn. Stat. ch. 15). *published in the State Register together with justification therefor, and shall take effect upon publication.* Following revision of the actuarial equivalence tables pursuant to this section, recertification of existing plans of health coverage may be required subject to the provisions set forth in 4 MCAR §§ 1.3202, 1.3203, and 1.3206.

4 MCAR § 1.3209 - 1.3224 Reserved for Future Use

PART II - Minnesota Comprehensive Health Association

4 MCAR § 1.3225 MCHA - Membership in the Association.

A. Mandatory membership. As a condition of doing accident and health insurance business, self insurance business or health maintenance organization business in Minnesota, all insurers, self insurers, fraternals and health maintenance organizations licensed or authorized to do business in this state shall become members of the Association and maintain their membership therein.

1. "Accident and health insurance business" means the issuance or renewal of any accident and health insurance policy as defined in Minn. Stat. § 62E.02, subd. 11.

a. An insurer is engaged in accident and health insurance business during the period in which any policy or contract which has been issued or renewed remains in effect.

b. Such business shall not include the issuance or renewal of policies or contracts providing coverage which is:

(1) Limited to disability or income protection coverage for a specified period of time;

(2) Limited to automobile insurance which provides coverage for medical payments as defined and authorized under Minn. Stat. § 60A.06, subd. 1(12);

(3) Supplemental to liability insurance, as defined and authorized in Minn. Stat. § 60A.06, subd. 1(13);

(4) Limited to policies or contracts issued prior to

July 1, 1976 under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend or change the terms, conditions or premium rate of the policy or contract in any way; provided that all policies and contracts designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis issued prior to June 3, 1977 under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend or change the terms, conditions or premium rate of the policy or contract in any way, are also excluded;

(5) Designed solely to provide payment on a per diem, fixed indemnity or non-expense incurred basis except that all policies and contracts designed solely to provide payments on a hospital indemnity basis issued or renewed by an insurer on or after June 3, 1977 are included to the extent that such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue;

(6) Limited to credit accident and health insurance, meaning insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy, as authorized by Minn. Stat. ch. 62B;

(7) Designed solely to provide dental or vision care;

(8) Limited to blanket accident and sickness insurance as defined in Minn. Stat. § 62A.11; or

(9) Limited to accident only coverage issued by a licensed and tested insurance agent or solicitor and which provides reasonable benefits in relation to the cost of covered services.

2. "Self insurance business" means the provision, directly or indirectly, of a plan of health coverage by a self insurer. "Self insurance business" does not include the direct provision of health care services to employees at no charge to them by an employer engaged in the business of providing health care services to the public, nor does it include provision of benefits which, if provided by an insurer doing accident and health insurance business, would be excluded under 4 MCAR § 1.3225 A.1.b.(1)-(9) of these rules. "Directly or indirectly" for the purposes of this section of the rules means that the employer or employee welfare benefit plan funds the plan of health coverage in any amount or collects any employee contributions which are used to pay for the plan of health coverage.

3. "Health maintenance organization business" means the operation of a nonprofit corporation licensed and operated as provided in Minn. Stat. ch. 62D.

4. "Licensed or authorized to do business" means:

   a. licensed by the commissioner to conduct business under Minn. Stat. chs. 62A, 62C, or 64A, or by the commissioner of health under Minn. Stat. Ch. 62D, or

   b. authorized by the secretary of state to carry on any business in the state of Minnesota or otherwise doing business in this state and acting as an insurer, self insurer, fraternal or health maintenance organization.

B. Assessment agreement. Each member shall enter into an assessment agreement with the Association for a one year term, renewable annually thereafter as required by the act. Signing this assessment agreement shall fulfill the requirement that members enter into a reinsurance contract with the Association under Minn. Stat. § 62E.10, subd. 5. The agreement shall be signed by an officer of the member who is authorized to enter into contracts on behalf of the member, shall be in a form adopted by the board of directors of the Association and approved by the commissioner, and shall include but not be limited to provisions regarding the members' obligation to:

1. Share proportionately in funding the operating and administrative expenses of the Association in accordance with 4 MCAR § 1.3225 C. and D. below;

2. Share proportionately in the losses of the Association in accordance with 4 MCAR § 1.3225 C. and D. below;

3. Pay all fiscal year-end assessments which shall be due within 30 days after the end of the Association's fiscal year (December 31 unless the Association establishes

a different fiscal year end) and shall be payable 30 days after receipt of a written assessment notice.

C. Assessments. Members, according to the assessment agreement, will be assessed for their proportionate share of the operating and administrative expenses of the Association, incurred or estimated to be incurred, together with losses, if any, incurred by the Association as a result of operation of the state plan. The total amount of operating and administrative expenses and losses:

1. Shall be determined annually by the board at each fiscal year end;

2. May, at the recommendation of the board, subject to the approval of the commissioner, consist of a reasonable estimate of the operating and administrative expenses of the Association for the succeeding fiscal year, which amount shall be adjusted at the end of the succeeding fiscal year to the amount of actual operating and administrative expenses, and members shall be entitled to credit for any excess or shall be assessed for any deficit in these expenses in the next annual fiscal year end assessment.

D. Levy of assessments. The Association may levy assessments following each fiscal year end.

1. The Association may also, upon approval of the commissioner, levy interim assessments when deemed necessary to assure the financial capability of the Association to meet the incurred or estimated operating and administrative expenses of the Association and losses resulting from the state plan.

Interim assessments shall be due and payable within 30 days of receipt by a member of a written interim assessment notice.

2. The Association shall levy each member's share of the total assessment based on the ratio of:

   a. The member's total accident and health insurance premium, subscriber contract charges or health maintenance organization contract charges (the preceding defined as charges for business defined in 4 MCAR § 1.3225 A.1. and 3. above) received from or on behalf of residents of Minnesota, or total cost of self insurance, as determined by the commissioner, to

   b. The total for all members of premiums, contract charges and benefit plan costs reported in 4 MCAR § 1.3225 D.2.a.

3. The costs and charges referred to in the ratio in 4 MCAR § 1.3225 D.2.a. and b. shall, to the extent possible, be determined by reference to a form issued by the Association or the commissioner which all members shall submit to the commissioner annually for the preceding calendar year.

   a. If the required information is not available to the commissioner when necessary to levy an assessment the commissioner may estimate the member's share based on other available information relative to its experience, including but not limited to the annual statement which all insurers are required to transmit to the commissioner under Minn. Stat. § 60A.13.

b. The commissioner shall have the authority to audit the accounts and records of any member and any agent, trust, third party administrator or other entity administering all or any portion of a plan of health coverage with or on behalf of a self insurer for the purpose of obtaining information necessary to levy an assessment.

4. The board may, in its discretion, decline to levy assessments against members which owe up to $5.00 or less in a given year.

E. Failure to execute assessment agreement or to pay assessments. The names of all insurers, self insurers, fraternals and health maintenance organizations which are required under the act to be members of the Association, but which fail to execute an assessment agreement, will be forwarded by the Association to the commissioner for appropriate action within the discretion of the commissioner. Any members which fail to pay annual or interim assessments when such assessments become payable will be reported by the Association to the commissioner for appropriate action within the discretion of the commissioner.

4 MCAR 1.3226 MCHA - Organization and approval.

The Association shall operate pursuant to the provisions of Minn. Stat. ch. 62E, with all the powers of a corporation formed under Minn. Stat. ch. 317, except that if the provisions of the two chapters conflict, ch. 62E shall govern.

A. Amendments to the articles of incorporation. Amendments to the articles of incorporation shall be submitted to and approved by the commissioner before filing with the secretary of state.

B. Amendments to the by-laws. All ~~Amendments~~ amendments to the by-laws of the Association shall be submitted to and approved by the commissioner before they become effective.

C. Operating rules. The board is authorized to adopt and to amend from time to time reasonable operating rules which are not inconsistent with the act and these rules ~~regulations~~ for the management and operation of the Association~~.~~ ~~and upon~~ Upon submission to and approval by the commissioner, these operating rules shall become effective.

4 MCAR § 1.3227 MCHA - Board of directors.

A. Composition. The management of the Association shall be vested in a board of seven directors who shall be representative of the membership of the Association, and be officers, employees or agents of members of the Association during their terms of office, and shall automatically be removed for failure to meet this qualification.

B. Election. The board shall be elected by members at the annual meeting of the Association in accordance with the by-laws of the Association, to the extent that such by-laws are consistent with the provisions of Minn. Stat. chs. 317 and 62E, and in accordance with the provisions relating to voting rights as outlined in 4 MCAR § 1.3228.

1. Prior to the election, the Association may submit the names of proposed board members to the commissioner for approval/ ~~which may be granted according to criteria as determined by the commissioner.~~

2. After the annual meeting, the results of the election shall be certified and submitted to the commissioner for approval/ pursuant to the criteria set forth in Minn. Stat. § 62E.10, subd. 2.

C. Duties. The duties of the board shall include management of the Association in furtherance of its purposes as provided in the act, and as authorized in the articles of incorporation and by-laws of the Association.

1. Members of the board may be reimbursed by the Association for expenses incurred by them in attending board or board

committee meetings and for other reasonable expenses incurred within the scope of their activities as directors and within guidelines established by the board and approved by the commissioner, but shall not otherwise be compensated for their services.

D. Officers and committees. The board may elect officers and establish committees as provided in the by-laws of the Association. These officers and committees shall be charged with such duties as authorized by the board in accordance with the by-laws of the Association.

4 MCAR § 1.3228 MCHA - Determination of Members' Voting Rights

A. Meetings. Every member is entitled to vote at the annual meeting and at any special meeting of the members.

B. Weighted vote. A member's vote shall be a weighted vote based on the member's cost of self-insurance, accident and health insurance premiums, subscriber contract charges or health maintenance contract charges derived from or on behalf of residents of Minnesota in the previous calendar year, as determined by the commissioner.

1. To the extent possible, this figure shall be determined by reference to the annual reporting form submitted to the commissioner in accordance with 4 MCAR § 1.3225 D.3.

2. If the necessary information is not available to the commissioner on the form described in 4 MCAR § 1.3228 B. at the time that voting rights must be determined, the commissioner may estimate the member's weighted vote based on other information available to the commissioner.

C. Voting procedures. Members are entitled to vote in person, by proxy, or by mail as determined by the board.

1. When a member elects to vote in person at a members' meeting, the representative casting the vote shall present credentials as may be required pursuant to the by-laws or operating rules of the Association. By the board.

2. When a member elects to vote by proxy, the proxy statement, as approved by the board and by the commissioner shall be returned on or before the date indicated in the meeting notice sent to the members.

3. Voting by mail may be permitted as authorized by the by-laws or operating rules of the Association, and ~~the board provided that~~ the meeting notice to members shall so indicate~~s~~.

4 MCAR § 1.3229 MCHA - Meetings of the Association

A. Annual Meeting. An annual meeting of the members shall be held for the purpose of electing directors as provided in 4 MCAR § 1.3227 B. and for the purpose of transacting any other appropriate business of the membership of the Association.

1. The meeting shall be held in the second calendar quarter of each year unless otherwise determined by the board, and shall occur at such date, time and place as the board determines.

2. "Appropriate business" includes any activities related to the powers and duties of the Association under Minn. Stat. chs. 62E or 317.

3. Notice and quorum requirements shall be as provided in the articles of incorporation or by-laws of the Association or as otherwise authorized by the board.

B. Special meetings. Special meetings of the members shall be held at the request of the commissioner and may otherwise be held as provided by the articles of incorporation or by-laws of the Association for the purpose of conducting any appropriate business of the Association.

1. A special meeting may be held at such date, time and place designated in the notice of the meeting.

2. Notice and quorum requirements shall be as provided in the articles of incorporation or by-laws of the Association or as otherwise authorized by the board.

C. Open meetings. All meetings of the Association membership, board and any committees established in accordance with 4 MCAR § 1.3227 D. shall be held in compliance with the provisions of the open meeting law (Minn. Stat. § 471.705).

4 MCAR § 1.3230 MCHA - Minimum Benefits of Comprehensive Health Insurance Plans

A. Duty to offer. The Association shall offer a number 1 and number 2 qualified plan, and a qualified medicare supplement plan to eligible persons. The Association shall offer health maintenance plans in areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier in accordance with 4 MCAR § 1.3233 A. The Association may provide for coverage for eligible dependents.

B. Benefits of a number 1 and number 2 qualified plan. Benefits shall meet or exceed the requirements of Minn. Stat. § 62E.06 or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables set forth in Appendix I of these rules, except where substitution of an actuarially equivalent benefit is not permissible under the act.

1. The minimum benefits shall be equal to at least 80% of the charges for covered expenses in excess of the annual deductible which shall not exceed:

   a. $500.00 for a number 2 qualified plan,

   b. $1,000.00 for a number 1 qualified plan.

2. Coverage shall include an annual (calendar year) limitation of not more than $3,000.00 per covered person on total out-of-pocket expenses, which out-of-pocket expenses shall include the deductible under the state plan policy or contract, and which benefit (copayment) is not

subject to substitution of an actuarially equivalent benefit (copayment).

3. Coverage shall be subject to a maximum lifetime benefit of not less than $250,000.00 per covered person, less any amount paid to or on behalf of the covered person under any other state plan policy or contract. This benefit is not subject to substitution of an actuarially equivalent benefit.

C. Benefits of a qualified medicare supplement plan. Benefits of a qualified medicare supplement plan shall meet or exceed the following minimum standards or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables set forth in Appendix I of these rules.

1. The plan shall provide benefits to covered persons who are 65 years of age or older by supplementing medicare through provision of 50% of the deductible and co-payment required under medicare;

2. The plan shall provide 80% of the covered charges for expenses as provided in Minn. Stat. § 62E.06 or the actuarial equivalence thereof, which charges are not paid or payable under medicare or would not have been paid or payable had the covered person who is or was entitled or eligible to enroll in medicare been so enrolled.

3. Coverage shall include an annual limitation of $1,000.00 total out-of-pocket expenses per covered person for covered expenses.

4. Coverage may not be subject to a maximum lifetime

benefit of less than $100,000.00/, or the unused portion of the maximum lifetime benefit under any policy or contract of the state plan under which the person was previously covered, whichever is less.

D. Benefits of a health maintenance plan. Benefits of a health maintenance plan shall include those comprehensive health maintenance services required by Minn. Stat. Ch. 62D and rules thereunder.

E. Pre-existing conditions. No person who obtains coverage under a policy or contract of the state plan shall be covered for any pre-existing condition during the first six months of coverage under the state plan if such covered person was diagnosed or treated for that condition during the 90 days immediately preceding the filing of a completed certificate of eligibility.

4 MCAR § 1.3231 MCHA - Approval of state plan.

A. Submission of proposed state plan. Members of the Association may submit to the Association policies or contracts which have been approved by the commissioner for selection by the Association as the state plan.

B. Approval of policies or contracts by the Association. The Association shall select policies or contracts to constitute the state plan from among the proposals submitted by the members or from proposals developed by the Association or others. These policies and contracts, or parts thereof, may be used to develop specifications for bids from members which wish to be selected as a writing carrier to administer the state plan.

C. Approval of the state plan. The policies or contracts approved by the Association as the state plan shall be approved by the commissioner prior to issuance.

4 MCAR § 1.3232 MCHA - Solicitation, Application and Enrollment of Eligible Persons in the State Plan

A. Open enrollment. The state plan shall be open for enrollment by eligible persons at all times.

1. "Eligible person" means a resident of Minnesota who submits or on whose behalf is submitted a complete certificate of eligibility and enrollment form to the Association or its writing carrier and who is not already covered by another state plan policy or contract.

a. A complete certificate of eligibility and enrollment form may, at the discretion of the Association, provide:

(1) name, address, age, sex, and length of time as a resident of Minnesota,

(2) name, address, and age of eligible dependents, if any, if they are to be insured;

(a) "eligible dependent" means the insured person's spouse who has not reached age 65 or unmarried child, excluding:

(i) a legally separated spouse;

(ii) a child who is nineteen years old or older unless that child is a student or disabled child;

(iii) a spouse or child who has applied for an individual state plan policy or contract pursuant to any

conversion privilege granted to such eligible dependent under the insured person's state plan policy or contract, and

(iv) a spouse or child on active duty in any military, naval or air force of any country.

(3) Evidence of rejection, or a requirement of a restrictive rider or pre-existing conditions limitation on a qualified plan the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, by at least two Association members within six months of the date of application. "Substantially reduce coverage from that received by a person who is considered a standard risk" includes any restriction on coverage as a result of an illness, condition, or risk which the Association deems substantial, any increase in rates for an applicant based on an illness, condition or risk, which the Association deems substantial, and any pre-existing conditions limitation which the Association deems substantial.

b. Before a person is determined to be an eligible person, the board may in its discretion require

that any items listed in 4 MCAR § 1.3232 A.1.a. or, if acting pursuant to provisions of the Association's operating rules, other necessary information deemed necessary by the board be submitted to the Association or its writing carrier and may also investigate the authenticity of information submitted as a part of the certificate of eligibility.

c. If a covered person, upon reaching age 65, wishes to purchase a state plan qualified medicare supplement plan, the requirement that the person obtain two rejections from members of the Association within the preceding six months may be waived by the board, if acting pursuant to provisions of the Association's operating rules.

d. A person who is age 65 or older shall be eligible for coverage only under the state plan's qualified medicare supplement plan and when an insured person under a qualified plan reaches age 65, the board may, if acting pursuant to provisions of the Association's operating rules, in its discretion, terminate or refuse to renew coverage under the qualified plan.

e. An applicant or any person proposed to be covered under the state plan who has previously been covered by a state plan policy or contract and who has exhausted the maximum lifetime benefit under the state plan shall not be an eligible person for coverage

under the state plan, and if such person has exhausted $100,000.00 of the maximum lifetime benefit under the state plan, such person shall not be an eligible person for coverage under a qualified medicare supplement policy or contract of the state plan, provided that an applicant for a qualified medicare supplement policy or contract of the state plan who has previously been covered under the state plan shall be eligible for a maximum benefit under the qualified medicare supplement policy or contract of $100,000.00, or the unused portion of the maximum lifetime benefit under any policy or contract of the state plan under which the person was previously covered, whichever is less.

f. When a covered person under the state plan no longer meets one or more of the requirements for eligibility for coverage under the state plan, the board may, if acting pursuant to the Association's operating rules, ~~in its discretion,~~ terminate or refuse to renew coverage under the state plan.

B. Association's response. Within 30 days of receipt of a complete certificate of eligibility and ~~application~~ enrollment form pursuant to 4 MCAR §1.3232 A.1.a. and b, the Association or the writing carrier shall accept the certificate of eligibility or shall reject the certificate of eligibility for failure to meet the eligibility requirements.

1. If the Association or its writing carrier accepts the certificate of eligibility, it shall forward a notice of acceptance, billing information and a policy or contract (or certificate) which shall evidence coverage under the state plan.

a. Such policy or contract (or certificate) of coverage shall include but not be limited to:

(1) a statement that the person is covered under the state plan from the effective date contained therein.

(2) specification of the type of state plan under which the person is covered,

(3) a statement that the plan is provided by the Association,

(4) a description of the benefits provided by the

plan, conditions for eligibility, and exclusions and limitations of coverage, and

(5) provision for an identification card for each insured person indicating the type of state plan and also that coverage is being provided by the Association.

b. When the state plan premium is received by the Association or its writing carrier for the first billing period (and accepted in accordance with 4 MCAR § 1.3232 B.,) the coverage shall be effective retroactive to the date of receipt by the Association or its writing carrier of the completed certificate of eligibility pursuant to 4 MCAR § 1.3232 A.1.a. and b. unless otherwise requested by the insured person and approved by the board.

2. If the Association does not accept the certificate of eligibility the applicant shall be informed of the reason for the rejection and shall have the opportunity to submit additional information to substantiate eligibility for coverage under the state plan and to request reconsideration of the decision. The board ~~may~~ shall establish a review mechanism for reviewing requests for reconsideration of rejected certificates of eligibility.

The Association shall give notice of a final determination of ineligibility to the applicant stating the reasons therefor and advising the applicant of the right to appeal to the commissioner within a reasonable period of time.

C. Appeal to commissioner. Any applicant or covered person who is determined by the Association to be ineligible for coverage under the state plan may appeal such determination to the commissioner within a reasonable period of time. Upon receipt of an appeal from a determination of ineligibility, the commissioner may, in his discretion, affirm, reverse, or modify the determination of the Association.

D. Solicitation of eligible persons. The Association shall develop a plan for use by the Association, upon approval by the commissioner, to publicize the existence of the state plan, the eligibility requirements and procedures for enrollment, and to maintain public awareness of and participation in the state plan.

1. The Association ~~may~~ shall prepare and ~~distribute~~ make available certificate of eligibility forms and enrollment instruction forms to insurance solicitators, agents and brokers, and to the general public in Minnesota.

2. The Association shall require the writing carrier to pay a referral fee of $25.00 for any certificate of eligibility accepted by the Association or its writing carrier. The referral fee shall be paid to the licensed agent whose signature appears as the agent on the accepted certificate of eligibility. The referral fee shall be paid from the premium received for the state plan.

4 MCAR § 1.3233 MCHA-Selection, Approval and Operations of Writing Carrier(s)

A. Selection and approval of a writing carrier(s).

1. The Association may select a writing carrier or writing carriers on the basis of criteria for selection which shall include but not be limited to:

   a. The member's proven ability to handle large group accident and health insurance cases,

   b. The efficiency of the member's claim paying capacity,

   c. An estimate of total charges for administering the plan, and

   d. Other criteria developed by the Association and set forth in its operating rules. ~~of the commissioner.~~

2. The writing carrier selected by the Association shall be approved by the commissioner prior to the establishment of a contract with the Association and prior to the commencement of its duties pursuant to Minn. Stat. § 62E.13 and 4 MCAR § 1.3233 B.

3. The writing carrier shall serve for a period of three years, unless the commissioner approves an earlier termination at the request of the writing carrier or the Association in accordance with the terms of its contract with the writing carrier.

   a. The commissioner shall approve or deny a request for termination within 90 days of receipt of such request.

b. Failure to make a determination within 90 days of receipt of such request shall be deemed to be an approval.

4. If termination is approved by the commissioner, the writing carrier shall serve for up to six months from the date of the writing carrier's request for termination, at the discretion of the Association, to allow the Association to select another writing carrier.

5. Six months prior to the expiration of each three year period of service by a writing carrier, the Association shall invite insurer and health maintenance organization members, including the current writing carrier(s), to submit bids to serve as writing carrier for the succeeding three year period.

B. Operations of the writing carrier.

1. The writing carrier shall perform all administrative and claims payment functions relating to the state plan.

a. The writing carrier shall establish a premium billing procedure for collection of premiums from insured persons.

(1) Billings shall be made on a periodic basis as determined by the board.

(2) The amount of the premium shall be as determined from time to time by the board pursuant to Minn. Stat. § 62E.08.

b. The writing carrier shall perform all necessary

functions to assure timely payment of benefits to covered persons under the state plan.

(1) The writing carrier shall make available information relating to the proper manner of submitting a claim for benefits under the state plan and shall distribute forms upon which submissions shall be made.

(2) The writing carrier shall evaluate the eligibility of the claim for payment under the state plan.

(3) The writing carrier shall determine the usual and customary charges for professional services, supplies or institutional care for which a claim is made under the state plan policy or contract.

(4) The writing carrier shall exercise reasonable efforts to advise covered persons within 15 working days of receipt of a properly completed and executed proof of loss, the covered person shall be advised whether the submitted claim was accepted or rejected by the writing carrier, unless sooner settled.

(5) The writing carrier shall establish an appeals procedure approved by the board to review claims which are denied in whole or in part. When a claim or any portion thereof is denied, the writing carrier shall inform the covered person of the existence of the procedure, including the right to appeal to the commissioner

within a reasonable period of time.

2. The writing carrier shall submit monthly reports to the commissioner and the board on the operation of the state plan. The content and form of the report shall be as determined by the board and approved by the commissioner.

3. The writing carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the state plan. If the writing carrier's payments for claims expenses exceed the portion of the state plan premiums allocated by the board for payment of claims expenses, the Association shall provide to the writing carrier additional funds for payment of claims expenses. Not less than 87½ % of the state plan premium as determined by the board, shall be used to pay claims expenses, and not more than 12½% of the state plan premium shall be used to pay agent referral fees (authorized by Minn. Stat. § 62E.15 subd. 3) and to pay the writing carrier's direct and indirect expenses (as defined and authorized in Minn. Stat. § 62E.13 subd. 7 and described in 4 MCAR § 1.3233).

4. The writing carrier shall be paid from time to time as provided in the Association's contract with the writing carrier for its direct and indirect expenses incurred in the performance of its services from the state plan premiums received in an amount not to exceed the lesser of:

   a. 12½% of the state plan premium, less agent referral fees payable under 4 MCAR § 1.3232 C.1.b.,

b. Direct and indirect operating and administrative expenses incurred in the performance of its services, ~~and~~ or per agency memo of 4-2-79 filed with A.G. in this matter

c. An amount agreed upon by the board and the writing carrier.

5. "Direct and indirect expenses" shall include that portion of the carrier's actual administrative, printing, claims administration, management, building overhead expenses and other actual operating and administrative expenses approved by the board as allocable to the administration of the state plan.

6. The board shall approve cost accounting methods of the writing carrier, which shall be consistent with generally accepted accounting p ciples.

7. The board shall have the authority to conduct periodic audits to verify the accuracy of financial data and reports submitted by the writing carrier.

C. Appeal to commissioner. Any covered person ~~whose~~ whose claim for benefits under the state plan is denied, in whole or in part, may appeal such determination to the commissioner within a reasonable period of time. Upon receipt of an appeal from a claim denial, the commissioner may, in his discretion, affirm, reverse or modify the determination of the Association.

4 MCAR § 1.3234 MCHA - Reinsurance

A. Authority to make available reinsurance. The Association may provide for reinsurance of risks incurred by insurer or fraternal members resulting from such members' issuance of all or any of the following categories of coverage as provided in the act:

1. Individual qualified plans (but not including group conversions),
2. Individual qualified medicare supplement plans (but not including group conversions),
3. Group conversions on qualified plans,
   a. "group conversions" means the conversion policies or contracts required to be issued under Minn. Stat. §§ 62A.16 ~~/~~ and 62A.17 or 62E.16.
4. Group qualified plans which cover fewer than 50 employees or insured persons.
5. Group qualified medicare supplement plans with fewer than 50 employees or insured persons,
6. Individual major medical coverage, and
7. Group major medical coverage.

A member may make a separate election to reinsure each of the above categories of coverage.

B. Reinsurance plan. The Association may enter into reinsurance pooling agreements with insurer and fraternal members to establish a reinsurance plan for risks of categories of coverage described in 4 MCAR § 1.3234 A. The reinsurance plan may

provide for a reinsurance pool.

1. Insurer or fraternal members wishing to participate in the pool shall apply to the Association for participation in the pool, specifying the categories of coverage which the member desires to reinsure.

   a. Members entering into a reinsurance pooling agreement for a particular category or categories of coverage shall offer to place in the pool all policies and contracts that it issues in the category or categories listed in 4 MCAR 1.3234 A. which it wishes to reinsure.

   b. Only policies and contracts acceptable to the Association or its reinsurance administrator may be accepted for reinsurance. The Association is under no obligation to accept any but standard risks in the reinsurance plan.

2. The Association may obtain commercial reinsurance to reduce the risk of loss through the pool to insurer or fraternal members entering into reinsurance pooling agreements. Any contract for commercial reinsurance entered into between the ssociation and a commercial reinsurer shall be binding on any insurer or fraternal member entering into a reinsurance pooling agreement.

3. The Association may administer the pool directly or through a reinsurance administrator.

a. The Association or its reinsurance administrator may establish underwriting standards with which participating members shall comply and may perform reinsurance underwriting on all policies or contracts submitted for reinsurance.

b. The Association or its reinsurance administrator may perform benefit calculation (claims processing) for all claims eligible for reimbursement to participating members. Only claims paid by participating members and approved by the Association or its reinsurance administrator shall be eligible for reimbursement by the ssociation or its reinsurance administrator in accordance with the reinsurance pooling agreement.

c. Except for underwriting and claims processing functions, the Association or the reinsurance administrator shall have no responsibility for other administration functions for any member's reinsured policies or contracts unless otherwise agreed to by the Association.

4. Participating members shall have the duties established in the reinsurance pooling agreement, including but not limited to:

a. Submitting reports which provide all information deemed necessary by the Association or its reinsurance administrator for performance of reinsurance, underwriting, and claims processing functions;

b. Paying all pooling payments; and

c. Paying all reinsurance assessments and interim reinsurance assessments as required by the board.

C. Pooling payments. The Association may require pooling payments from all participating members, to provide for reimbursement to participating members for claims paid under reinsured policies and contracts and for payment of administrative expenses of the pool incurred or estimated to be incurred during the period for which the pooling payment is made. Pooling payments shall be established by the Association to provide at least 110% of total anticipated expenses for reinsurance and for administration of the policies or contracts which are reinsured.

D. Assessment of participating members.

1. At the end of each calendar year (or other fiscal year end established by the Association) the board may assess participating members on the basis of the formula established in or as a part of the reinsurance pooling agreement.

2. The board may also levy interim reinsurance assessments to assure the financial ability of the Association to reimburse participating members for claims paid under reinsured policies and contracts and operating and administrative expenses incurred or estimated to be incurred in the operation of the reinsurance plan until the calendar year end (or other fiscal year end established by the Association) reinsurance assessment.

a. Interim reinsurance assessments shall be due and payable within 30 days of receipt by a participating member of an interim reinsurance assessment notice.

b. Interim reinsurance assessments shall be credited to each participating member in the year end reinsurance assessment calculation.

3. Each participating member's reinsurance assessment (net after credit for any interim reinsurance assessment) shall be billed to the member by the Association following each calendar year end (or other fiscal year end established by the Association) and shall be due and payable within 30 days of receipt by the member of the reinsurance assessment notice.

E. Excess receipts. If pooling payments, reinsurance assessments and other receipts by the Association or its reinsurance administrator as a result of the reinsurance plan exceed actual reinsurance losses and administrative expenses of the pool, such excess shall be held at interest and used by the Association to offset losses (including but not limited to reserves for incurred but not reported claims) due to claims expenses of the state plan or allocated to reduce state plan premiums.

4 MCAR § 1.3235 MCHA - Severability

If any section or provision of these rules is declared unconstitutional or void by any court of competent jurisdiction or its applicability to any person or circumstances is held invalid, the constitutionality or validity of the remainder of the rules and applicability to other persons and circumstances are not affected, and to this end, the sections and provisions of these rules are declared to be severable.

RESERVED FOR FUTURE USE -- 4 MCAR § 1.3236 - 1.3250

DEPARTMENT OF COMMERCE
INSURANCE DIVISION

Adopted Appendix Governing the Minnesota Comprehensive Health Insurance Act of 1976, as Amended.

March 2, 1979

APPENDIX I

Minnesota Comprehensive Health Insurance Act of 1976
Actuarial Equivalence of Qualified Plans and
Qualified Medicare Supplement Plans

I. How to Use the Test

A. Basic and Comprehensive Major Medical Plans.

1. List the Plan benefits, ignoring deductibles and coinsurance.

2. For each benefit, find the appropriate Table of Equivalent Points for Basic and Major Medical Plans.

3. Extract the appropriate point value for the benefit from the Table, interpolating as necessary or indicated, and place it opposite the listed benefit.

4. Ignore benefits for which no Table exists.

5. List deductible, coinsurance and plan maximum if the Plan is a Comprehensive Major Medical Plan.

6. Find Table(s) of points for deductible, coinsurance and plan maximum.

7. Extract the appropriate point values for deductible, coinsurance and plan maximum, usually negative, interpolating as necessary, and place the values in the list of points.

8. Add algebraically the list of points.

9. Refer the result to the Test For Actuarial Equivalence to determine Qualification.

B. Superimposed Major Medical Plans.

1. Follow steps A.1 through A.4 for Basic Health Plan Benefits.

2. Total the points for the Basic Plan.

3. Enter Tables 21, 22 and 23 of the Tables of Equivalent Points to determine the point value of a Qualified Plan superimposed on the Basic Plan with the Deductible and Benefit Period of the Plan at hand, interpolating as necessary. Put the points in the point column.

4. Compare the benefits in the Superimposed Major Medical Plan with the benefit structure of a Qualified Plan:

a. $250,000 Lifetime Maximum.

b. 80/20 Coinsurance.

c. $3,000 annual per person out-of-pocket maximum.

d. Eligible Expenses are Usual and Customary Expenses For:

(1) Hospital Services.

(2) Physician Care.

(3) Prescription Drugs.

(4) Nursing-Home Care of up to 120 days in one year commencing within 14 days of hospitalization of at least three days.

(5) Home Health Care.

(6) Radium and Radioactive Therapy.

(7) Oxygen.

(8) Anesthetics.

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(9) Prostheses.

(10) Rental or purchase of durable medical equipment.

(11) Diagnostic X-Rays and laboratory tests.

(12) Oral surgery on impacted teeth, teeth roots and gums and tissues, not in connection with tooth extration.

(13) Physical therapy.

(14) Maternity same as any illness.

(15) Minnesota statutorily mandated benefits.

(16) Coordination of Benefits.

5. Consult the Tables for point adjustments (usually negative) for Qualified Plan benefits not in the Superimposed Major Medical Plan being tested. Put the adjustments in the point column.

6. Add algebraically the points for the Basic Plan (B.2.), the Superimposed Major Medical Plan (B.3.) and the adjustments (B.5.).

7. Refer the result to the Test for Actuarial Equivalence to determine Qualification.

C. Medicare Supplement Plans.

1. Follow the rules for Basic and Comprehensive Major Medical Plans but use the Tables of Equivalent Points for Medicare Supplement Plans and the Medicare Supplement Table of Actuarial Equivalence.

II. Benefit Variations Not Covered by Tables.

Only those plan variations that are most common are recognized. For instance, Comprehensive Plan coinsurance was assumed to normally not exceed 20%. Therefore, no points are shown for 25%. However, points for such missing benefit variations can be extrapolated or estimated.

III. Use of Tables.

Any insurer, self insurer, or policyholder may use the Test for Actuarial Equivalence as a Guide. However, to obtain certification of any plan of health benefits as "Qualified", it must be submitted to the commissioner. If an uninsured plan description or a policy form number or policy identification number is sent to the commissioner, together with a statement of its total Equivalent Point Value from the Tables, and with a certification by a principal or officer of an insurer, or by a Member of the Academy of Actuaries for plans submitted by employers, that the plan is Qualified by virtue of the Test of Actuarial Equivalence as either a Plan 1, 2 or 3 or a Medicare Supplement Plan, the plan will be deemed certified as filed. If the Test does not qualify a plan or does not result in qualification for the Plan (i.e., 1, 2 or 3) desired by the insurer or self insurer, the filing must include the plan document or policy, the Equivalent Point Calculation and a statement of specific reasons for the desired qualification. Such plan will not be qualified until and unless so certified by the commissioner.

IV. Update of Tables.

Periodically, the Tables may be revised as health care cost change. The commissioner may re-evaluate actuarial equivalence of any plan or policy at any time as he believes appropriate. Annual re-evaluation of plans is therefore suggested. When a plan is re-evaluated and its qualification status changes, the filing procedures in III, above, will be followed.

V. Mis-Use of Tables.

The tables of Equivalent Points are not intended for any other use, especially not for premium calculations. They represent a composite of dat, adjusted to be useable for testing actuarial equivalence. No other use is contemplated.

VI. Why the Test was Developed.

Minn. Stat. § 62E.02 defines Qualified Plans and Qualified Medicare Supplement Plans as health benefit plans that provide the benefits required in Minn. Stat. §§ 62E.06 or 62E.07, "or the actuarial equivalent to those benefits"; Minn. Stat. § 62.06 describes three Qualified Plans and Minn. Stat. § 62E.07 describes a Qualified Medicare Supplement Plan. These statutes require all plans of health coverage to be labelled as Qualified or Non-Qualified. The commissioner may be requested to determine whether a plan is qualified and he may take up to 90 days to make that determination.

The composite point values for a Qualified Plan number 3 and the point values for the Qualified Medicare Supplement Plan are as shown herein.

Composite Point Values For
Minnesota Qualified Plan No. 3
Arbitrary Radix = 1,000 Points

Points	Benefit
395	Hospital Room and Board — unlimited days, semi-private.
485	Hospital Extras (i.e., Hospital Services, Hospital Miscellaneous, Hospital Special Services, or Ancillary Services) including anesthesia.
210	Surgery, including oral surgery but no tooth repair or extraction.

220	Home and Office Physician Care — unlimited.
55	Physician Care in Hospital — unlimited.
75	Obstetrics — unlimited.
125	Hospital maternity — unlimited.
90	X-Rays and Laboratory tests — outpatient and out of hospital.
90	Prescription Drugs and Medicine — outpatient and out of hospital.
20	Emergency Accident Care.
15	Radioactive Therapy — outpatient and out of hospital.
20	Nursing or Convalescent Facility.
10	Home Health Agency Care.
10	Physical Therapy.
20	$3,000 annual "out of pocket" expense limit.
−75	Coordination of Benefits.
−45	Non-Duplication with No-Fault.
−430	$150 Deductible.
−290	20% Coinsurance.
1,000	Total

Note: When setting up the above table, some minor benefits (e.g., student dependents to age 25, oxygen, etc.) specified in the Statute were overlooked. All have extremely nominal point value so no re-calculation has been made for them at this time.

Composite Point Values For
Minnesota Qualified Medicare Supplement Plan
Arbitrary Radix = 100 Points

Points	Benefit
26.13	Hospital Room and Board — unlimited days, semi-private, reasonable and customary — Net of Medicare payments.
3.90	Skilled Nursing Home — Net of Medicare Payments.
.15	Blood and Blood Plasma (In Hospital) — Not provided by Medicare.
45.78	*Surgery, including oral surgery but no tooth repair or extraction.
104.66	*Home and Office Physician Care — unlimited.
22.70	*Physician Care in Hospital — unlimited.
57.58	*X-Rays and Laboratory tests — outpatient and out of hospital.
5.00	*Radioactive Therapy — outpatient and out of hospital.
3.75	*Home Health Agency Care.
1.48	*Miscellaneous.
48.67	Drugs and Medicine — outpatient and out of hospital.
5.00	Private duty nursing.
−158.89	Part B Medicare payments credit.
−54.64	50% of Medicare Coinsurance and Deductibles.
−11.27	20% of expenses not covered by Medicare.
100.00	Total

*Gross expense — before Medicare payment under Part B.

Plan Name _____ Plan No. _____

WORKSHEET
Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other then Medicare Supplement Plans

			Major Medical	
Table	Benefit	Basic	Superimposed	Comprehensive
21-23	Superimposed Major Medical	XXX		XXX
1.	Hospital Room and Board			
2.	Hospital Extras			
3	Surgery			
4.	Physician Care — Home, Office			
5.	Physician Care — Hospital			
15-18	Benefits In Full			

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6.	Maternity			
7.	Diagnostic X-Ray and Lab			
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident			
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility			
13.	Home Health Care			
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents			
24.	Limit on Out of Pocket			
25.	Maximum Benefit	XXX		
XX.	Subtotal			
26.	COB/No-Fault			
19-20	Coinsurance/Deductible	XXX		
XX.	Total			
XX.	Combined Basic and Superimposed		XXX	XXX

Equivalent to Minnesota Qualified Plan Number _____ Non-Qualified ☐

Date _____ By _____

Plan Name _____ Plan No. _____

WORKSHEET
Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

B. Medicare Supplement Plan

Table	Benefit	Days	Daily Benefit	Factor	Product
27.	Hospital — Defined daily benefit				
		1	_____	9.59	
		2-60	_____	83.56	
		61-90	_____	1.50	_____
		91-150	_____	.61	_____
		151 & Over	_____	1.02	_____
		Total	XXX		_____
		Divisor			_____
		Quotient			_____
		Multiplier			_____
		Product			

27.	Hospital — Usual and customary charges not paid by Medicare	
	A. Medicare Deductible and Coinsurance	
	B. Benefits not covered by Medicare	
28.	Skilled Nursing Facility	
29.	Blood	
30.	Surgery	
31.	Physician Care — Home and Office	
32.	Physician Care — Hospital	
33.	Home Health Care	
34.	Diagnostic X-Ray and Laboratory	
35.	Radioactive Therapy	
36.	Drugs and Medicine	
37.	Private Duty Nursing	
38.	Miscellaneous	
41.	Comprehensive Major Medical	
XX.	Subtotal	
39.	Medicare Part B Payments	
40.	Medicare Part B Deductible not Eligible	
XX.	Total	

Equivalent to Minnesota Qualified Medicare Supplement Plan: Yes ☐ No ☐

Date _____ By _____

Test For
Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. For Plans Other Than Medicare Supplement Plans

If the Point Value of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualified Plan No.:
1,000 + points	3
700 + points	2
550 + points	1
Less than 550 points	Non-Qualified

B. For Medicare Supplement Plans

If the Point Value of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualified Plan No.:
100 + points	Minnesota Medicare Supplemental Plan

Location of Tables
of
Equivalent Points

A. Basic and Major Medical Health Plans

Table	Name
1.	Hospital Room and Board
2.	~~H~~Hospital Extras
3.	Surgery
4.	Home and Office Physician Care
5.	In Hospital Physician Care
6.	Maternity
7.	Diagnostic X-Ray and Laboratory
8.	Drugs and Medicine
9.	Emergency and Supplemental Accident
10.	Radioactive Therapy
11.	Student Dependents
12.	Nursing or Convalescent — Home Care
13.	Home Health Care Agency Service
14.	Physical Therapy
14.	Oxygen
14.	Prostheses
14.	Durable Medical Equipment
15.	Hospital Room and Board in Full
16.	All Hospital Charges in Full
17.	All Hospital and Surgical Charges in Full
18.	All Hospital, Surgical and In-Hospital Physicians Care in Full
19.	Coinsurance and Deductibles
20.	Combined Dental and Health Insurance Deductible
21.	Superimposed Major Medical
22.	Superimposed Major Medical
23.	Superimposed Major Medical
24.	Limit on "Out of Pocket" Expenses
25.	Major Medical Maximums
26.	Coordination and Non-Duplication of Benefits

B. Medicare Supplement Plans

27.	Hospital Room and Board and Extras
28.	Skilled Nursing Facility
29.	Blood
30.	Surgery
31.	Home and Office Physician Care
32.	In-Hospital Physician Care
33.	Home Health Care
34.	Diagnostic X-Ray and Laboratory
35.	Radioactive Therapy
36.	Drugs and Medicines
37.	Private Duty Nursing
38.	Physical Therapy
38.	Oxygen
38.	Prostheses
38.	Durable Medical Equipment
39.	Medicare Part B Payments
40.	Medicare Part B Deductible
41.	Comprehensive Major Medical

Table of Equivalent Points For Basic and Major Medical Health Plans
(Not To Be Used For Medicare Supplement Plans)

1. Hospital Room and Board.

Maximum Days	Semi-Private Room at $81.00 Per Day	Deduct for Each $10/Day Less than Semi-Private
31	330	40
70	370	46
120	380	48
365	390	49
Unlimited	395	50

Additional Points Per $1.00
Excess of Private over Semi-Private 2

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2. Hospital Extras (i.e., Hospital Services, Special Hospital Services, Ancillary Services, Hospital Therapeutics, etc.)

Maximum Amount	Anesthesia	
	Included	Not Included
$ 250	250	245
500	335	305
1,000	410	265
2,000	450	400
5,000	475	415
Unlimited	485	425

3. Surgery.

Limit	Assistant Surgeon Included	Anesthesia	
		Included	Not Included
1957 Intercompany			
a. $420 Maximum	No	100	85
b. $900 Maximum	No	195	170
Prevailing Fee*	No	230	200
Deduct for each "$1.00 per 1964 CRVS Unit" less than Prevailing Fee		25	22
Prevailing Fee*	Yes	240	210
Deduct for each "$1.00 per 1964 CRVS Unit" less than Prevailing Fee		25	22

*Equivalent to $9.00 per 1964 CRVS Unit.

4. Home and Office Physician Care.

Annual Maximum	First Visit Accident	
	First Visit Sickness	Third Visit Sickness
$ 100	115	65
200	140	75
500	170	95
Unlimited	220	120

5. In-Hospital Physician Care.

Maximum Number of Visits	Prevailing Fee at Average $15.50/Day/Visit	Deduct for Each $1.00 Per Day Per Visit Less Than Prevailing Fee
31	40	3
70	46	3
120	49	3
365	52	4
Unlimited	55	4

6. Maternity.

A. Complications only:

a.	Limited to some specified list	20
b.	Any complications	25

B. Full Maternity (including complications):

Limit	Deductible	Flat Maternity	Obstetrics	Hospital Maternity
$ 150	None	—	25	30
300	None	55	50	60
500	None	90	70	90

1,000	None	170	—	—
Unlimited	None	200	75	125
Unlimited	$500	100	—	—
Unlimited	$1,000	30	—	—

7. X-Rays and Laboratory Tests (Out of Hospital).

Maximum	Scheduled (Any Schedule)	Unscheduled
$ 50	40	50
100	55	70
200	60	80
Unlimited	65	90

8. Prescription Drugs and Medicine (Out of Hospital).

Deductible Per Prescription	
$ 2.00	60
1.00	75
None	90

9. Emergency and Supplemental Accident (Basic Plans Only).

Maximum	Emergency	Supplemental
$ 25	10	—
50	15	20
150	—	30
300	—	35
500	—	40
Unlimited	20	—

10. Radioactive Therapy (Out of Hospital).

Scheduled (Any Schedule)	10
Unscheduled	15

11. Student Dependents.

Student Extension Beyond Age 19	
None	0
To Age 21	2
To Age 23	4
To Age 25	5

12. Nursing or Convalescent Home Care (Within 14 days of hospital confinement of at least three days).

Maximum Days	
120 or More	20
Less than 120	0

13. Home Health Care Agency Services

Maximum Visits/Year	
180 or More	10
Less than 180	0

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14. Miscellaneous (Out of Hospital).

A. Physical Therapy	10
B. Oxygen	5
C. Prostheses	5
D. Durable Medical Equipment Rental or Purchase	5

15. Hospital Room and Board in Full to Indicated Limit (Basic and Comprehensive Major Medical Plans) — Use in leiu of Room and Board points in Number 1, above.

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Limit $1,000	Limit $2,000	Limit $5,000	Limit Unlimited
Basic	0	100%	300	325	365	395
Comprehensive	0	20%	455	460	470	475
Comprehensive	$ 50	20%	480	485	500	505
Comprehensive	100	20%	495	505	520	530
Comprehensive	150	20%	510	520	535	550

16. All Hospital Charges in Full to Indicated Limit (Basic and Comprehensive Major Medical Plans) — Use in lieu of Room and Board and Hospital Extras in Numbers 1 and 2, above.

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Limit $1,000	Limit $2,000	Limit $5,000	Limit Unlimited
Basic	0	100%	615	710	805	880
Comprehensive	0	20%	1005	1025	1045	1060
Comprehensive	$ 50	20%	1050	1080	1100	1130
Comprehensive	100	20%	1090	1125	1150	1180
Comprehensive	150	20%	1120	1160	1195	1225

17. All Hospital and Surgical Charges In Full to Indicated Limit (Basic and Comprehensive Major Medical Plans) — Use in lieu of Room and Board, Hospital Extras and Surgery points in Numbers 1, 2 and 3, above.

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Hospital Surgery	$1,000 $5 CRVS	$2,000 $6 CRVS	$5,000 $8 CRVS	Unlimited Unlimited
Basic	0	100%		740	855	955	1090
Comprehensive	0	20%		1240	1265	1295	1310
Comprehensive	$ 50	20%		1295	1330	1370	1400
Comprehensive	100	20%		1340	1385	1440	1465
Comprehensive	150	20%		1375	1425	1480	1515

18. All Hospital, Surgical and In Hospital Physicians Care In Full to Indicated Limit (Basic and Comprehensive Major Medical Plans) — Use in lieu of Room and Board, Hospital Extras, Surgical and In Hospital Physician Care points in Numbers 1, 2, 3 and 5, above.

Plans	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Hospital Surgical Physician	$1,000 $5 CRVS $5/Day	$2,000 $6 CRVS $6/Day	$5,000 $8 CRVS $8/Day	Unlimited Unlimited Unlimited
Basic	0	100%		750	865	1015	1145
Comprehensive	0	20%		1290	1320	1350	1375
Comprehensive	$ 50	20%		1355	1390	1430	1465
Comprehensive	100	20%		1400	1440	1490	1530
Comprehensive	150	20%		1440	1485	1540	1585

19. Coinsurance and Deductibles (Comprehensive Major Medical Plans).

Deductible	Coinsurance: Insured Pays Designated Percent of Expense in Excess of Deductible		
	0%	10%	20%
$ 0	0	−170	−375
50	−170	−325	−520
100	−310	−455	−630
150	−410	−520	−720
200	−520	−640	−790
500	−820	−910	−1020
1,000	−1010	−1080	−1170

20. Combined Dental and Health Insurance Deductible (Comprehensive Major Medical Plans).

Deductible	Added Points
$ 50	90
100	75
150	65
200	40
500	35
1,000	15

21. Superimposed Major Medical Plans — Over Basic Health Plans With Less than 500 Points.

1. Calculate point value of a Comprehensive Major Medical Plan using deductible $100 greater than actual.
2. Add Basic Health Plan points.

22. Superimposed Major Medical Plans — 80/20 Coinsurance — Over Basic Health Plans With 500-799 Points.

Deductible:	Add to Basic Plan Points			
	Calendar Year Plan		2 Year Benefit Period Plan	
	Individual	2 × Family	Individual	2 × Family
A. Corridor				
$ 50	740	780	745	765
100	665	705	680	700
150	615	655	630	650
200	575	615	590	610
500	365	405	380	400
B. Integrated				
$ 500	615	635	650	670
1,000	515	525	535	545

NOTE: Points assume Major Medical contains Minnesota Qualified Plan Number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

23. Superimposed Major Medical Plans — 80/20 Coinsurance — Over Basic Health Plans With 800 or More Points.

Deductible:	Add to Basic Plan Points			
	Calendar Year Plan		2 Year Benefit Period Plan	
	Individual	2 × Family	Individual	2 × Family
A. Corridor				
$ 50	505	535	515	525
100	445	475	455	465
150	405	435	415	425
200	365	395	375	385
500	205	235	215	225

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B.	Integrated				
	$ 500	505	525	530	550
	1,000	405	415	420	430

NOTE: Points assume Major Medical contains Minnesota Qualified Plan Number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

24. Limit on "Out of Pocket" Expenses (i.e., maximum Co-payment and Deductible per benefit year) — Comprehensive and Superimposed Major Medical Plans.

Out of Pocket Limit	Deductible: Coinsurance:	$50 20%	$150 20%	$500* 20%	$1,000 20%
$ 500		80	100	200	—
1,000		36	40	55	60
3,000		20	20	22	25
5,000		10	10	11	13
10,000		5	5	5	6

*Use this column for Superimposed Major Medical Plans

25. Major Medical Maximum (Comprehensive and Superimposed Plans).

Maximum	Add (+) or Subtract (−)
$ 10,000	−50
20,000	−40
50,000	−20
100,000	− 7
250,000	0
Unlimited	+ 5

26. Coordination and Non-Duplication of Benefits (All Plans)

		Deduct the Following Percentage of Total Points Before Crediting Points For Deductible and Coinsurance
a.	With other health plans	4.0%
b.	With No Fault	2.5%
c.	With both a. and b.	6.5%
d.	With neither	0

TABLES OF EQUIVALENT POINTS FOR MEDICARE SUPPLEMENT

27. Hospital Room and Board and Extras

During a spell of illness, Medicare Part A pays all expenses except for the deductible and coinsurance amounts for hospital services during the first 90 days of hospitalization. If hospitalization continues, Medicare will pay the expenses greater than the coinsurance amount until the life-time reserve of 60 days is reached.

Use the following procedure to obtain the Equivalent Point value for a benefit which pays a certain amount if the individual is hospitalized a specified number of days:

a. Multiply the benefits provided by the policy by the appropriate adjustment factors given below and sum.

b. Calculate value of Medicare Deductible and Coinsurance — Multiply the current Medicare deductible and coinsurance amounts by the appropriate adjustment factors and sum. (Calculated below for July 1, 1976 deductible and coinsurance — recalculate each time Medicare changes deductible and coinsurance.)

c. Divide the value from step (a) by step (b).

d. Multiply step (c) by 23.78

	Value of July 1, 1976 Medicare Deductible and Coinsurance		
Days In Hospital	Adjustment Factor	Medicare Deductible and Coinsurance	Value
1	09.59	$104	997.36
2-60	83.56	0	0.00
61-90	1.50	26	39.00
91-150	.61	52	31.72
151	1.02	0	0.00
Total			1068.08

Since the Medicare Deductible and Coinsurance provisions change annually, policies using the defined benefit approach should be re-evaluated annually.

If the policy does not pay a defined benefit during hospitalization but pays all usual and customary charges for hospital inpatient services not paid by Medicare, then use 23.78 and 2.35 as the Equivalent Point value for the benefits providing for the Medicare Deductible and Coinsurance amounts and for the benefits not covered by Medicare respectively.

28. Skilled Nursing Facility

Medicare Part A pays the usual and customary expenses of a qualified Skilled Nursing Facility exclusive of a coinsurance amount after twenty days of confinement up to a maximum of 100 days per spell of illness.

Payment of the Coinsurance Amount (currently $13) up to 100 days	3.50
Payment of reasonable and customary expenses 100 to 120 days	.30
Payment of reasonable and customary expenses after the 120th day	.10

29. Blood

Medicare does not pay for the first 3 pints of blood while in the hospital. If the policy covers this, then the Equivalent Point value is .15.

30. Surgery

	Assistant Surgeon Included	Anesthesia Included	Anesthesia Not Included
Prevailing Fee*	No	48.70	43.60
Deduct for each "1.00 per 1964 CRVS Unit" less than Prevailing Fee		5.05	4.60
Prevailing Fee*	Yes	50.45	45.78
Deduct for each "$1.00 per 1964 CRVS Unit" less than Prevailing Fee		5.05	4.60

*Equivalent to $9.00 factor on the 1964 CRVS

31. Physician Care — Home and Office

	First Visit Accident	
	First Visit Sickness	Third Visit Sickness
Unlimited	104.46	74.50

32. Physician Care — Hospital

Maximum Number of Visits	Prevailing Fee at Average 14.50/Day/Visit	Deduct for each 1.00 Per Day Per Visit Less than Prevailing Fee
31	17.51	1.21
70	19.10	1.32
120	20.30	1.40
365	21.46	1.48
Unlimited	22.70	1.57

33. Home Health Care*

Maximum Visits/Year	
180 or More	3.75
Less than 180	0

*Excludes Home Health Care after individual is discharged from a hospital after a stay of at least 3 days.

34. Diagnostic X-Ray and Laboratory (Outpatient or out of hospital)

	Scheduled	Unscheduled
Unlimited	40.60	57.58

35. Radioactive Therapy (Outpatient or out of hospital)

Scheduled	3.00
Unscheduled	5.00

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36. Drugs and Medicines (Outpatient or out of hospital)

Deductible Per Prescription	
2.00	30.00
1.00	38.75
None	48.67

37. Private Duty Nursing (Either RN or LPN) 5.00

38. Miscellaneous (In Clinic or as Outpatient) 1.48

a. Physical Therapy
b. Oxygen
c. Prostheses
d. Durable Medical Equipment (Rental or Purchase)

39. Medicare Part B Payments

Deduct 158.89

40. Medicare Part B Deductible ($60)

Deduct if not eligible 28.50

41. Comprehensive Major Medical Plans

Type	Equivalent Points
a. With C.O.B. against Medicare A and B, Maximum of $50,000 or more, Deductible of $100 or less, and Coinsurance of 20% or less.	100
b. Other, including "Medicare Carve Out" Plans	*

*File with Commissioner.

EXAMPLE I

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesota Qualified Plan?

Deductible:	$100
Coinsurance:	80/20
Maximum:	$10,000
Maternity:	Any Complications
Student Dependents:	To 23
Limits on Specified Benefits:	Outpatient Mental limited to Minnesota Required Benefits
Excluded Care:	Home Health Care
Out of Pocket Limit:	$5,000 per year
Coordination of Benefits	Yes, but no COB with No-Fault

II. Answer (calculated January 1, 1977): Test result is 919 points
This Plan is a Minnesota Qualified Plan Number 2.

Plan Name Comprehensive Plan Plan No. Example I.

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

			Major Medical	
Table	Benefit	Basic	Superimposed	Comprehensive
21-23	Superimposed Major Medical	XXX		XXX
1.	Hospital Room and Board			395
2.	Hospital Extras			485
3.	Surgery			240
4.	Physician Care — Home, Ofice			210
5.	Physician Care — Hospital			55
15-18	Benefits In Full			—
6.	Maternity			25
7.	Diagnostic X-Ray and Lab			90
8.	Drugs and Medicine			90
9.	Emergency/Supplemental Accident			0
10.	Radioactive Therapy			15
12.	Nursing/Convalescent Facility			20
13.	Home Health Care			0
14.	Physical Therapy			10
14.	Oxygen			5
14.	Prostheses			5
14.	Durable Medical Equipment			5
11.	Student Dependents			4
24.	Limit on Out of Pocket			10
25.	Maximum Benefit	XXX		–50
XX.	Subtotal			1614
26.	COB/No-Fault			–65
19-20	Coinsurance/Deductible	XXX		–630
XX.	Total			919
XX.	Combined Basic and Superimposed		XXX	XXX

Equivalent to Minnesota Qualified Plan Number 2 Non-Qualified ☐

Date _____ By _____

EXAMPLE II
Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesota Qualified Plan?

Hospital:	$70 per day, 365 days, $2,000 Extras
Surgery:	$7 CRVS, an assistant surgeon
In Hospital Physicians Calls:	$10 per day, 365 days
Maternity	Specified complications only
Coordination of Benefits	No

II. Answer (calculated January 1, 1977): Test result is 1016 points.

This Plan is a Minnesota Qualified Plan Number 3.

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Plan Name Basic Plan Plan No. Example II

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

Table	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
21-23	Superimposed Major Medical	XXX		XXX
1.	Hospital Room and Board	336		
2.	Hospital Extras	450		
3.	Surgery	180		
4.	Physician Care — Home, Office	30		
5.	Physician Care — Hospital	20		
15-18	Benefits In Full			
6.	Maternity			
7.	Diagnostic X-Ray and Lab			
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident			
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility			
13.	Home Health Care			
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents			
24.	Limit on Out of Pocket			
25.	Maximum Benefit	XXX		
XX.	Subtotal			
26.	COB/No-Fault			
19-20	Coinsurance/Deductible	XXX		
XX.	Total	1016		
XX.	Combined Basic and Superimposed		XXX	XXX

Equivalent to Minnesota Qualified Plan Number 3 Non-Qualified ☐

Date _____ By _____

EXAMPLE III

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesoda Qualified Plan?

Hospital:	$30 per day, 70 days, $500 Extras
Surgery:	$420 Intercompany
Superimposed Major Medical:	
Deductible	$100 corridor
Coinsurance:	80/20
Maximum:	$10,000
Maternity	Any complications
Student Dependents:	No
Out of Pocket Limit:	None
Excluded Care:	Home Health Care
	Nursing Home Care

Limits on Specified Benefits:	Maximum Eligible Charges as follows:
1. Room & Board	$50, less Basic Benefit
2. Hospital Extras:	$2,000 less Basic Benefit
3. Surgery:	$7.00 per CRVS unit.
Coordination of Benefits	yes, including No/Fault

II. Answer (calculated January 1, 1977): Test result is 611 points.

This Plan is a Minnesota Qualified Plan Number 1.

Plan Name Basic and Superimposed Plan No. Example III

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

			Major Medical	
Table	Benefit	Basic	Superimposed	Comprehensive
21-23	Superimposed Major Medical	XXX	665	XXX
1.	Hospital Room and Board	135	-143 (3.1 times 46)	
2.	Hospital Extras	335	-95 (402 less 305)	
3.	Surgery	85	-50 (2 times 25)	
4.	Physician Care — Home, Office			
5.	Physician Care — Hospital			
15-18	Benefits In Full			
6.	Maternity		-175 (200 less 25)	
7.	Diagnostic X-Ray and Lab			
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident			
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility		-20	
13.	Home Health Care		-10	
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents		-4	
24.	Limit on Out of Pocket		-20	
25.	Maximum Benefit	XXX	-50	
XX.	Subtotal	555	98	
26.	COB/No-Fault	-36	-6	
19-20	Coinsurance/Deductible	XXX		
XX.	Total	519	92	
XX.	Combined Basic and Superimposed	611	XXX	XXX

Equivalent to Minnesota Qualified Plan Number 1 Non-Qualified ☐

Date _____ By _____

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EXAMPLE IV

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesota Qualified Plan?

Hospital:	First $3,000 of all Hospital Charges in Full
Surgery:	$420 Intercompany
Emergency Accident:	$25
Superimposed Major Medical:	
Deductible:	$500 Integrated
Coinsurance:	80/20
Maximum:	$25,000
Maternity:	Full
Student Dependents:	No
Out of Pocket Limits	None
Excluded Care:	Home Health Care
Coordination of Benefits:	Yes, Other Health and No Fault Plans

II. Answer: (Calculated January 1, 1977). Test result is 1290 points.

This Plan is a Minnesota Qualified Plan Number 3.

Plan Name Basic With Benefits In Full and Comprehensive Plan No. Example IV

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

Table	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
21-23	Superimposed Major Medical	XXX	615	XXX
1.	Hospital Room and Board			
2.	Hospital Extras			
3.	Surgery	85		
4.	Physician Care — Home, Office			
5.	Physician Care — Hospital			
15-18	Benefits In Ful	741 (710 plus 33% of 95)		
6.	Maternity			
7.	Diagnostic X-Ray and Lab			
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident	10		
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility			
13.	Home Health Care		−10	
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents			
24.	Limit on Out of Pocket		− 5	
25.	Maximum Benefit		−22	
XX.	Subtotal	XXX	−35	
26.	COB/No/Fault	836	543	
19-20	Coinsurance/Deductible	−54	−35	
XX.		XXX		
XX.	Combined Basic and Superimposed	782	508	508
		1290	XXX	XXX

Equivalent to Minnesota Qualified Plan Number 3 Non-Qualified ☐

Date _____ By _____

EXAMPLE V.

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to a Minnesota Qualified Medicare Supplement Plan?

Hospital Benefit	$100 first day $21 61 to 90 days
Skilled Nursing Home	$13 100 days
Blood	3 pints in hospital
Surgery	$1.50 CRVS with anesthesia, no assistant surgeon
Physician Care — In Hospital	$4 per day, 90 days
Drugs and Medicines	$2 deductible per prescription

II. Answer: (calculated January 1, 1977): Test result is 72.1 points. This Plan is not a Minnesota Qualified Medicare Supplement Plan.

Plan Name Medicare Supplement Plan No. Example V

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

B. Medicare Supplement Plan

Table	Benefit	Days	Daily Benefit	Factor	Product	
27.	Hospital — Defined daily benefit					
		1	100	9.59	959.00	
		2-60	0	83.56		
		61-90	26	1.50	39.00	
		91-150		.61		
		151 & Over		1.02		
		Total	XXX		998.00	
		Divisor			1068.08	
		Quotient			.9344	
		Multiplier			23.78	
		Product				22.22
27.	Hospital — Usual and customary chanrges not paid by Medicare					
	A. Medicare Deductible and Coinsurance					
	B. Benefits not covered by Medicare					
28.	Skilled Nursing Facility					3.50
29.	Blood					.15
30.	Surgery					10.82
31.	Physician Care — Home and Office					
32.	Phycician Care — Hospital					5.41
33.	Home Health Care					
34.	Diagnostic X-Ray and Laboratory					
35.	Radioactive Therapy					
36.	Drugs and Medicine					30.00
37.	Private Duty Nursing					
38.	Miscellaneous					
41.	Comprehensive Major Medical					

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XX. Subtotal	
39. Medicare Part B Payments	72.10
40. Medicare Part B Deductible not Eligible	
XX. Total	72.10

Equivalent to Minnesota Qualified Medicare Supplement Plan: Yes ☐ No ☒

Date _____ By _____

EXAMPLE VI

Use of Actuarial Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to a Minnesota Qualified Medicare Supplement Plan?

Benefit: (a) 100% of reasonable and customary hospital and nursing home expenses in excess of Medicare Part A.

(b) 20% of reasonable and customary charges for medical services after $60 deductible applied to expenses eligible under Part B of Medicare.

II. Answer (Calculated January 1, 1977): Test result is 84.3 points.

The Plan is not Qualified.

Plan Name Medicare Supplement Plan No. Example VI

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

B. Medicare Supplement Plan

Table Benefit

27. Hospital — Defined daily benefit

Days	Daily Benefit	Factor	Product
1		9.59	
2-60		83.56	
61-90		1.50	
91-150		.61	
151 & Over		1.02	
Total	XXX		
Divisor			
Quotient			
Multiplier			
Product			23.78

27.	Hospital — Usual and customary charges not paid by Medicare	
	A. Medicare Deductible and Coinsurance	23.78
	B. Benefits not covered by Medicare	2.35
28.	Skilled Nursing Facility	3.90
29.	Blood	.15
30.	Surgery	10.09 (=20%)
31.	Physician Care — Home and Office	20.89 (=20%)
32.	Physician Care — Hospital	4.54 (=20%)
33.	Home Health Care	.75 (=20%)
34.	Diagnostic X-Ray and Laboratory	11.52 (=20%)

35.	Radioactive Therapy	1.00 (=20%)
36.	Drugs and Medicine	9.73 (=20%)
37.	Private Duty Nursing	1.00 (=20%)
38.	Miscellaneous	.30 (=20%)
41.	Comprehensive Major Medical	
XX.	Subtotal	90.00
39.	Medicare Part B Payments	
40.	Medicare Part B Deductible Not Eligible	-5.70 (=20%)
XX.	Total	84.30

Equivalent to Minnesota Qualified Medicare Supplement Plan: Yes ☐ No ☒

Date _____ By _____

APPROVED AS TO FORM AND LEGALITY
APR. — 2 1979
_____ 19____
WARREN SPANNAUS, ATTORNEY GENERAL
BY _____
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
APR – 3 1979
Joan Anderson Growe
Secretary of State

1:26 P.M.

ATTORNEY GENERAL

KAREN SCHANFIELD
Special Assistant
Attorney General

September 18, 1979

JOANNE E. HINDERAKER
Special Assistant
Attorney General

296-4692

Rule File #513 - Comprehensive Health Insurance Act Rules

Attached are copies for your files of the relevant documents re: the Comprehensive Health Insurance Rules.

Let me know if you have any further questions.

JEH/bw

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE
INSURANCE DIVISION

In the Matter of Proposed Rules Relating to the Minnesota Comprehensive Health Insurance Act

STATEMENT OF NEED AND REASONABLENESS OF PROPOSED RULES

STATEMENT OF NEED AND AUTHORITY

The Minnesota Comprehensive Health Insurance Act (hereinafter "Act") was originally enacted in 1976 and subsequently amended by Laws of Minn. ch. 409 (1977) and Laws of Minn. ch. 793 §15,subd.2(1978).The above-captioned rules are newly proposed by the Commissioner of Insurance (hereinafter "Commissioner") for adoption as permanent rules. The present authority of the Commissioner for promulgation of these rules is set forth in Minn. Stat. §62E.09(a) and (i)(Supp. 1977). Prior to June 3, 1977, the Commissioner's rulemaking authority with respect to promulgation of the subject rules was set forth at Minn. Stat. §62E.09(a) (1976). Pursuant to Minn. Stat. §62E.09(9) (Supp. 1977) and Minn. Stat. §15.0412, subd. 5 (Supp. 1977), temporary rules on the subject matter were promulgated by the Commissioner at 2 S.R. 1672 and were effective on April 20, 1978. In accordance with the provisions of Minn. Stat. §15.0412, subd. 5 (Supp. 1977), temporary rules are valid for no longer than 180 days beyond their date of enactment. Thus, it is necessary for the Commissioner to institute this administrative proceeding for adoption of the temporary rules on a permanent basis.

The Act, as originally enacted and subsequently amended, evidences a comprehensive legislative attempt to achieve two primary social welfare purposes; namely, (1) broadening the scope of health coverage available to Minnesota residents through existing sources of commercial health coverage and (2) providing health coverage through the Minnesota Comprehensive Health Association (hereinafter "Association") for persons otherwise unable to purchase adequate coverage through the existing voluntary health insurance market. As will be more fully shown herein, these proposed rules are intended to more precisely delineate the duties, privileges, and relationships created by the Act. The proposed rules are also intended to implement and make effective the general provisions of the Act in accordance with legislative intent.

In an effort to achieve its dual legislative purpose, the Act establishes a standard against which health insurance coverage may be determined to be either "qualified" or "unqualified". (Minn. Stat.

§62E.06 and §62E.07). The Act encourages health care providers to make "adequate" health insurance coverages (i.e., qualified plans) available to Minnesota residents. (Minn. Stat. §§62E.04, 62E.05, and 62E.16). The Act further encourages certain employers who provide, or otherwise make available, group health insurance coverage to their employees, to so provide or make available"adequate" health insurance coverages. (Minn. Stat. §§62E.03, 62E.16, and 62E.17).

Minn. Stat. §§62E.08 through 62E.15 provide for the establishment and operation of the Association, the primary function of which is to provide adequate health insurance coverage to Minnesota residents who are otherwise unable to secure such coverage in the voluntary market (i.e., through the purchase of coverage from insurers, fraternals, nonprofit health service plan corporations, and health maintenance organizations). The proposed rules are intended to delineate the manner in which the Association shall function in the provision of health coverages to eligible persons in accordance with its statutory mandate. The proposed rules further delineate the statutory relationship and mutual obligations of the Association and its constituent members.

As more fully indicated below, the proposed rules reasonably address the above-stated needs.

FACTS ESTABLISHING REASONABLENESS

Enactment of the Act in 1976 culminated a three-year legislative effort to draft a unique and comprehensive statutory scheme designed to remedy certain deficiencies in Minnesota's existing mechanisms for providing health insurance coverage. This legislative research effort is, in part, documented in the report of the Special Senate Subcommittee on Health Costs. (See Exhibit). Following the enactment of the Act, the Commissioner established a Special Task Force consisting of insurance industry representatives, health care coverage providers, interested consumer groups, and other persons affected by the Act. Pursuant to the creation of this Task Force, five advisory committees were formed in the following areas: (1) legal, (2) forms review, (3) administration, (4) actuarial, and (5) public information. These five advisory committees received input over an approximate span of six months and laid much of the groundwork for the

implementation of the Act in a timely manner. In many respects, the work of the advisory committees was incorporated into the temporary rules and subsequently incorporated into the proposed regulations.

Subsequent to enactment of the Act, a legal action was instituted in Ramsey District Court which challenged the constitutionality of the Act on several grounds. Insurers Action Council, Inc., et al. v. Heaton, et al. This lawsuit was subsequently removed to Federal District Court where a motion by the plaintiffs for a preliminary injunction enjoining the implementation and enforcement of the Act was denied in December, 1976. Insurers Action Council, Inc. v. Heaton, et al., Civ. 3-76-440, Dist. Ct. Minn. This action is currently pending trial on the merits in said Court. The Act has also been challenged in a separate lawsuit entitled St. Paul Electrical Workers Welfare Fund, et al. v. Heaton, et al., Civ. 3-78-269 Dist. Ct. Minn. Trial on the merits in this action is also currently pending before the Court.

On March 7, 1977, at 1 S.R. 1287, the Commissioner first published Notice of Intent to Solicit Outside Opinion for his consideration in the promulgation of regulations under the Act. Subsequent to the initial solicitation of outside information, additional notices were published at 1 S.R. 1526 (April, 1977) and 2 S.R. 277 (August 15, 1977). In response to the solicitation, an industry task force was created for the purpose of developing a comprehensive draft of proposed regulations for the Commissioner's consideration. The final product of this industry drafting committee is set forth at Exhibit . Additionally, Blue Cross-Blue Shield of Minnesota submitted a proposal which differed in certain respects from the industry draft. Subsequent to receipt of the industry draft proposal and that of Blue Cross-Blue Shield, the Commissioner evaluated said proposals, together with comments received from individuals and interested persons, and promulgated the temporary rules as published at 2 S.R. 1672 on March 13, 1978. In most respects, the proposed rules are identical in substance to those adopted on a temporary basis. As more specifically set forth herein, the proposed rules reasonably address the requirements of the Act and constitute a reasonable attempt to further delineate and give effect to the duties, responsibilities, and rights designated therein.

Proposed Rule 4 MCAR, §1.3200 sets forth the authority, scope, and purpose underlying promulgation of the proposed rules. The provisions of this section are intended to provide affected persons with a concise statement of the general scope and applicability of the proposed rules.

4 MCAR §1.3201 sets forth the definitions given to terms otherwise undefined in the Act. Promulgation of these definitions is deemed by the Commissioner to be reasonable and necessary to enable persons affected by the Act and these rules to comprehend the full meaning and effect thereof. These definitions may be grouped in five general categories: Category 1 - types of insurance coverages; Category 2 - terms arising under accident and health insurance contract provisions; Category 3 - terms relating to the enrollment process applicable to the State Plan coverages offered by the Association and relating to benefits afforded to individuals enrolled thereunder; Category 4 - miscellaneous statutory terms otherwise undefined; Category 5 - terms which function as shorthand references to other provisions; and Category 6 - terms relating to the operations of the Association as directly related to the duties and privileges of Association members.

Category 1 Definitions: Subdivisions A, N, U, and KK of this proposal rule define certain types of policies or coverages referred to in Minn. Stat. §62E.04 (Supp. 1977) which are undefined by the Act. The language of these definitions was originally proposed by the industry task force (See Exhibit at INS §201) and conforms to the commonly accepted meanings of such coverages within the insurance industry.

Category 2 Definitions: Subdivisions G, J, O, Q, R, S, T, V, X, Y, Z, DD, GG, II, OO, PP, QQ, SS and DDD of this proposed rule define certain terms used to describe certain benefits contained in accident and health insurance policies. The Act refers to these terms in §§62E.06 and 62E.07 in describing the minimum standards to be contained in policies of accident and health insurance and Medicare supplement insurance. With the exception of subdivision DDD (definition of "student"), these definitions were originally proposed by the industry drafting committee and generally comport with the meanings given to said terms throughout the industry.

Category 3 Definitions: Subdivisions H, M, ZZ, BBB, CCC, and FFF of this proposed rule define certain terms used in the Act which relate to the manner in which the Association shall offer health coverage under the State Plan and the manner in which a State Plan enrollees' benefits shall be determined. The language incorporated in these definitions was originally proposed by the industry drafting committee and is deemed to be a reasonable construction of said terms within the context of the Act.

Category 4 Definitions: Subdivisions C, P, W. BB, FF, RR, and AAA of this proposed rule define certain terms otherwise undefined in the Act. Where material to a full understanding of the proposed rules, these terms will be more fully discussed below in the context of the substantive provisions of these proposed rules in which they occur.

Category 5 Definitions: Subdivisions B, E, F, and LL of this proposed rule set forth certain definitions which are merely intended to serve as shorthand references to the phrases which they define. These definitions are offered in the interest of conciseness and clarity in the text of these proposed rules.

Category 6 Definitions: Subdivisions D, I, K, AA, CC, EE, HH, JJ, MM, NN, TT, UU, VV, WW, XX and YY of this proposed rule define certain terms which relate to or identify the functional relationship between the Association and its members. Where material, these definitions will be more fully discussed in those portions of the proposed rules in which they arise. These definitions were originally proposed by the industry task force and are deemed to be reasonable constructions of said terms as they arise within the context of the Act and these proposed rules.

4 MCAR §1.3202 sets forth the duties of employers as they arise within the context of Minn. Stat. §62E.03. In substance, Minn. Stat. §62E.03 provides that each employer who provides or makes available a plan of health coverage to its employees shall make available a plan, or combination of plans, of accident and health insurance coverage certified as at least a number 2 qualified plan. The plans offered or made available by said employers may consist of any combination of self-insurance, health maintenance organization contracts, group

insurance policies, or individual insurance policies. In the event that an employer fails to make available at least a number 2 qualified plan to his affected employees, the employers' costs for health benefits shall not qualify as a state income tax deduction. Subdivision A of the proposed rule is intended to clarify that either a number 2 qualified plan or a number 3 qualified plan (or a health maintenance plan which is deemed to be a number 3 qualified plan may be offered. This subdivision is further intended to clarify that the employer is not obligated under the statute to pay the cost of any additional coverage which is offered to its employees.

Subdivision B of this proposed rule clarifies the duties of employers who provide health coverages to their employees under a collectively bargained plan of health benefits. The provisions of this rule acknowledged the statutorily prescribed employer-employee relationship recognized under the Labor Management Relations Act (29 U.S.C. §141, et seq.). In such situations where an employer offers employee health care benefits pursuant to a collective bargaining agreement, the employer need only make the required offer to the authorized bargaining representative. This subdivision further acknowledges that collectively bargained agreements entered into prior to the effective date of the Act, or amendments thereto, shall not be affected by the Act or subsequent amendments until the expiration of the existing agreement.

Subdivision C of this proposed rule requires affected employers to make the required offer during each fiscal year. This provision is reasonable and needed in that it clarifies the statutory ambiguity as to whether the required offer should be made on a calendar year basis as opposed to a fiscal tax year basis.

4 MCAR §1.3203 sets forth and clarifies the duties of insurers (including fraternals who offer accident and health insurance coverages) arising under Minn. Stat. §62E.04 (Supp. 1977). In substance, subdivisions 1 through 3 of section 62E.04 require each insurer who offers individual policies. Medicare supplement policies, or group insurance policies to develop and file with the Commissioner a qualified plan in each respective category of coverage. The insurer is then required to

offer the respective qualified plan to each person who applies for coverage. Thus, insurers and fraternals are encouraged to offer policies which provide at least the minimum level of benefits determined by the Legislature to be "adequate" coverage. Insurers are not prohibited from selling unqualified policies. However, in the event that an unqualified policy is issued or renewed, the insurer must "affirmatively offer" coverage of major medical expenses to each policyholder pursuant to subdivision 4 of section 62E.04, pursuant to Minn. Stat. §62E.05, subd. 5. Insurers which are not in compliance with section 62E.04 are prohibited from issuing or renewing any policies of accident and health insurance in Minnesota. Subdivision 7 allows the insurer to underwrite the mandatory offerings required under section 62E.04.

With respect to subdivision A of the proposed rule, the applicability of section 62E.04 to insurers depends on the type of insurance business in which such entities are engaged. The Act applies to insurers which issue policies of accident and health insurance. Minn. Stat. §62E.02, subd. 11 (Supp. 1977) defines "accident and health insurance policy" to exclude from coverage under the Act insurers which issue only certain specified types of coverage. This statutory exception includes policies providing coverage which is:

> (1) limited to disability or income protection coverage, (2) automobile medical payment coverage, (3) supplemental to liability insurance, (4) designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis, (5) credit accident and health insurance issued pursuant to Chapter 62B, (6) designed solely to provide dental or vision care, (7) blanket accident and sickness insurance as defined in §62A.11, or (8) accident only coverage issued by licensed and tested insurance agents or solicitors which provides reasonable benefits in relation to the cost of covered services. The provisions of clause (4) shall not apply to hospital indemnity coverage which is sold by an insurer to an applicant who is not then currently covered by a qualified plan.

The last sentence quoted above limits the application of the the exception in clause (4) to "hospital indemnity coverage" which is offered to an applicant who is "then currently covered by a qualified plan". Thus, per diem policies (as defined at 4 MCAR §1.3201) are not construed to be accident and health insurance policies unless they are of the hospital indemnity variety (as defined at 4 MCAR §1.3201) and are sold to a person who is not covered by a qualified plan at the

time of application for coverage under the hospital indemnity per diem policy. The proposed rule further allows the exception in clause (4) to apply if an applicant for coverage is currently covered by a health maintenance plan rather than a qualified plan, since a health maintenance plan is deemed to be a number 3 qualified plam under the Act..

With respect to subdivision B of proposed rule 4 MCAR §1.3202, this provision clarifies that the offer of a qualified plan required by section 62E.04, subds. 1 through 3 shall be made no later than the date of delivery of a policy to the applicant. While an earlier offer is not prohibited, it is reasonable to allow the required offer to occur upon delivery of an unqualified policy because insureds may terminate any policy within 10 days of delivery by an insurer pursuant to Minn. Stat. §72A.51 .

With respect to subdivision C of this proposed rule, this provision acknowledges the industry's existing custom and practice whereby insurers may only market either individual policies, group policies, or Medicare supplement policies. Thus, it would be inconsistent with industry custom and unreasonable to require an insurer which exclusively offers Medicare supplement policies to offer non-Medicare supplement policies. Similarly, it would be inconsistent with existing industry custom to require an insurer which exclusively offers individual policies to engage in the sale of policies on a group basis. The provisions of this rule would continue the present industry practice and is not inconsistent with the provisions of section 62E.04, subds. 1 through 3.

With respect to subdivision D of this proposed rule, the provisions thereof are intended to clarify and delineate the duties of insurers as mandated by Minn. Stat. §62E.04, subd. 4 (Supp. 1977). The proposed rule defines the term "affirmatively offer" and sets forth the manner in which such offer shall be made. In lieu of a written offer, an insurer may satisfy its obligations through the inclusion of a contractual provision in an unqualified policy which gives the insured the option to later apply for major medical coverage. By allowing a contractual option in favor of the insured, this provision reasonably addresses the administrative burdens which may be attendant upon insurers in attempting to determine the identity of unqualified policy

owners and the issuance of notice to such owners that major medical coverage is available.

With respect to subdivision E of the proposed rule, this provision clarifies that the terms of the Act do not extend to policies issued outside the State of Minnesota. The need for, and authority for, this provision may be found in reference to the ruling in Bosman v. Connecticut General Life Insurance Co., 301 U.S. 196 (1937) and related case law which holds to the effect that state statutes which regulate the content of insurance policies are not to be construed to be extra-territorial in effect, unless a clear legislative purpose to do so is indicated within the subject statute.

With respect to subdivision F of the proposed rule, the language contained therein acknowledges that some insurers have withdrawn from active business in Minnesota. However, insurers which terminate their activities in this state and relinquish their authority to transact business may nevertheless be contractually obligated to issue individual conversion policies to Minnesota residents pursuant to the contractual terms of previously issued policies pursuant to Minn. Stat. §62A.17 or §62E.16. This provision of the proposed rule is reasonably intended to allow insurers which cease doing business in Minnesota to do so, while at the same time allowing said insurers to fulfill the statutory and contractual obligation of providing conversion coverage to their former insureds. The need and authority for this exclusion is based upon the constitutional prohibition against impairment of existing contractual obligations as found in Article I, §10 of the U.S. Constitution and is consistent with the legislative goal of promoting greater accessibility to adequate health coverage for Minnesota residents.

The provisions of subdivision G of the proposed rule exempt from the requirements of the Act certain designated policies of accident and health insurance other than those expressly exempted by Minn. Stat. §62E.02, subd. 11. By its language, subdivision G exempts certain policies "under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend, or change the terms, conditions or premium rate of the policy or contract in any way." Similar language appears in the Readability of Insurance Policies Act (Minn. Stat. §72C.03,

(Supp. 1977)). The quoted language refers to policies generally known as noncancellable policies. Noncancellable policies are commonly understood within the insurance industry to be those policies under which the insured person has the contractual right to continue coverage to a specified age by the timely payment of premiums, and during which time the insurer has no unilateral right to make any change in any provision of the policy, including changes in premium rates. The reference to the July 1, 1976, and June 3, 1977, dates within this provision refers respectively to the effective date of the Act as originally enacted, and as subsequently amended by the 1977 revision. Thus, noncancellable policies issued prior to the effective date of the Act are unaffected by the Act's application. Similarly, hospital indemnity per diem policies issued prior to the effective date of the 1977 amendment to §62E.02, subd. 11 (definition of accident and health insurance policy) and which were sold to persons not then covered by qualified plans are likewise uneffected by the Act.

The underlying rationale for the exemption provided by subdivision G lies in the fact that the Act applies to insurers issuing or renewing policies subsequent to the Act's effective dates. Minn. Stat. §62E.02, subd. 11, and §62E.04, subds. 4 and 5. To the extent that policies otherwise includible within the Act's provisions are issued prior to the Act's effective date, and not subsequently renewed or modified by either party thereto, said policies must be exempted from the Act. The continuation in force of noncancellable contracts where the insurer lacks the capacity to alter or modify coverage in any way is not construed a renewal of said policy.

In contrast to the exemption provided for noncancellable policies, the provisions of subdivision G of the proposed rule does not extend to "guaranteed renewable" policies. Guaranteed renewable policies differ from noncancellable policies in that the former type of policy generally contain a provision which permits a change in premium rate to be made by the insurer. Some guaranteed renewable policies also allow the insurer to terminate coverage of an individual insured if the insurer terminates all other policies within the designated

class. Thus, on a class basis, the insurer retains the right to unilaterally terminate guaranteed renewable coverages or to effect a change in premium rates to be charged for coverage thereunder. Coverage provided under guaranteed renewable policies are therefore deemed to "renew" upon the expiration of the state policy term and are consequently affected by the Act when such renewals occur. 4 MCAR §1.3201 AAA (definition of "renewal date") is intended to clarify the time at which policies are deemed to renew, for purposes of the Act and 4 MCAR §§1.3203, 1.3206D, and 1.3225 A1.

With respect to subdivision H of this proposed rule, the language contained therein is intended to clarify the manner in which Minn. Stat. §62E.04, subd. 5 applies to non-compliant insurers. The provisions of subdivision H parallel the exemptions set forth in subdivision G. To the extent that policies set forth in subdivision G are excluded from the Act, insurers which otherwise cease doing accident and health insurance business shall not be precluded from honoring their pre-existent contractual obligations.

Proposed Rule 4 MCAR §1.3204 is intended to clarify that insurers may continue to exclude coverage for an insured's pre-existing conditions when coverage under a qualified plan is offered. While similar language is not found in the Act, §62E.04, subd. 7 authorizes insurers to continue to underwrite coverages issued pursuant to the Act. Exclusion of benefits for pre-existing conditions is consistent with generally accepted underwriting practices.

Proposed Rule 4 MCAR §1.3205 is intended to make the rules more comprehensive by providing a convenient reference to provisions of the Act and the proposed rules which set forth the minimum benefits standard for determining the qualification of Medicare supplement policies.

Proposed Rule 4 MCAR §1.3206 sets forth the procedures to be followed by insurers in the submission of plans of health coverage to the Commissioner for certification. Subdivision B of this proposed rule likewise sets for the procedure to be followed by the Commissioner in the evaluation of plans submitted for certification. Subdivision C of this proposed rule incorporates the 1977 amendment to Minn. Stat.

§62E.04 which precluded substitution of actuarially equivalent benefits for the $3,000 out-of-pocket expense limitation and minimum $250,000 lifetime benefit provisions. Subdivision D of this proposed rule clarifies the effect of a prior certification of an employers plan of health coverage in the event that minimum benefit standards are changed during the term of a benefit program. Thus, legislative amendment to the minimum benefit levels set forth a Minn. Stat. §62E.06, or revision of the actuarial equivalence tables, would have to be reflected in an employers' section 62E.03 duty to offer qualified plans at such time as the policy or plan of health coverage is renewed.

Proposed Rule 4 MCAR §1.3207 attempts to clarify and concisely delineate the relationship between the potentially conflicting statutory privileges granted by Minn. Stat. §62A.17 and Minn. Stat. §62E.16. Pursuant to the provisions of section 62E.17, an employee insured under a group insurance policy is granted the right to continue such coverage for a period of time no greater than six months after employment is terminated. After the expiration of the six-month continuation of coverage period, the employee is granted the right to convert from coverage continued under the group insurance continuation provision and to be issued an individual policy of health insurance. In contrast, however, the provisions of section 62E.16 allow an employee insured under his employer's group insurance policy to convert to an individual policy within thirty days of leaving the insured group. The provisions of section 62E.16 are silent with respect to continuation of coverage. In the face of the overlapping provisions of the subject statutes, the possibility exists that an employee or an insurer will be confused in seeking to determine its respective rights and obligations thereunder. For example, the statute does not address the question of whether an employee may elect to continue coverage under Minn. Stat. §62A.17 and, at the same time, convert to an individual policy under section 62E.16, the result of which would be the issuance of dual coverage upon the electing employee. The proposed rule addresses this apparent ambiguity by treating the continuation and conversion coverages as mutually exclusive coverages. The election of the appropriate form

of coverage is left exclusively with the employee.

Subdivision B of this proposed rule clearly delineates the scope of the health coverage provider's duty to offer the conversions required by the subject statutes. Similarly, subdivision C of this proposed rule delineates the health care provider's duty to provide due notice of the cancellation of coverage extended to employees under a plan of accident and health benefits.

Proposed Rule 4 MCAR §1.3208 incorporates the actuarial equivalence tables set forth as an Appendix to the proposed rules. Minn. Stat. §62E.02, subds. 4 and 5 requires the Commissioner to certify as being "qualified", those plans of health benefits which meet or exceed the minimum benefits requirements set forth at section 62E.06 and section 62E.07 regarding plans of health coverage and Medicare supplement plans, respectively. In lieu of providing the benefits specifically enumerated at Minn. Stat. §§62E.06 and 62E.07, plans of health coverage and Medicare supplement plans may substitute other equivalent benefits without jeopardizing the qualified status of the plans. By allowing the substitution of equivalent benefits for those individual benefits specifically enumerated in the Act, the statute requires that a common basis for evaluating the relative values of benefits be provided. A test for actuarial equivalence of benefits was therefore devised for use by the Commissioner, insurers, and others seeking certification of plans of health coverage and Medicare supplement plans. This test for actuarial equivalence is set forth at Appendix I.

The test for actuarial equivalence was designed by the Actuarial Advisory Committee of the special task force created by the Commissioner immediately following enactment of the Act. Because the Act creates two distinct categories of qualified plan benefits (i.e., Medicare supplement policies under section 62E.07 and non-Medicare supplement policies under section 62E.06), two separate tables were required. In constructing the appropriate tables, it was determined that the test for actuarial equivalence should be designed to the following characteristics: (1) to adequately reflect the relative cost relationships between individual

benefits; (2) to be useable for most benefits found in group and individual policies; (3) internal consistency between the relative values of benefits must be achieved; and (4) use of the tables should be as simple and uncomplicated as possible.

In designing the tables applicable to the non-Medicare supplement benefits, the actuarial advisory committee sent a questionnaire to a selected sampling of health actuaries. This sampling approach was a modification of the Delphi Estimation Method. The committee then reviewed the responses to determine for each subtable, (1) the average estimation, (2) the median estimation, (3) the largest estimation, and (4) the smallest estimation. The tables of relative values were then created using the responses as a base and making appropriate actuarial adjustments to reflect reasonableness and consistency.

In designing the tables applicable to the Medicare supplement benefits the actuarial advisory committee utilized Medicare benefit utilization statistics and other national health utilization data. The appropriate tables were then devised after discussion with actuaries outside the committee.

The provisions of 4 MCAR §1.3208 give due allowance for the periodic fluctuation of relative values of individual benefits. Given the need for up-to-date assessment of the relative values of benefits, this proposed rule delineates the responsibilities of the Commissioner to update the tables and further delineates the effect of revision upon existing plans.

Part II of the proposed rules relate to the organization and operation of the Association and delineate the respective duties and obligations of the Association and its members.

The Commissioner's decision to implement the Act through these proposed rules is further based on a variety of duties imposed on the Commissioner by the Act. In addition to the rulemaking authority set forth at Minn. Stat. §62E.09(i) (Supp. 1977), the Commissioner is authorized and has responsibility:

(1) to supervise the creation of the Association (Minn. Stat. §62E.09(b);

(2) to approve the Association's enabling documents, including By-Laws and operating rules (Minn. Stat. §62E.10, subd. 3).

(3) to determine the weighted vote of the members of the Association based on the prescribed statutory formula (Minn. Stat. §62E.10, subd. 2).

(4) to approve the directors elected to the Board of the Association (Minn. Stat. §62E.10, subd. 2).

(5) to assure broad and fair industry representation from the membership on the Board (Minn. Stat. §62E.10, subd.2).

(6) to approve the writing carrier(s) selected by the Association to administer the state plan and approve the Association's contract with the writing carrier(s) (Minn. Stat. §62E.09(c)).

(7) to approve the rates to be charged by the Association for the state plan coverages (Minn. Stat. §62.09(c)).

(8) to approve the state plan coverages issued by the Association (Minn. Stat. §62E.13, subds. 1 and 2).

(9) to determine the members' cost of self insurance, accident and health insurance premium, subscriber contract charges and health maintenance organization contract charges to be used by the Association as the basis for assessment of the members for losses and expenses of the Association (Minn. Stat. §62E.11, subd. 5).

(10) to approve the terms of the assessment agreement required to be entered into between the Association and each member (Minn. Stat. §62E.11, subd. 5).

(11) to approve the reinsurance plan established by the Association (Minn. Stat. §62E.10, subd. 7(e)).

(12) to receive monthly reports regarding the Association activities and monitor the operation of the state plan by the Association (Minn. Stat. §62E.13, subd. 5).

(13) to approve the plan of advertising of the state plan (Minn. Stat. §62E.15, subd. 1).

(14) to conduct periodic audits to assure the general accuracy of the financial data submitted by the Association and the writing carrier (Minn. Stat. §62E.09(e)).

(15) to undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the health benefits mandated under the Act, including the state plan offered through the Association, so that the residents of Minnesota may best avail themselves of the mandated health benefits (Minn. Stat. §62E.09(g)).

(16) to contract with insurers and others for administrative services (Minn. Stat. §62E.09(h)).

As set forth herein, proposed rules 4 MCAR §1.3225 through §1.3234 reasonably reflect the statutory intent underlying the creation and operation of the Association.

Proposed rule 4 MCAR §1.3225 delineates Association membership. Subdivision A of this proposed rule is necessary to implement Minn. Stat. §62E.10, subd. 1, which delineates the membership of the Association. The proposed rule ties the language contained in the definitional sections of the Act relating to "insurer," (Minn. Stat. §62E.02, subd. 10), "accident and health insurance policy," (Minn. Stat. §62E.02, subd. 11), "fraternal beneficiary association," (Minn. Stat. §62E.02, subd. 19), "health maintenance organization," (Minn. Stat. §62E.02, subd. 3), "self insurer," (Minn. Stat. §62E.02, subd. 21), and "self insurance," (Minn.Stat. §62E.02, subd. 22) to the requirement in members retain their Association membership as a condition of continuing to transact "accident and health insurance", "self insurance", or "health maintenance organization" business in this state. Minn. Stat. §62E.10, subd. 3 (Supp. 1977).

In addition to integrating the definitional sections of the Act to the basic membership requirement, this proposed rule adds further detail to the membership requirements of Minn. Stat. §62E.10, subds. 1 and 3, to clarify the exceptions. Similar to the provisions of 4 MCAR §1.3203, this proposed rule delineates the exceptions to mandatory membership for insurers which issue those types of coverages --exempted from the requirements of the Act, pursuant to Minn. Stat. §62E.02, subd. 11 (Supp. 1977).

Similar to the provisions of 4 MCAR §1.3203 G.1, clause (4) of 4 MCAR §1.3225 A.1.b. exempts policies or contracts issued prior to the effective date of the Act under which an insurer or fraternal may not "cancel, nonrenew, amend, or change the terms, conditions, or premium rate of the policy or contract in any way." Rather, the rationale for such language is that the duties of insurers (as stated in Minn. Stat. §62E.04, subd. 5, relating to noncompliance) relate to policies or contracts which are "issued or renewed," and if certain policies were issued prior to the effective date of the Act and are not renewed or susceptible to changes in any provisions of the policy (including premium rate) it appears reasonable to exempt from membership in the Association insurers or fraternals to the

extent that they continue only such coverage. Clause (4) also contains an exception for policies or contracts providing payment on a per diem, fixed indemnity or non-expense incurred basis issued prior to June 3, 1977, under which there is no unilateral right of the insurer or fraternal to cancel, non-renew, amend or change the terms, conditions, or premium rate of the policy or contract in any way. Again, similar to the provisions of 4 MCAR §1.3202 G.2 reference to the June 3, 1977, date reflects the effect of the 1977 amendment to the definition of "accident and health insurance policy" (Minn. Stat. §62E.02, subd. 11 (Supp. 1977)).

Clause (5) of 4 MCAR §1.3225 A.1.b. states the exception for policies designed to provide payment on a per diem, fixed indemnity or non-expense incurred basis and also reflects the effect of the 1977 amendment to the definition of "accident and health insurance policy" to the extent that hospital indemnity policies issued or renewed on or after the effective date of the amendment (June 3, 1977) were included in the Act's provisions. This provision exempts unqualified policies sold to persons then currently covered by a health maintenance plan. While Minn. Stat. §62E.02, subd. 11 (Supp. 1977) does not include the reference to a health maintenance plan, this phrase is added to the rules because coverage under an HMO is deemed to be the provision of a number 3 qualified plan. Therefore, it appears reasonable and in furtherance of statutory intent to deem a health maintenance plan to be a qualified plan for the purpose of this exception.

Proposed rule 4 MCAR §1.3225 a.4 defines "licensed or authorized to do business." This phrase is crucial to interpreting the mandatory membership requirement and is broadly defined to achieve the largest membership in the Association. Such a liberal construction appears to be reasonably consistent with the remedial purposes of the Act. The definition is applicable to insurers, fraternals, HMOs and self insurers and is phrased in such a way as to extend application of the membership requirement to all such entities who are actually carrying on accident and health insurance, self insurance, or health maintenance organization business in this state.

Subdivision B of proposed rule 4 MCAR §1.3225 describes the Association member's obligation to enter into an agreement to pay its proportionate share of any Association operating and administrative expenses and losses incurred in operating the State Plan. This provision is needed to clarify a confusing reference in Minn. Stat. §62E.10, sub. 5 requiring members to execute a "contract of reinsurance." Since this statutory term is easily confused with the Association's entirely separate reinsurance function (described in Minn. Stat. §62E.10, subd. 7(e) and 4 MCAR §1.3234), the proposed rules use instead the term "assessment agreement."

The proposed rule specifically sets forth in 4 MCAR §1.3225 B.1., 2. and 3. the requirements included in Minn. Stat. §62E.11, subd. 5 relating to members' obligations. Since the statute uses the terms "losses," "claims expenses," and "operating and administrative expenses of the association" without definition, these terms have been defined in the rules at 4 MCAR §§1.3201 CC., 1.3201 I., and 1.3201 HH., respectively. These definitions clarify that the terms "losses" and "claims expenses," which appear to be used interchangeably in the statute, mean the same thing, and "operating and administrative expenses of the association" means normal business expenses, some of which are enumerated in the definition. The definition or "operating and administrative expenses of the association" clearly indicates that the writing carrier's expenses are not included in this term, which means that the writing carrier's expenses cannot be the basis for an assessment since this does not appear permissible under Minn. Stat. §62E.11, subd. 3.

Proposed rule 4 MCAR §1.3225 B.3., relating to payment of assessments, is based on the requirement in Minn. Stat. §62E.11, subd. 5 that payment of an assessment is <u>due</u> within 30 days of the end of the Association's fiscal year, but clarifies that assessments are <u>payable</u> within 30 days of receipt by a member of a written assessment notice. This provision is included for the practical reason that the Association will not be able to complete the required computations to release the assessment notices prior to the end of

its fiscal year and therefore members might be expected to pay their assessments with very little notice, in the absence of this provision. It appears reasonable to clarify this provision to assure that members will have 30 days' notice of any assessment which must be paid.

Subdivision C of proposed rule 4 MCAR §1.3225 is based on Minn. Stat. §62E.11, subd. 5 and the definitions in the rules of the terms "losses" and "operating and administrative expenses of the Association." This provision clarifies that the Board shall make a determination of losses and operating and administrative expenses following each fiscal year end. This provision of the rules also clarifies that where an estimate of operating and administrative expenses of the Association is made for the succeeding fiscal year (as permitted by Minn. Stat. §62E.11, subd. 5), members will be assessed for any deficit in the actual amount of operating and administrative expenses or losses -- or credited with any excess in the next fiscal year and assessment. Thus, to the extent that there is an excess assessment for losses and administrative expenses of the Association, this excess is not subject to the provision in Minn. Stat. §62E.11, subd. 5 which states that "net gains, if any, from the operation of the State Plan, shall be held at interest and used by the Association to offset future losses due to claims expenses of the State Plan or allocated to reduce State Plan premiums." The term "net gains" is defined in the rules at 4 MCAR §1.3201 EE. to further clarify that net gains relates to excess premiums or contract charges -- not assessments. This appears to be a reasonable accommodation of the assessment mechanism with the function of the State Plan premium.

Subdivision D of proposed rule 4 MCAR §1.3225 reorganizes and restates the levy authority of the Association as set forth in Minn. Stat. §62E.11, subd. 5. The proposed rules at 4 MCAR §1.3201 EEE., define "total cost of self insurance" which appears in this section of the rules and in Minn. Stat. §62E.11, subd. 5, and tie this definition into the definition of "self insurance business" contained in 4 MCAR §1.3225 A.2. This is necessary to specify the basis on which an assessment gainst a self insurer will be computed. 4 MCAR §1.3225 D.3.

clarifies that the Commissioner will determine the amount of a member's assessment (as required by Minn. Stat. §62E.11, subd. 5) in accordance with a form which members will be required to submit to the Commissioner annually. In order to allow the Association to conduct levies effectively if the information is not made available to the Commissioner, this proposed rule further allows the Commissioner to estimate the member's share of an assessment based on other information available to the Commissioner. The rules also restate the Commissioner's broad authority to audit members and their agents, trusts and third party administrators to obtain information necessary to levy an assessment if the Commissioner is otherwise unable to determine the amount of an assessment. 4 MCAR §1.3225 D.4, which allows the Association to decline to levy assessments against members which owe not more than $5.00 is a reasonable and necessary accommodation to the practical problem of levying assessments which are so small in amount that the cost of levying such assessment is not justified and may well exceed the amount of the assessment.

Subdivision E of proposed rule 4 MCAR §1.3225 is a necessary clarification that the Commissioner, rather than the Association, has the responsibility of assuring that members of the Association will comply with the provisions of Minn. Stat. §62E.11, subd. 5, but that the Association will cooperate by providing information to the Commissioner. This is reasonable and consistent with the Commissioner's general supervisory and enforcement powers, as well as the specific futies of the Commissioner regarding this Act, set forth in Minn. Stat. §62E.09, and the effect of non-compliance with the Act by insurers stated at Minn. Stat. §62E.04, subd. 5.

The Association was created under Minn. Stat. §62E.10, subd. 1, and duly incorporated under the Minnesota Nonprofit Corporations Act, (Minn. Stat. ch. 317). proposed rule 4 MCAR §1.3226 is necessary to clarify that any potential conflict between the provisions of the two chapters shall be resolved in favor of ch. 62E. This proposed rule further requires all amendments to the Association's Articles of Incorporation and Bylaws to be subject to approval by the Commissioner.

Subdivision C of this proposed rule further defines the Commissioner's duties regarding the Association and specifically requires that the Commissioner approve all operating rules developed by the Association before such rules may become effective.

Proposed rule 4 MCAR §1.3227 sets forth the requirements applicable to the Association's Board of Directors. Subdivision A of this provision implements Minn. Stat. §62E.10, subd. 2 and requires in addition that the members of the Board shall be officers, employees, or agents of members of the Association and shall be removed from office if they do not retain that status. This is a requirement of the Association Bylaws and seems reasonable to assure that the Board is representative of the membership of the Association as required by Minn. Stat. §62E.10, subd. 1.

Subdivision B of this proposed rule reflects the content of the Association Bylaws and further delineates Minn. Stat. §62E.10, subd. 2. These provisions are intended to facilitate the orderly conduct of elections.

Subdivision C of this proposed rule acknowledges that the Association, through its Board, acts in conformance with its Articles of Incorporation and with its Bylaws as well as with the provisions of the Act. The language relating to reimbursement of expenses implements Minn. Stat. §62E.10, subd. 2, limiting the scope of reimbursement, and tying reimbursement to guidelines established by the Board and approved by the Commissioner.

Subdivision D of this proposed rule also recognizes the corporate structure of the Association and authorizes appointment of officers and committees by the Association. Such officers and committees are not specifically provided for under the Act, but are contemplated in the Bylaws of the Association and are reasonably necessary for the efficient operation of the Association.

Proposed rule 4 MCAR §1.3228 relates to the determination of members' voting rights. 4 MCAR §1.3228 A. and B., relating to meetings and members' weighted votes, implement Minn. Stat. §62E.10, subd. 2 and the Bylaws of the Association which entitle members to vote at

annual and special meetings and which establish the formula for the weighted vote. Since Minn. Stat. §62E.10, subd. 2 relates only to the organizational meeting of members, this proposed rule is needed to provide procedures for subsequent meetings and elections. The specific method for determining the weighted vote is consistent with the Association procedures set forth in the Bylaws and is necessary to explain how the Commissioner will determine "the member's cost of self insurance, accident and health insurance premium, subscriber contract charges or health maintenance contract payments . . ." as required by Minn. Stat. §62E.10, subd. 2. Voting procedures are not addressed by the Act, but are included in this proposed rule to provide for orderly voting by the membership. This rule is consistent with the procedures contained in the Association Bylaws and with ordinary business procedures.

Proposed rule 4 MCAR §1.3229 relates to the conduct of meetings of the Association. The provisions of Subdivisions A and B, relating to annual and special meetings are needed because the Act does not specify the means for conducting business of the Association subsequent to the organizational meeting provided for in Minn. Stat. §62E.10, subd. 2. These provisions are consistent with the Association Bylaws and Minn. Stat. ch. 317. Subdivision C relating to open meetings, reiterates the provisions of Minn. Stat. §62E.10, subd. 4, and is included for comprehensiveness of this rule.

Proposed rule 4 MCAR §1.3230 delineates the minimum benefits of the comprehensive health insurance plans provided by the Association. Subdivision A of this proposed rule integrates the provisions of Minn. Stat. §62E.11, subd. 1 (enrollment by eligible persons), §62E.12 (relating to qualified plans one and two, qualified Medicare supplement plans and health maintenance plans), and §62E.14, subd. 1 (which indicates that the Association may provide coverage for eligible dependents), into a single provision which clearly states the coverages to be offered by the Association.

Subdivision B of the proposed rule does not attempt to restate the provisions of Minn. Stat. §62E.06. However, this proposed rule

incorporates the actuarial equivalence concept included in Minn. Stat. §62E.02, subd. 4, except in these instances where Minn. Stat. §62E.06 precludes the use of actuarially equivalent benefits.

The term "out-of-pocket expenses" used in this provision and in Minn. Stat. §62E.06, subd. 1, is defined at 4 MCAR §1.3201 II to clarify that out-of-pocket expenses are computed on a calendar year basis in relation to covered services under the State Plan contract under which the person is covered if the expenses are not paid or payable by any plan of health coverage, Medicare, or other governmental program. This definition is essential to clear understanding of the meaning of Minn. Stat. §62E.06, subd. 1 and 4 MCAR §3230 B. Similarly, the terms "covered person," "insured dependent," and "insured person" are defined in the proposed rules at 4 MCAR §1.3201 M., Y. and Z., respectively. These terms are needed to specifically define the persons who are covered under policies or contracts of the State Plan, and are consistent with industry terminology.

Subdivision C of the proposed rule is necessary to clarify that, pursuant to Minn. Stat. §§62E.02, subd. 5 and 62E.07, the qualified Medicare supplement plan offered under the State Plan is subject to substitution of actuarially equivalent benefits, and that the policy pays only for section 62E.06 expenses which are not paid by Medicare or payable if the person had been enrolled in Medicare. This provision is consistent with industry practices and necessary to avoid overpayment. The provisions of Minn. Stat. §§62E.06 and 62E.07 are integrated in this proposed rule. The definition of "covered expenses" as used in 4 MCAR §1.3230 C.3 is defined in 4 MCAR §1.3201 L. This definition is needed to tie the benefits of Minn. Stat. §62E.06; the actuarial equivalence concept included in the statutory definition of qualified Medicare supplement plans; and the limitations on the expenses which will be paid under Minn. Stat. §62E.07.

Subdivision D of the proposed rule is necessary to incorporate the definition of health maintenance organization at Minn. Stat. §62E.02, subd. 3 and the provision relating to health maintenance plans included

in Minn. Stat. §62E.06, subd. 4. This provision further clarifies that HMO's be in compliance with the regulations implementing Minn. Stat. ch. 62D in order to constitute a health maintenance plan under the Act. This constitutes a reasonable accommodation to the Commissioner of Health's jurisdiction over HMO's under Minn. Stat. ch. 62D.

Subdivision E of the proposed rule incorporates the requirement of Minn. Stat. §62E.14, subd. 3 and the concept of filing a completed certificate of eligibility as described in 4 MCAR §1.3232. This provision clarifies when the time periods relating to the pre-existing conditions limitation begin to run.

Proposed rule 4 MCAR §1.3231 relates to the approval of State Plan coverages by the Commissioner. The provisions of Subdivisions A., B., and C. of this proposed rule are necessary to implement Minn. Stat. §62E.13, subds. 1 and 2. Subdivision B clarifies that the Association may develop specifications for bids which may be solicited from members wishing to serve as a writing carrier to administer the State Plan. This procedure has been successfully utilized by the Association to select-the present writing carrier and is a reasonable and efficient procedure to follow. Subdivision C emphasizes that the Commissioner's approval of policies and contracts must be obtained prior to issuance of such policies or contracts. This filing requirement is consistent with forms filing requirements imposed upon commercial insurers.

Proposed rule 4 MCAR §1.3232 delineates the procedures applicable to the solicitation, application and enrollment of eligible persons in the State Plan coverages. Subdivision A of this proposed rule implements Minn. Stat. §62E.14, subd. 1. The term "certificate of eligibility and enrollment form" is defined at 4 MCAR §1.3201 H. as the application to be completed by persons wishing to enroll in the State Plan.

Subdivision A.1.a.(2)(a) of this proposed rule establishes the definition for "eligible dependents," a term otherwise undefined in the statute. The exclusions in this provision are part of the State Plan policies and contracts. The rules include definitions of the

terms "student," "disabled child," and "financially dependent" at 4 MCAR §1.3201 DDD., O. and Q., respectively, which give further meaning to this provision. These are standard definitions within the insurance industry for these terms.

Subdivision A.1.a.(3) of this proposed rule implements the requirement of two rejections, or the requirement of a restrictive rider or pre-existing conditions limitation on a qualified plan by two Association members as set forth at Minn. Stat. §62E.14. The terms "rejection," "restrictive rider," and "pre-existing conditions limitation" are defined in the proposed rules at 4 MCAR §1.3201 ZZ., CCC., and PP., respectively, to give specific meaning to the statutory eligibility requirement for enrollment in the State Plan. These definitions are based on definitions used by the insurance industry. With the approval of the Commissioner, and in accordance with the discretionary language in this section of the rules, the Association is currently allowing persons who suffer from one of the illnesses on a list of presumptive conditions to enroll in the State Plan without meeting the requirement of two rejections, riders or pre-existing conditions limitations. Such a procedure saves time and expense in situations where a person will clearly be able to meet the requirements of two rejections, restrictive riders or pre-existing conditions limitations where there is need to actually obtain such proof. Similar discretion is allowed the Board at 4 MCAR §1.3232 A.1.c. in relation to persons already covered under the State Plan who, upon reaching age 65, wish to obtain coverage under a qualified Medicare supplement plan. Persons uninsurable prior to reaching age 65 are likely to continue to be uninsurable thereafter and may be deemed to meet the enrollment requirements for a qualified Medicare supplement plan. Thus it is reasonable and efficient to allow such persons to convert automatically.

Subdivision A.1.b. of this proposed rule allows the Board to investigate the authenticity of information submitted by persons wishing to enroll in the State Plan, and is a reasonable procedure to ensure that only persons meeting the requirements of the Act are allowed to enroll.

The provisions of 4 MCAR §1.3232 A.1.d. and e. clarify that persons age 65 and older are eligible only for the qualified Medicare supplement plan and that the qualified Medicare supplement plan limitation of $100,000 takes into consideration utlization of maximum lifetime benefits under any prior policy or contract of the State Plan where a person previously received benefits thereunder. This appears to be a reasonable integration of the provisions of the Act which establish a maximum lifetime benefit under the State Plan.

The provisions of Subdivision A.1.f. is necessary to clarify that eligibility requirements continue to apply after persons have become covered under the State Plan. If covered persons fail to continue to meet these requirements, the Board has the authority to terminate or refuse to renew coverage.

Subdivision B of proposed rule 4 MCAR §1.3232 implements Minn. Stat. §62E.14, subd. 2 and delineates the Association's response to enrollment applications. This provision clarifies that the thirty (30) day time period for response by the Association begins to run upon receipt of a complete certificate of eligibility. This provision is intended to avoid penalizing the Association in situations where applicants have not provided all the necessary information for a determination of eligibility. This provision further integrates the requirements of Minn. Stat. §§62E.13, subd. 4 and 62E.14, subd. 2 relating to information which covered persons must receive upon being enrolled in the State Plan.

The provision of proposed rule 4 MCAR §1.3232 B.2. is similar to the claims dispute mechanism required by Minn. Stat. §62E.13, subd. 6 and 4 MCAR §1.3233 B.1.b.(5). This provision allows a reasonable means for persons whose certificate of eligibility is not accepted to question the determination.

Subdivision C of proposed rule 4 MCAR §1.3232 is consistent with the general supervisory powers of the Commissioner over the Association, as stated in Minn. Stat. §62E.09 and elsewhere in the Act. After the Association has taken final action with respect to determination of an applicant's eligibility, it is reasonable for the Commissioner to have an opportunity for final review.

Subdivision D of proposed rule 4 MCAR §1.3232 implements Minn. Stat. §62E.15 of the Act by specifying the Association's responsibilities with respect to solicitation of eligible persons.

Proposed rule 4 MCAR §1.3233 delineates those procedures applicable to the selection, approval and operations of the writing carrier. Subdivision A of this proposed rule implements Minn. Stat. §62E.13, subds. 1., 2., and 3. This provision clarifies that the Commissioner's approval of the writing carrier is required prior to commencement of its operations and reflects the bidding process used for selection of a writing carrier. The provisions of 4 MCAR §1.3233 A.5. acknowledge that, in view of the six-month period established in Minn. Stat. §62E.13, subd. 3, relating to inviting proposals from members to be a writing carrier, the Board should be allowed to require the existing writing carrier to remain as the writing carrier for six months from the date of a request to terminate its contract. This provision allows the selection of another writing carrier in a manner which facilitates continuation of Association operations.

Subdivision B of this proposed rule integrates the requirements of several sections of the Act including: Minn. Stat. §62E.13, subd. 3 (relating to administration and claims payment function of the writing carrier); §62E.13, subd. 6 (relating to claims payment); §62E.08 (relating to premium for the State Plan); §62E.13, subd. 5 (relating to reports on the operation of the State Plan); §62E.11, subd. 3 (relating to payment of claims, agent referral fees and writing carrier expenses); and §62E.13, subd. 7 (relating to writing carrier expenses). The proposed rule also establishes reasonable guidelines for the writing carrier relating to billing insured persons and making timely payment of benefits. The proposed rule delineates specific functions of the writing carrier relating to claims payment including evaluating the eligibility of claims for payment of benefits and determining the usual and customary charges for benefits to be paid. The term "usual and customary charge" used in Minn. Stat. §62E.06, subd. 1 is included in this section of the rules and defined at 4 MCAR §1.3201 FFF.

The provisions of Subdivision B of proposed rule 4 MCAR §1.3233 further clarifies that although reimbursement of the writing carrier's expenses cannot exceed the lesser of 12-1/2% of State Plan premium (less agent referral fees) or the actual direct and indirect operating and administrative expenses incurred by the writing carrier, it is possible to carry forward writing carrier expenses incurred furing the three-year period of its contract if in one year such expenses exceed the reimbursable amount, so long as neither the 12-1/2% of premiums less agent referral fees nor the actual direct and indirect expenses over the three-year contract are exceeded. This provision is necessary since the writing carrier's expenses and agent referral fees may be concentrated in the initial year of service.

Subdivision C of this proposed rule creates a mechanism for covered person appeal of denied claims to the Commissioner. In view of the Commissioner's broad supervisory jurisdiction over the Association, this provision is reasonable and in furtherance of giving insured persons and independent review of disputes arising under State Plan coverages.

Proposed rule 4 MCAR §1.3232 implements Minn. Stat. §62E.10, subd. 7 clauses (e) and (f). While to date this has not been a major aspect of Association operations, this section provides the details necessary to implement that function of the Association.

A number of terms are used in this proposed rule and are defined in 4 MCAR §1.3201. Many of these definitions are needed to clarify that the reinsurance mechanism administered by the Association is not an insurance underwriting function and is entirely separate from the Association's function of issuing State Plan coverage. This proposed rule relates only to the insurer and fraternal members' opportunity to reinsure certain coverage which the Act requires them to offer. Terms which are defined in the rules and which are essential to an understanding of the reinsurance function include: "Reinsurance Plan: (4 MCAR §1.3201 VV.), "Reinsurance Pooling Agreement (4 MCAR §1.3201 XX.), "Reinsurance Pool" (4 MCAR §1.3201 WW.), "Commercial

Reinsurance" (4 MCAR §1.3201 K.), "Reinsurer" (4 MCAR §1.3201 YY.), "Reinsurance Administrator" (4 MCAR §1.3201 TT.), "Pooling Payment" (4 MCAR §1.3201 MM.), "Pooling Rates" (4 MCAR §1.3201 NN.), "Reinsurance Assessment" (4 MCAR §1.3201 UU.), "Interim Reinsurance Assessment" (4 MCAR §1.3201 AA.) and "Administrative Expenses of the Pool" (4 MCAR §1.3201 D.). These terms appear in the Act and the proposed rules and are defined within the proposed rules to avoid confusion with similar terms relating to operation of the State Plan. This proposed rule, and related definitions, allow the Association flexibility to engage a reinsurance administrator and to develop a reinsurance plan in a workable manner, consistent with Minn. Stat. §62E.10, subd. 7.

Proposed rule 4 MCAR §1.3235 contains a severability provision. This provision is necessary to allow the rules, in part, to remain in effect if a portion of the rules is held invalid by a court of competent jurisdiction. Severability allows for the most efficient and consistent operation of the Association.

Dated: October ___, 1978.

Thomas L. O'Malley

THOMAS L. O'MALLEY
Assistant Insurance Commissioner
500 Metro Square Building
St. Paul, Minnesota 55101

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE BERTON W. HEATON

COMMISSIONER OF INSURANCE

In the Matter of the Proposed Rules of the Minnesota Department of Commerce, Insurance Division, Relating to the Comprehensive Health Insurance Act, Minn. Stat. ch. 62E

NOTICE OF HEARING

Notice is hereby given that a public hearing in the above-entitled matter will be held in the hearing room at 500 Metro Square Building, Seventh and Robert Streets, Saint Paul, Minnesota, on November 1, 1978, at 9:30 a.m. and continuing until all representatives of associations or interested groups or persons have had an opportunity to be heard concerning the adoption of the proposed rules captioned above by submitting either oral or written data, statements or arguments. Statements may be made orally and written materials may be submitted at the hearing. In addition, written materials may be submitted by mail to Mr. George A. Beck, State Office of Hearing Examiners, 1745 University Avenue, Room 300, St. Paul, Minnesota 55104, (612) 296-8108, the Hearing Examiner appointed to hear this matter, either before the hearing or within five (5) working days after the close of the hearing. (The Hearing Examiner may order a longer period of time for comments which may not exceed twenty (20) days.)

Proposed rules if adopted would establish standards and procedures for the certification of qualified plans by the Commissioner of Insurance and would clarify the statutory duties of insurers, fraternals, employers, and self-insurers in the offering of qualified plans and major medical coverages. A qualified plan is a plan of

health coverage certified by the Commissioner of Insurance as meeting certain statutorily established levels of health insurance benefits. The Comprehensive Health Insurance Act (Minn. Stat. ch. 62, hereinafter "Act") requires all licensed accident and health insurers and fraternals to offer qualified plans to applicants and requires employers to make available certain qualified plans to their employees as a condition of eligibility for state income tax deduction of the employer's health care costs on behalf of its employees. Insurance companies which sell accident and health insurance must make available qualified plans to their prospective insureds or lose their right to transact accident and health insurance business in Minnesota.

The proposed rules further set forth the operational procedures and organizational structure which govern the Minnesota Comprehensive Health Association (hereinafter "Association") in the offering of State Plan coverages to Minnesota residents. Pursuant to the Act, the Association is required to offer State Plan coverages to residents who are otherwise unable to purchase accident and health insurance coverage in the voluntary insurance market. Benefits paid by the Association as a result of the issuance of State Plan coverages are to be funded through premiums collected from persons insured thereunder, and excess costs of the operation of the State Plan are to be borne in part by pro rata assessments against Association members. The proposed rules also set forth the manner in which the Association shall operate as a reinsurance facility upon which individual Association members may rely for the reinsurance of certain designated insurance coverages which the Act requires that individual insurers

or fraternals offer to Minnesota residents.

One free copy of the proposed rules in their entirety may be obtained by writing to John T. Ingrassia, Supervisor of the Life and Health Section, Insurance Division, 500 Metro Square Building, St. Paul, Minnesota 55101. Additional copies of the rules will be available at the door on the day of the hearing.

These rules are proposed pursuant to the authority vested in the Insurance Division by the provisions of Minn. Stat. § 62E.09(a).

Notice is hereby given that adoption of these rules may result in the expenditure of public moneys by local public bodies which establish or maintain self-insurance programs providing accident and health insurance benefits to their employees. Such cost would accrue by virtue of statutorily mandated membership in the Minnesota Comprehensive Health Association and the attendant liability of individual members for a pro rata share of assessments, if any, arising from operation of the State Plan. No reasonable estimate of the cost accruing to affected local public bodies is available. However, it is anticipated that the total cost to public bodies will not be in excess of $100,000 in either of the two years immediately succeeding adoption of the rules as proposed.

Temporary rules relating to the subject matter of these proposed rules were promulgated and published in the State Register, Volume 2, Number 36, and were effective on April 20, 1978.

Any person may request notification of the date on which the Hearing Examiner's report will be available, after which date the agency may not take any final action on the rules for a period of five (5) working days. Any person may request notification of the date on which the hearing record has been submitted (or resubmitted)

to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Hearing Examiner (in the case of the Hearing Examiner's report), or to the agency (in the case of the agency's submission or resubmission to the Attorney General).

Notice is hereby given that 25 days prior to the hearing, a statement of need and reasonableness will be available for review at the agency and at the Office of Hearing Examiners. This statement of need and reasonableness will include a summary of all of the evidence which will be presented by the agency at the hearing justifying both the need for and the reasonableness of the proposed rule/rules. Copies of the Statement of Need and reasonableness may be obtained from the Office of Hearing Examiner at a minimal charge.

Minn. Stat.§§ 10A.01 - 10A.34 requires each lobbyist to register with the Ethical Practices Board within five (5) days after commencing lobbying. Lobbying includes attempting to influence rulemaking by communicating or urging others to communicate with public officials. A lobbyist is defined in Minn. Stat. §10A.01, subd. 11 as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than §250, not including his <u>own</u> travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) Who spends more than $250, not including his own traveling expenses and membership dues, in any year for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, phone number (612) 296-5615.

Dated: September 11, 1978.

Berton W. Heaton

BERTON W. HEATON
Commissioner of Insurance

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT OF COMMERCE - INSURANCE DIVISION

In the Matter of the Proposed Rules of the Minnesota Department of Commerce, Insurance Division, Relating to the Comprehensive Health Insurance Act, Minn. Stat. Ch. 62E.

REPORT OF HEARING EXAMINER

The above-entitled matter came on for hearing before State Hearing Examiner George A. Beck, at 9:30 a.m. on Wednesday, November 1, 1978, in the Department of Commerce Hearing Room at 500 Metro Square Building, Seventh and Robert Streets in the City of Saint Paul, County of Ramsey, State of Minnesota.

This report is a part of a rule hearing procedure pursuant to Minn. Stat. Sec. 15.0411 to Sec. 15.0417 and Sec. 15.052, to determine whether the proposed rules should be adopted and given the force of law. A copy of this report may be obtained from the Office of Hearing Examiners for the cost of reproduction.

Members of the agency panel appearing at the hearing included: John T. Ingrassia, Supervisor, Life and Health Section, Insurance Division, Department of Commerce; Ernie Frankovich, Consulting Actuary; William R. Howard, Special Assistant Attorney General; Andrew Czajkowski, President, Minnesota Comprehensive Health Association and James P. Smith, Treasurer, Minnesota Comprehensive Health Association.

Four public witnesses appeared and spoke at the hearing. The Insurance Division submitted 21 written exhibits. Seventeen written comments were received from the public subsequent to the mailing of the Notice of Hearing through the end of the 20 day period for written comment following the hearing.

Based upon all the testimony, exhibits and written comments, the Hearing Examiner makes the following:

FINDINGS OF FACT

1. On September 12, 1978, the Insurance Division filed the following documents with the Chief Hearing Examiner:

(a) A copy of the proposed rules with an appendix;
(b) An Order for Hearing;
(c) A proposed Notice of Hearing; and
(d) A statement of the number of persons expected to attend and length of hearing.

2. On September 25, 1978, a Notice of Hearing and a copy of the proposed rules were published at 3 State Register 611.

3. On September 29, 1978, the Insurance Division mailed the Notice of Hearing to all persons and associations who had registered their name with the Secretary of State for the purpose of receiving such notice, to all members of the Minnesota Legislature, to all members of the Minnesota Comprehensive Health Association, and to supplementary lists kept by the Insurance Division.

4. On October 6, 1978, the Insurance Division filed the following documents with the Hearing Examiner:

(a) The Order for Hearing;
(b) The Notice of Hearing as mailed;
(c) A statement of the number of persons expected to attend and length of hearing;
(d) The Affidavit of Mailing;
(e) The Affidavit of Receipt of the Secretary of State's list;
(f) The Secretary of State's list and the other mailing lists;
(g) The list of witnesses and agency panel;
(h) The Statement of Need and Reasonableness.

The documents were available for inspection at the Office of Hearing Examiners from the date of filing to the date of the hearing.

The record remained open through November 21, 1978, for the receipt of written comments. Based upon a request by the Insurance Division and the Hearing Examiner, the Chief Hearing Examiner ordered that the due date for the Report of the Hearing Examiner would be extended to December 29, 1978.

5. The Insurance Division cites Minn. Stat. Sec. 62E.09 (a) and (i) (1977 Supp.) as authority for the promulgation of the proposed rules. Minn. Stat. Sec. 62E.09 is a portion of the Minnesota Comprehensive Health Insurance Act ("Act"). The provisions cited state as follows:

The commissioner may:

(a) Formulate general policies to advance the purposes of sections 62E.01 to 62E.17;

. . .

(i) Adopt, amend, suspend and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of sections 62E.01 to 62E.17. The commissioner may until December 31, 1978 adopt emergency rules.

6. The Act (Minn. Stat. Sec. 62E.01 - 62E.55) was enacted in 1976, and subsequently amended. The Act establishes standards for "qualified" health insurance coverage and encourages health care providers and employers to offer "qualified" or "adequate" health care insurance coverage. The Act also establishes a Minnesota Comprehensive Health Association ("MCHA") comprised of insurers and others which is required to provide adequate health insurance coverage to Minnesota residents who are otherwise unable to secure such coverage.

7. The Commissioner of Insurance first published a Notice of Intent to Solicit Outside Opinion at 1 State Register 1287 on March 7, 1977. An industry task force was created which drafted a set of proposed rules (Ex. 2, 3) for the Commissioner's consideration. The Commissioner published temporary rules on March 13, 1978, at 2 State Register 1672.

8. At the hearing, the Insurance Division distributed a list of essentially typographical corrections to the proposed rules as they were published in the State Register on September 25, 1978. (Ex. 11) An Errata Sheet for the Statement of Need and Reasonableness was also handed out at the hearing. (Ex. 14)

9. In a number of places in the proposed rules, the word "regulations" is used when referring to the proposed rules. See, e.g., 4 MCAR Sec. 3200, Sec. 1.3201, introductory paragraph, and Sec. 1.3206 B. Since the 1975

amendments to the Administrative Procedures Act deleted the word "regulations", this term should be replaced throughout the proposed rules by the word "rules".

10. A number of the proposed rule subsections appear to grant a good deal of discretion to the association or the commissioner without criteria to guide a decision. A number of subsections also approach being "non rules" in that they do not actually require anything since they are permissive rather than mandatory. The Commissioner should scrutinize the following rule subsections in this regard: 4 MCAR Sec. 1.3227 B.1., Sec. 1.3228 C. and C.1. and C.3., Sec. 1.3229 A.1., Sec. 1.3232 A.1.a., b., c., d. and B.2. and D.1., Sec. 1.3233 B.1., b.(4). Section 1.3233 A.1., for example, sets out four criteria for selecting a writing carrier, but states the Association is not limited to these criteria. Even so the last criterion listed is "d. other criteria developed by the Association or the Commissioner." The problem is that an insurer cannot know from this rule what criteria will be used to judge selection of the writing carrier and the language gives unlimited discretion to the Association or Commissioner to add to the requirements. The MCHA and the Division suggest that this flexibility is necessary to such a process and that the statute does not limit the Association to the three criteria. (Ex. N, p. 7-8; Ex. 20, p. 26) The defect is not, however, that the rule cites more criteria than the statute (Minn. Stat. Sec. 62E.13, subd. 2) but that it does not specifically set out further criteria.

11. The proposed rules should be reviewed to ensure that each rule subsection is in proper outline form. For example, Section 1.3232 A. contains a "1" but no "2".

12. The following subsections of the proposed rules drew no comment during the rule hearing procedure. The Statement of Need and Reasonableness, the written exhibits and the oral agency presentation adequately support the need and reasonableness of these portions of the proposed rules:

4 MCAR Sec. 1.3201 A, B, C, D, E, F, G, H, I, J, K, L, M, N, P, Q, R, S, T.1. and 2., U, W, X, Y, Z, AA, BB, CC, DD, EE, FF, HH, II, JJ, KK, LL, MM, NN, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, ZZ, AAA, BBB, CCC,

Sec. 1.3203 B, C, D, E, F, H
Sec. 1.3205
Sec. 1.3206 B and C
Sec. 1.3207 B and C
Sec. 1.3225 A.2., 3., and 4.; B, C, D, and E
Sec. 1.3226 A and B
Sec. 1.3227
Sec. 1.3228
Sec. 1.3229
Sec. 1.3230 A, B, D, and E
Sec. 1.3231
Sec. 1.3232 A.1.b, c., d., and f.; B and D
Sec. 1.3233 A.2., 3., 4., 5., and B.1.a. and b.(1), (2), (3), (4) and B.2., 3., 4., 5., 6. and 7.
Sec. 1.3234 A, B.1, 3., 4.; C, D, E
Sec. 1.3235.

4 MCAR Sec. 1.3200 - Authority, Scope and Purpose

13. This section sets out the authority, scope and purpose. The subsection is needed and reasonable; however, the reference to the Minnesota

Administrative Procedures Act could well be deleted since it does not provide authority for these proposed rules. It should also be noted that the language indicating to whom the rules apply might incorrectly lead one to believe that these rules are not applicable generally to members of the public.

4 MCAR Sec. 1.3201 - Definitions

14. The Minnesota Comprehensive Health Association (MCHA) suggested that a new definition be inserted following the definition of actuarial equivalence at Section 1.3201 C. The new definition would define "actuarial equivalent" as follows:

> "Actuarial equivalent" or "an actuarially equivalent benefit" means a benefit, the expected value of which when substituted for another benefit or benefits in a plan of health coverage will be the same as the benefit or benefits for which it was substituted, and which, after substitution of the actuarially equivalent benefit, will result in the plan of health coverage being the actuarial equivalence, as defined herein, of the original plan of health coverage.

The MCHA states that the definition will provide additional clarity. (Ex. N, p. 9) The Division may consider this suggestion.

15. Section 1.3201 O. defines "disabled child" or a "dependent child of any age who is disabled". The Minnesota Governor's Planning Council on Developmental Disabilities (MGPCDD) suggested defining the term "limiting age" which appears in this definition. (Ex. G, p. 1) The Division stated that selection of a limiting age is a matter of contract between the insurer and policyholder and therefore, not an appropriate matter for definition. (Ex. 20, p. 8) The Equitable Life Insurance Society ("Equitable") stated that they do not think that disabled married children should continue to be eligible as dependents since the active marriage normally assumes termination of dependency. (Ex. Q, p. 1) Minn. Stat. Sec. 62E.02, subd. 7 defines a "dependent" as a "spouse or unmarried child under the age of 19 years, a dependent child who is a student under the age of 25 and financially dependent upon parent, or a dependent child of any age who is disabled." The Division's interpretation of the statutory definition in proposing its rule definition cannot be said to be unreasonable. The definition, as proposed, is needed and reasonable.

16. Section 1.3201 T.3. provides that the term "hospital" shall not include a nursing home, convalescent facility, rest facility, nursing facility or facility for the aged. The Equitable recommended that this exemption be expanded to include facilities "providing primarily educational or custodial care". (Ex. Q, p. 1) The definition is reasonable and needed as proposed.

17. Section 1.3201 V. defines "illness" and specifically includes pregnancy. CNA commented that in light of recently enacted Federal legislation, the requirements and exceptions of the Federal enactment should be followed. (Ex. H) The Division stated that relevant Minnesota Statutes, i.e., Minn. Stat. Sec. 62A.041, Sec. 62A.042, Sec. 363.01, subd. 29, Sec. 363.02, subd. 1 (iii) make express reference to pregnancy as a health condition and therefore requires the definition as proposed. The definition is needed and reasonable.

18. Section 1.3201 GG. defines "nursing home". The Equitable suggested adding the following language to the proposed rule:

> In no event will the term "nursing home" include any institution or part thereof which is used principally as a rest facility, a facility for the aged, or as a facility providing primarily custodial or educational care.

The rule is needed and reasonable as proposed. The Division may consider the suggestion.

19. Section 1.3201 DD. defines "student". The Equitable suggested that the definition should provide a minimum time period during a calendar year during which a student must be enrolled in an educational institution. (Ex. Q. p. 2) The definition is needed and reasonable as proposed; however, the Division may consider this suggestion as a matter of clarity.

20. Section 1.3201 EE. defines "total cost of self insurance". In its post-hearing written comments, the MCHA suggested deleting the words "an employer which is" from the definition since self insurers, as defined in the Act at Minn. Stat. Sec. 62E.02, subd. 21, include not only employers but also employee welfare benefit funds or plans. (Ex. N, p. 9-10) The definition is needed and reasonable as proposed; however, the Division may consider whether the proposed amendment more accurately reflects the intent of the rule.

21. Section 1.3201 FF. defines "usual and customary charge". The MCHA suggested that the word "supply" in this definition should be changed to the word "article" to conform more closely to Minn. Stat. Sec. 62E.06 B., which ties covered expenses to the "usual and customary charges for the following services and articles when prescribed by a physician". (Ex. N, p. 10-11) The definition is needed and reasonable as proposed; however, the Division may consider the proposed change.

PART I - QUALIFIED COMPREHENSIVE HEALTH INSURANCE PLAN

4 MCAR Sec. 1.3202 - Duties of Employers

22. This section implements the statutory requirement that an employer must offer a qualified plan to employees. This rule attracted two comments directed toward the requirement that self insurers, whether an employer or an employee welfare benefit fund, must comply with Section 1.3202 and must join the Association pursuant to Section 1.3225. The Saint Paul Electrical Workers Welfare Fund has commenced a lawsuit in Federal District Court in Minnesota alleging that the Employee Retirement Income Security Act of 1974 (ERISA) preempts the states from regulating employee welfare benefit plans. The lawsuit in Federal Court seeks to enjoin the Commissioner of Insurance from enforcing the Minnesota Comprehensive Health Insurance Act of 1976 against such plans. (Ex. L) Koch Refining Company objected to the inclusion of all self insurers within the statute and the proposed rules. Koch suggested that certain employers are statutorily exempt from the Act and that further clarification is necessary in the rules as to who is and who is not a self insurer. (Ex. M) Any finding that the proposed rules are outside the scope of authority of the agency because the state statute is preempted by

the Federal legislation would necessarily involve a judgment on the constitutionality of the state statute. Neither the Hearing Examiner nor the Commissioner has the power to determine the constitutionality of state statutes. This is a judicial function. See, 3 K. Davis, Administrative Law Treatise, Sec. 20.04 (1958), Johnson v. Elkin, 263 N.W.2d 123 (N. Dak. 1978). This matter should properly be left to the determination of the Federal District Court where the question is currently pending.

4 MCAR Sec. 1.3203 - Duties of Insurers and Fraternals

23. Section 1.3203 A.1. applies the exclusion contained in Minn. Stat. Sec. 62E.02, subd. 11 (4) to hospital indemnity coverage which is sold by an insurer to an applicant who is then currently covered by a health maintenance plan. Northwestern National Life Insurance Company (NWNL) suggested that the following language be added to the proposed rule subsection: "or Medicare as that term is defined in Minn. Stat. Sec. 62E.02, subd. 15". NWNL states that the purpose of the amendment which added the last sentence to subdivision 11 of Section 62E.02 was in recognition of the supplemental nature of such hospital indemnity policies. NWNL suggests that including Medicare within the exception is consistent with the overall intent of the Act. (Ex. E, p. 4, 8-10) Blue Cross/Blue Shield of Minnesota (BC/BS) pointed out that while the health maintenance plan is deemed under the Act to be a qualified plan no. 3, no where in the Act is Medicare defined as constituting a qualified plan. BC/BS states that Medicare cannot meet the requirements for a qualified plan under the Act since it does not provide the extent of comprehensive coverage which the Legislature found to be sufficient to relieve insurers from the obligation to offer major medical coverage. (Ex. F, p. 2-3; Ex. O, p. 3-5) The rule, as proposed, cannot be said to be an unreasonable interpretation of the Act. The rule, as proposed, is needed and reasonable.

24. Section 1.3203 G. sets out two exceptions to the duties of insurers and fraternals for certain policies and contracts. The first exception deals with non-cancelable policies and generally provides that such policies issued prior to the effective date of the Act are not governed by the Act. NWNL suggested that the phrase "or premium rate" be deleted from this subsection and the word "or" be inserted before the word "conditions". NWNL believes that this change in language would extend the exception to guaranteed renewable policies which are similar to non-cancelable except that the insurer has the right to change rates on a class basis for a guaranteed renewable contract. NWNL suggests that the application of the statute to existing guaranteed renewable policies constitutes an unconstitutional impairment of contracts. (Ex. E, p. 2-3; 4-7)

25. The Health Insurance Association of America (HIAA) submitted a brief suggesting that there is no basis under the Act as amended for a retroactive application of the law to existing contracts. They also suggest that to so apply the statute would constitute a violation of the contract clause of the United Stated Constitution. The HIAA cites New York case law for the proposition that retroactive application is not permissible as to health insurance

policy contracts where the insurer has no unilateral right to exercise non-renewal and that the right to increase premiums alone is not sufficient to justify retroactivity. HIAA v. Harnett, 44 N.Y. 2d 302. The HIAA supported deletion of Section 1.3203 G.1. (Ex. D, p. 4-12) BC/BS noted that the Act specifically applies to policies "issued or renewed" after the effective date of the Act (Minn. Stat. Sec. 62E.04, subd. 5).

26. In regard to the contract clause question, BC/BS stated that the Act will not apply to previously issued guaranteed renewable policies until the policies are renewed subsequent to the effective date of the Act. At the next renewal date, the insurer would be required to provide major medical coverage pursuant to the Act and, pursuant to the terms of its guaranteed renewable contract, the insurer would have the right to charge an additional premium. (Ex. O, p. 5-12) The Insurance Division commented that retention of the right by the insurer to increase a premium rate signifies an intent on the part of the contracting parties to provide for periodic re-evaluations of the terms of performance and can therefore be viewed as the constructive re-issuance of the policy. (Ex. 16, p. 12) The continuation in force of non-cancellable contracts where the insurer lacks a capacity to alter or modify coverage in any way is not construed to be a renewal. (Ex. 9, p. 10)

27. In its final written submission, the Insurance Division stated that in the arguments in regard to impairment of contract obligations are in fact directed against the statutory requirements set out at Minn. Stat. Sec. 62E.04, Sec. 62E.10, subd. 1 and 3 and Sec. 62E.11, subd. 5. The Division believes that the Act contains no provision which may be construed to exempt the renewal of any designated type of policy from the statutory requirements. (Ex. 20, p. 16) The Division points out that Minnesota U.S. District Judge Devitt did not find an unconstitutional impairment of the guaranteed renewable policies in his ruling on a preliminary injunction in connection an action brought by 25 insurance companies seeking a declaration that certain portions of the Act are unconstitutional. The matter (Insurer's Action Council, Inc., et al. v. Heaton) remains before Judge Devitt pending final disposition. The Division's interpretation of the statute in formulating this rule is clearly reasonable. It appears that the question of constitutionality is in fact directed at the statute and is a matter beyond the authority of the Hearing Examiner or the Commission and is a matter which should properly be settled in Federal District Court where it is now at issue.

28. Subsection 1.3203 G.2. was commented upon by the HIAA which supported deletion of the words "or renewal" in the first sentence for the same reasons indicated in regard to the prior subsection. (Ex. D, p. 11) Such a change was opposed by BC/BS (Ex. O, p. 6-7) for the reasons indicated above. The rule, as proposed, is needed and reasonable.

4 MCAR Sec. 1.3204 - Qualified Plan Pre-existing Conditions

29. This section makes it clear that a qualified plan may include a denial of coverage for a previously diagnosed and treated conditions during the first two years of the policy. The MGPCDD questioned whether the 24

month time period still applied if an individual had not received treatment in the 90 days immediately prior to application. (Ex. G, p. 1) The Division stated that if a person is not treated within the 90 day period prior to enrollment, the 24 month benefit exclusion period does not apply. (Ex. 20, p. 8-9) The rule, as proposed, is needed and reasonable.

4 MCAR Sec. 1.3206 - Certification of Qualified Plans

30. Section 1.3206 A. deals with an application for certification of a qualified plan. The subsection requires inclusion of the qualification number of the plan pursuant to the procedures set out in Appendix I of the rules. Appendix I provides an actuarially equivalence test and worksheets to be used in connection therewith which may be used to determine whether or not a plan is qualified under the Act. The Appendix, at Section III, requires that a certification be made by a principal or officer of an insurer or by a member of the Academy of Actuaries, that the plan is qualified by virture of the test of actuarial equivalence under the Act.

31. The Employee Benefit Plans, Inc. (EBP) which is an administrator for approximately 70 self-funded Minnesota corporations and public body groups, objected to the requirement that equivalency be certified by either an insurance company officer or principal or qualified actuary. EBP believes that this is unfair to self-funders and requests that the rule be modified to allow certification by an officer of the self-funding corporation or an officer of the self-funding corporation's administrative company. EBP believes that hiring a qualified actuary is an unnecessary expense and states that they have filed some 70 equivalence tests with no accuracy problems. (Ex. I, p. 1-2) The Division states that since it does not possess the staff necessary to review each plan submission, a procedure must be adopted which will promote the accuracy of data submissions. The Division states that a qualified actuary could perform the review and certification at a minimal cost and that the equivalence test is sufficiently complicated to justify requiring actuary certification. (Ex. 20, p. 5-6) The rule, as proposed, cannot be said to be unreasonable. This type of decision is a matter of policy properly within the discretion of the Commissioner.

32. Section 1.3026 D. provides that a qualified plan continues to be qualified until the next renewal date. CNA stated that they believe an affirmative request for plan qualification certification to be made each year by every group policyholder would be unreasonable and unnecessary and should be required only if the law affecting the coverage or the plan undergo substantial modification. (Ex. H) The Division stated that it might well be difficult to define a "substantial modification". They commented that in light of the proposed method of self-certification, the requirement of a supplementary filing upon renewal is not an unreasonable burden and that it need not be done annually but only upon renewal of the plan. (Ex. 20, p. 7-8) Since the statute requires evaluation of a plan upon renewal to determine compliance, the rule, as proposed, is needed and reasonable.

4 MCAR Sec. 1.3207 - Termination of Coverage: Conversion Privileges

33. Section 1.3207 A. provides that a terminated employee may elect for continued coverage under a qualified plan of health coverage which is self-insured, or may convert to an individual coverage qualified plan. Health Care Administrators, Inc. (HCA) states that it is inappropriate for the rule to require self-insurers to provide for continuation of coverage when Minn. Stat. Sec. 62E.16 includes no reference to self-insurers. HCA believes that only the conversion privilege should apply to self-insureds. (Ex. C) Minn. Stat. Sec. 62E.16 states in part: "Every program of self-insurance, . . . shall include, in addition to the provisions required by section 62A.17, the right to convert to an individual coverage qualified plan . . ." The Division states that this language incorporates the provisions of Sec. 62A.17, including the right to continuation of coverage, into those requirements made of self-insurers. (Ex. 20, p. 6; Ex. O, p. 1-2) The Division's interpretation is accurate and reasonable.

34. The HIAA suggests that a new paragraph D. be added to Section 1.3207 which would read as follows:

> D. The requirements of 62A.16 and 62A.17 shall apply with respect to group policies issued in the state as to covered employees who are both residents of, and employed, in the state. The requirements of 62E.16 shall apply with respect to all covered employees under group policies issued in the state. (Ex. D, p. 15-16)

HIAA believes that Section 1.3207 fails to provide sufficient direction in the case of a group health insurance policy issued in a state other than Minnesota which also covers some members of the group who happen to work and reside in Minnesota as well as other states. They state that Section 62A.17 appears to require the conversion rights only as to "a Minnesota resident employed within the state". Section 62E.16, however, contains no such limitation and applies to group policies issued in Minnesota regardless of the state of residence or employment of an individual employee. The Division issued a circular letter number 1, dated May 11, 1976, which announced that the provisions of Section 62A.16 and Sec. 62A.17 apply to all group insurance policies issued or renewed in <u>any</u> state if coverage is provided for . . . expenses incurred by a Minnesota resident employed within Minnesota. The HIAA sees an attempt to implement these requirements on an "extraterritorial" basis as contrary to Chapter 62A. (T. p. 131-132) The Division points out that the interpretation of Chapter 62A is not properly a matter for rule-making being conducted to implement Chapter 62 E. (Ex. 20, p. 13) The failure to include the suggested language cannot be said to make this rule arbitrary; however, the Commissioner should carefully consider whether or not the problem of an insurance company being unable to comply the law of two different states at the same time can be alleviated by clarifying language within Section 1.3207.

4 MCAR Sec. 1.3208 - Revision of Actuarial Equivalence Tables

35. This section purports to give the Commissioner the authority to periodically review Appendix I to actuarially update the relative point values set therein to more accurately reflect changes in the relative values

of benefits. It suggests that any revisions be set out in the State Register together with a justification to take effect upon publication. At the request of the Examiner, the Insurance Division addressed the nature of the Appendix in its final written submission. The Division explains that the Appendix sets forth the actuarial formula which serves as the basis for comparison of plans or policies of health coverage when such comparison is required by the Act. The Division states that:

> The appendix, therefore, serves an integral part of the administration of the act. To this extent, it is submitted for approval pursuant to the rulemaking procedures. However, given the unique and complex nature of the actuarial equivalence test, the language and structure of the appendix may necessarily depart from traditional rulemaking considerations. Thus, the actuarial equivalence test is proposed as a distinct, though integral, part of the proposed rules.

In its Statement of Need and Reasonableness, the Division states that Sec. 1.3208 incorporates the actuarial equivalence tables as set forth in the Appendix into the proposed rules. (Ex. 9, p. 13) Assuming that the Appendix is being promulgated as a rule, the need and reasonableness has been demonstrated through testimony at the hearing and through Exhibit 9, page 13 and Exhibit 15. However, the Examiner is unaware of any statutory authority which would permit the Commissioner to circumvent the Administrative Procedures Act in regard to rulemaking in the manner as suggested in Section 1.3208. If the relative point values are promulgated as a rule, then they must be modified in accordance with the APA.

PART II - MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION

4 MCAR Sec. 1.3225 MCHA - Membership in the Association

36. The Saint Paul Electrical Workers Welfare Fund also cited an objection to this section since it restates the mandatory membership in the Association by self-funded employee welfare benefit plans as required by statute. (Ex. L) This issue was discussed at Finding of Fact No. 22.

37. Section 1.3225 A.1. defines "accident and health insurance business". The HIAA supported four amendments to this subsection namely the deletion of the words "or renewal" from Section 1.3225 A.1., the deletion of the words "or renewed" from Section 1.3225 A.1.a. and Section 1.3225 A.1.b.(5) and the deletion of Section 1.3225 A.1.b.(4) in its entirety. The HIAA suggested these amendments for the reasons set out at Findings of Fact No. 24-28. NWNL suggested, in regard to Section 1.3225 A.1.b.(4) that the words "or premium rate" be deleted and the word "or" be inserted before the word "conditions" for the same reasons set out at Finding of Fact No. 24. (Ex. D, p. 11-12) BC/BS again opposed these changes. (Ex. O, p. 6-7) NWNL again suggested that the phrase "or medicare as that term is defined in Minn. Stat. Sec. 62E.02, subd. 15" be inserted before the last four words of Section 1.3225 A.1.b.5. similar to and for the same reasons as its suggestion in regard to Section 1.3203 A.1. The matter is discussed at Finding of Fact No. 23.

38. The Equitable offered a comment in regard to Section 1.3225 A.1.b.(7) which exempts policies designed solely to provide dental or vision care.

The Equitable suggested the exemption under this provision for other types of specific coverage contracts, such as hearing aids. (Ex. Q, p. 2) The Commissioner may wish to consider this as a matter of policy. Section 1.3225 A.1. is needed and reasonable as proposed.

4 MCAR Sec. 1.3226 MCHA - Organization and Approval

39. Section 1.3226 C. purports to authorize the board of the Association to adopt operating rules not inconsistent with the Act which would become effective upon approval of the Commissioner. The MCHA points out that the basis for this section is Section 62E.10, subd. 3, which states in part that "the Association shall submit bylaws and operating rules to the commissioner for approval". The MCHA suggests that rulemaking by the MCHA would not be subject to the Administrative Procedures Act since the Association is not an agency of statewide jurisdiction, but is merely a statutorily created non-profit association or at most, a quasi-state agency. Insofar as the operating rules govern only the internal management of the Association, they would not be subject to Chapter 15 at any rate. (Ex. N, p. 5-7) The Insurance Division agrees with this reasoning. (Ex. 20, p. 25) The Legislature clearly intended a process other than Chapter 15 for the adoption of "operating rules" for the Association. The Association does not possess normal state agency rulemaking power since the Commissioner must approve its operating rules. If such is the intent, the Commissioner may wish to specify in this rule that these rules relate only to the internal management of the Association. The rule, as proposed, is needed and reasonable.

4 MCAR Sec. 1.3230 MCHA - Minimum Benefits of Comprehensive Health Insurance Plans

40. Section 1.3230 C. speaks to benefits of a qualified medicare supplement plan, and provides at C.4. that coverage may not be subject to a maximum lifetime benefit of less than $100,000. At the hearing, the Division proposed an amendment to this language which would add the following words to the end of Section 1.3230 C.4.:

> or the unused portion of the maximum lifetime benefit under any policy or contract of the state plan under which the person was previously covered, whichever is less.

The amendment was proposed to preserve the concept of a single maximum lifetime benefit under the state plan, was supported by the MCHA (Ex. 9, p. 4) and would not appear to be a substantial change.

4 MCAR Sec. 1.3232 MCHA - Solicitation Application and Enrollment of Eligible Persons in the State Plan

41. A portion of Minn. Stat. Sec. 62E.14, subd. 1 is duplicated in Section 1.3232 A.1.a. the Insurance Division suggests that this is necessary since some language is added by the rule; it is necessary to include procedures for enrollment in the rules; and frequent amendment of the Act makes it difficult to use. (Ex. 20, p. 24) The duplication is crucial to the ability of a person affected by the rule to comprehend its meaning and effect within the meaning of Minn. Stat. Sec. 15.0412, subd. 1.

42. At the hearing, the Insurance Division proposed an amendment to Section 1.3232 A.1.e. which would strike the last half of the proposed subsection beginning with the words "and if such person . . ." and substitute the following language:

> provided that an applicant for a qualified medicare supplement policy or contract of the state plan who has previously been covered under the state plan shall be eligible for a maximum benefit under the qualified medicare supplement policy or contract of $100,000, or the unused portion of the maximum lifetime benefit under any policy or contract of the state plan under which the person was previously covered, whichever is less.

The amendment was supported by the MCHA (Ex. N, p. 4) for the same reasons indicated at Finding of Fact No. 40. (Ex. 12; Ex. 20, p. 12) So amended, the proposed subsection is needed and reasonable.

43. Section 1.3232 C. permits an appeal to the Commissioner from a determination by the Association of ineligibility for coverage. The MGPCDD suggested that a termination or refusal to renew coverage under Section 1.3232 A.1.f. ought also to give rise to an appeal under this proposed subsection. (Ex. G, p. 1) The Division agreed with this suggestion and suggested in its written submission that the phrase "or covered person" be inserted after the word "applicant" and before the word "who". (Ex. 20, p. 9) So amended, the rule subsection is needed and reasonable.

4 MCAR Sec. 1.3233 MCHA - Selection, Approval and Operations of Writing Carrier(s)

44. Two provisions in this rule, namely Section 1.3233 B.1.5. and Section 1.3233 C. permit an appeal within a "reasonable" period of time. The MGPCDD commented that a definite time period should be specified. (Ex. G, p. 2) The Commissioner may wish to consider this suggestion. The rule is needed and reasonable as proposed.

4 MCAR Sec. 1.3234-MCHA - Reinsurance

45. Section 1.3234 B.2. allows the Association to obtain commercial reinsurance to reduce the risk of loss through the pool to insurer members entering into reinsurance pooling agreements. North Central Life Insurance Company ("North Central") proposed that this obligation be made mandatory through the following amendment:

> The Association shall obtain commercial reinsurance at a cost which shall be passed on to the participating insured persons to reduce the risk of loss through the pool to insurer or fraternal members entering into reinsurance pooling agreements.

North Central states that commercial reinsurance for the MCHA has been cancelled because of a lack of participation and that North Central itself has no outlet for health reinsurance. It states that without commercial reinsurance, participating members cannot rely on the Association for reinsurance and the Association is not, therefore effectively fulfilling its duties to operate as a reinsurance facility. (Ex. B) North Central also suggests the addition of three new sections to this rule which would read as follows:

4 MCAR Sec. 1.3234 MCHA F

In the event the association or reinsurance administrator does not contract with a commercial reinsurer for the required reinsurance, the association shall provide equivalent reinsurance from its own resources.

4 MCAR Sec. 1.3234 MCHA G

In the event the association is required to provide reinsurance from its own resources, the cost of such reinsurance shall be allocated to all companies issuing or renewing accident and health insurance in the state based on their share of total premiums issued or renewed in the state.

4 MCAR Sec. 1.3234 MCHA H

In the event the association is unable to provide the required reinsurance so that member companies may "rely for the reinsurance of certain designated insurance coverages which the act requires", then participating members shall stop offering such coverage and cancel any existing coverage.

46. The MCHA stated that it believed that the Commissioner would not be empowered to adopt these amendments since Minn. Stat. Sec. 62E.10, subd. 7(e) states in part that "the Association . . . may provide for reinsuring of risks . . . ." (emphasis added) It also suggests that shifting the financial responsibility in regard to pro rata payment for losses on coverages which may be reinsured with the Association would require amendment of Section 62E.11, subd. 5, since this particular item is not cited therein as one of the items for which all Association members may be assessed on a proportionate basis. (Ex. N, p. 1-2) The Insurance Division agreed that the statutory language prevents adoption of the suggestions made by North Central. (Ex. 20, p. 6-7) Such an interpretation is not unreasonable.

47. In line with its other suggestions in regard to retroactivity, the HIAA suggested that a new rule be added as Section 1.3236, which would read as follows:

4 MCAR 1.3236. Effective Date and Applicability.

These rules shall become effective on _____, and shall apply in their entirety to policies as defined in 62E.02, subd. 11 which are issued on and after the effective date of the act, and to insurers with respect to policies issued on and after the effective date of the act. (Ex. D, p. 10)

BC/BS again objected to this proposal. (Ex. O, p. 6) This issue was previously discussed at Findings of Fact No. 24-28.

Based upon the foregoing Findings of Fact, the Hearing Examiner makes the following:

CONCLUSIONS

1. That the Insurance Division gave proper notice of the promulgation of the proposed rules.

2. That the Insurance Division has statutory authority to take the action proposed, to wit, the promulgation of the proposed rules.

3. That the Insurance Division has fulfilled all relevant substantive and procedural requirements of law or rule, except as provided at Finding of Fact No. 35.

4. That the Insurance Division has demonstrated the need for and the reasonableness of the proposed rules by an affirmative presentation of facts in the record.

5. That the Insurance Division is not precluded from and should not neglect to consider further modification of these proposed rules despite a finding of need and reasonableness by the Hearing Examiner, provided that the modification is not substantial and is based upon evidence contained in this rule hearing record.

Based upon the foregoing Conclusions, the Hearing Examiner makes the following:

RECOMMENDATION

It is recommended that the proposed rules as amended be adopted by the Commissioner of Insurance with attention given to the Findings of Fact herein.

Dated: December 29, 1978.

GEORGE A. BECK
Hearing Examiner

N O T I C E

Pursuant to Minn. Stat. Sec. 15.0412, subd. 4, this Report shall be available for review to all affected individuals upon request for at least five days.

The Commissioner of Insurance shall, if he proposes to adopt the rules as originally proposed or amended, submit the complete hearing record, including his Findings and Order, to the Chief Hearing Examiner no earlier than five days subsequent to the receipt of this Report. This submission shall clearly indicate any changes made to the rules as originally proposed, preferably in the format that will be submitted to the State Register for publication. The Chief Hearing Examiner shall complete his review and submit his report to the Commissioner of Insurance on the issues of substantial changes in the rule and compliance with Minn. Stat. Sec. 15.0412 within ten calendar days. Thereafter, the Commissioner of Insurance shall be responsible for filing the rules with the Attorney General and for notifying persons who have indicated that they wish to be notified of such filing.

STATE OF MINNESOTA

DEPARTMENT OF COMMERCE

INSURANCE DIVISION

In the Matter of the Proposed Rules of the Minnesota Department of Commerce, Insurance Division, Relating to the Comprehensive Health Insurance Act, Minn. Stat. ch. 62E.

FINDINGS OF FACT

The above-entitled matter came on for hearing before George A. Beck, duly appointed Hearing Examiner, on the 1st day of November, 1978, at 9:30 a.m. in the Department of Commerce Hearing Room at 500 Metro Square Building, 7th and Robert Streets in the City of Saint Paul, County of Ramsey, State of Minnesota, after proper notice required by Minn. Stat. §15.0412 was served upon all persons, associations, and other interested groups registered with the Secretary of State for that purpose.

Members of the agency panel appearing at the hearing included: John T. Ingrassia, Supervisor, Life and Health Section, Insurance Division, Department of Commerce; Ernie Frankovich, Consulting Actuary; William R. Howard, Special Assistant Attorney General; Andrew Czajkowski, President, Minnesota Comprehensive Health Association; and James P. Smith, Treasurer, Minnesota Comprehensive Health Association.

Four public witnesses appeared and spoke at the hearing. The Insurance Division submitted 21 written exhibits. Seventeen written comments were received from the public subsequent to the mailing of the Notice of Hearing through the end of the 20-day period for written comment following the hearing.

Hearing Examiner Beck prepared the Report of Hearing Examiner (hereinafter "Report"), dated December 29, 1978, pursuant to Minn. Stat. §15.052, subd. 3 and Minn. Rules HE 106.

After affording interested persons an opportunity to present written and oral data, statements and arguments, having considered all of the testimony, and all of the other evidence adduced, and upon the records, files and proceedings herein, the Commissioner makes the following:

FINDINGS OF FACT

1. He adopts Findings 1 through 47 of the Report of the Hearing Examiner as those findings relate to the procedural requirements, statutory authority and the determination of need for and the reasonableness of the proposed rules governing the Comprehensive Health Insurance Act. The following amendments to the proposed rules, as they appeared in the State Register, September 25, 1978 (2 S.R. 617 - 647) are incorporated in this adoption as integral to the Report findings numbered:

FINDINGS

9 and 13 4 MCAR §1.3200 - Authority, Scope and Purpose.

These rules are promulgated pursuant to Minn. Stat. §62E.09(i) relating to qualified comprehensive health insurance plans and the operations of the Minnesota Comprehensive Health Association ~~in particular, and Minn. Stat. §§15.0411 to 15.052, as amended, relating generally to the promulgation of administrative rules and regulations.~~ These rules and all future changes herein apply to all insurers, (including nonprofit health service plan corporations), self-insurers, fraternals, health maintenance organizations and other organizations which are at the time of adoption of these rules, or at any time in the future, licensed or authorized to do business in this state and thereby ~~are~~ subject to the provisions of the Minnesota comprehensive health insurance act of 1976, as amended. These rules are promulgated to carry out the act, as amended, and to facilitate its full and uniform implementation, ~~and~~ enforcement, and application to all persons affected thereby.

9 4 MCAR §1.3201 - Definitions.

All terms used herein which are defined in Minn. Stat. ch. 62E shall have the meanings atrributed to them therein. For the purpose of Minn. Stat. ch. 62E and these rules ~~regulations~~, the terms defined herein shall have the meanings given to them.

. . . .

14 C. ~~Actuarial Equivalence.~~ Actuarial Equivalent. "Actuarial

equivalent" or"an actuarially equivalent benefit" means a benefit, the expected value of which when substituted for another benefit or benefits in a plan of health coverage will be the same as the benefit or benefits for which it was substituted, and which will result in the plan of health coverage after substitution of the actuarially equivalent benefit, being the actuarial equivalence of the original plan of health coverage. "Actuarial equivalence" shall be recognized for two plans where, employing the same set of assumptions for the same population, the expected value of benefits provided by the plans is equal. Expected value of benefits shall ~~will~~ be measured by the probability of the claim for each benefit multiplied by the average expected amount of each of those benefits.

. . . .

20 EEE. Total cost of self-insurance. "Total cost of self-insurance" includes any direct and indirect administrative expenses incurred which are related to the operation of a plan of self-insurance, plus the sum of any payment made to or on behalf of Minnesota residents for costs or charges for health benefits by ~~an employer which is~~ a self-insurer under a plan of health coverage, regardless of the amount incurred or relationship of the cost to an insured or partially insured plan of health coverage, which is not counted as premium by an insurer, except to the extent of such payments made for coverage of the types described in clauses 1 through 8 of Minn. Stat. §62E.02, subd. 11.

21 FFF. Usual and customary charge. "Usual and customary charge" for the purpose of the state plan means the normal charge, in absence of insurance, of the provider for a service or article ~~supply~~, but not more than the prevailing charge in the area for a like service or article ~~supply.~~ A "like service" is of the same nature and duration, requires the same skill and

is performed by a provider of similar training and experience. A "like article ~~supply~~" is one which is identical or substantially equivalent. "Area" means the municipality (or, in the case of a large city, a subdivision thereof) in which the service or article ~~supply~~ is actually provided or such greater area as is necessary to obtain a representative cross-section of charges for a like service or article ~~supply~~.

4 MCAR §1.3206 - Certification of Qualified Plans.

. . . .

B. Certification by the commissioner. An accident and health insurance policy or plan is deemed certified as a qualified plan or qualified medicare supplement plan for the purposes of Minn. Stat. §62E.05 if it meets the requirements of these rules ~~regulations~~ and other relevant laws of this state upon the expiration of 90 days after receipt of the request for certification by the commissioner, unless earlier rejected or certified by the commissioner. In the event the commissioner rejects such request, he shall given written notice of the grounds for rejection to the person submitting the plan, and the insurer, fraternal or employer has the same rights in the event of such rejection as provided in Minn. Stat. §62A.02.

. . . .

4 MCAR §1.3208 - Revision of Actuarial Equivalence Tables. The commissioner shall periodically, no less frequently than biennially, review the actuarial equivalence tables set forth in Appendix I of these rules, and shall require that the relative point values set forth therein be actuarially updated when required to more accurately reflect changes in the relative values of benefits (including copayments). Any revision of relative point values which the commissioner shall make shall be promulgated pursuant to the rulemaking requirements of the Administrative Procedures Act (Minn. Stat. ch. 15). ~~published in the State Register, together with justification~~

FINDINGS

~~therefor, and shall take effect upon publication.~~ Following revision of the actuarial equivalence tables pursuant to this section, recertification of existing plans of health coverage may be required subject to the provisions set forth in 4 MCAR §§1.3202, 1.3203, and 1.3206.

9 and 39 4 MCAR §1.3226 MCHA - Organization and approval.

The Association shall operate pursuant to the provisions of Minn. Stat. ch. 62E, with all the powers of a corporation formed under Minn. Stat. ch. 317, except that if the provisions of the two chapters conflict, ch. 62E shall govern.

. . . .

C. Operating rules. The board is authorized to adopt and to amend from time to time reasonable operating rules which are not inconsistent with the act and these rules ~~regulations~~ for the management and operation of the Association. ~~and~~ Upon submission to and approval by the commissioner, these operating rules shall become effective.

10 4 MCAR §1.3227 MCHA - Board of directors.

. . . .

B. Election. The board shall be elected by members at the annual meeting of the Association in accordance with the by-laws of the Association, to the extent that such by-laws are consistent with the provisions of Minn. Stat. chs. 317 and 62E, and in accordance with the provisions relating to voting rights as outlined in 4 MCAR §1.3228.

1. Prior to the election, the Association may submit the names of proposed board members to the commissioner for approval, ~~which may be granted according to criteria as determined by the commissioner~~.

2. After the annual meeting, the results of the election shall be certified and submitted to the commissioner for formal approval, pursuant to criteria set forth in Minn. Stat. §62E.10, subd. 2.

. . . .

FINDINGS

10 4 MCAR §1.3228 MCHA - Determination of Members' Voting Rights.

. . . .

C. Voting procedures. Members are entitled to vote in person, by proxy, or by mail as determined by the board.

1. When a member elects to vote in person at a members' meeting, the representative casting the vote shall present credentials as ~~may be~~ required pursuant to the by-laws or operating rules of the Association. ~~by the board.~~

2. When a member elects to vote by proxy, the proxy statement, as approved by the board and by the commissioner, shall be returned on or before the date indicated in the meeting notice sent to the members.

3. Voting by mail may be permitted as authorized by the by-laws or operating rules of the Association, and ~~the board, provided that~~ the meeting notice to members shall so indicates.

40 4 MCAR §1.3230 MCHA - Minimum Benefits of Comprehensive Health Insurance Plans.

. . . .

C.4. Coverage may not be subject to a maximum lifetime benefit of less than $100,000.00, or the unused portion of the maximum lifetime benefit under any policy or contract of the state plan under which the person was previously covered, whichever is less.

10, 42 and 43 4 MCAR §1.3232 MCHA - Solicitation, Application and Enrollment of Eligible Persons in the State Plan.

A. Open enrollment. The state plan shall be open for enrollment by eligible persons at all times.

1. "Eligible person" means a resident of Minnesota who submits or on whose behalf is submitted a complete certificate of eligibility and enrollment form to the Association or its writing carrier and who is not

FINDINGS

already covered by another state plan policy or contract.

a. A complete certificate of eligibility and enrollment form may~~,-at-the-discretion-of-the-Association,~~ provide:

(1) name, address, age, sex, and length of time as a resident of Minnesota,

(2) name, address, and age of eligible dependents, if any, if they are to be insured;

(a) "eligible dependent" means the insured person's spouse who has not reached age 65 or unmarried child, excluding:

(i) a legally separated spouse;

(ii) a child who is nineteen years old or older unless that child is a student or disabled child;

(iii) a spouse or child who has applied for an individual state plan policy or contract pursuant to any conversion privilege granted to such eligible dependent under the insured person's state plan policy or contract, and

(iv) a spouse or child on active duty in any military, naval or air force of any country.

(3) Evidence of rejection, or a requirement of a restrictive rider or pre-existing conditions limitation on a qualified plan the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, by at least two Association members within six months of the date of application. "Substantially reduce coverage from that received by a person who is considered a standard risk" includes any restriction on coverage as a result

of an illness, condition, or risk which the Association deems substantial, any increase in rates for an applicant based on an illness, condition or risk, which the Association deems substantial; and any pre-existing conditions limitation which the Association deems substantial.

b. Before a person is determined to be an eligible person, the board may ~~in-its-discretion~~ require that any items listed in 4 MCAR §1.3232 A.1.a. or, if acting pursuant to provisions of the Association's operating rules, other necessary information ~~deemed-necessary-by-the-board~~ be submitted to the Association or its writing carrier and may also investigate the authenticity of information submitted as a part of the certificate of eligibility.

c. If a covered person, upon reaching age 65, wishes to purchase a state plan qualified medicare supplement plan, the requirement that the person obtain two rejections from members of the Association within the preceding six months may be waived by the board if acting pursuant to provisions of the Association's operating rules.

d. A person who is age 65 or older shall be eligible for coverage only under the state plan's qualified medicare supplement plan and when an insured person under a qualified plan reaches age 65, the board may, if acting pursuant to provisions of the Association's operating rules, ~~in-its discretion~~.

e. An applicant or any person proposed to be covered under the state plan who has previously

been covered by a state plan policy or contract and who has exhausted the maximum lifetime benefit under the state plan shall not be an eligible person for coverage under the state plan, and ~~if such person has exhausted $100,000.00 of the maximum lifetime benefit under the state plan such person shall not be an eligible person for coverage under a qualified medicare supplement plan or contract of the state plan,~~ provided that an applicant for a qualified medicare supplement policy or contract of the state plan who has previously been covered under the state plan shall be eligible for a maximum benefit under the qualified medicare supplement policy or contract of $100,000.00, or the unused portion of the maximum lifetime benefit under any policy or contract of the state plan under which the person was previously covered, whichever is less.

f. When a covered person under the state plan no longer meets one or more of the requirements for eligibility for coverage under the state plan, the board may, if acting pursuant to the Association's operating rules, ~~in its discretion,~~ terminate or refuse to renew coverage under the state plan.

B. Association's response. Within 30 days of receipt of a complete certificate of eligibility and enrollment form ~~application~~ pursuant to 4 MCAR §1.3232 A.1.a. and b, the Association or the writing carrier shall accept the certificate of eligibility or shall reject the certificate of eligibility for failure to meet the eligibility requirements.

1. If the Association or its writing carrier accepts the

FINDINGS

certificate of eligibility, it shall forward a notice of acceptance, billing information and a policy or contract (or certificate) which shall evidence coverage under the state plan.

a. Such policy or contract (or certificate) of coverage shall include but not be limited to:

(1) a statement that the person is covered under the state plan from the effective date contained therein,

(2) specification of the type of state plan under which the person is covered,

(3) a statement that the plan is provided by the Association,

(4) a description of the benefits provided by the plan, conditions for eligibility, and exclusions and limitations of coverage, and

b. When the state plan premium is received by the Association for its writing carrier for the first billing period (and accepted in accordance with 4 MCAR §1.3232 B.), the coverage shall be effective retroactive to the date of receipt by the Association or its writing carrier of the completed certificate of eligibility pursuant to 4 MCAR §1.3232 A.1.A. and b. unless otherwise requested by the insured person and approved by the board.

2. If the Association does not accept the certificate of eligibility, the applicant shall be informed of the reason for the rejection and shall have the opportunity to submit additional information to substantiate eligibility for coverage under the state plan and to request reconsideration of the decision. The board may shall establish a review mechanism for reviewing

requests for reconsideration of rejected certificates of eligibility. The Association shall give notice of a final determination of ineligibility to the applicant stating the reasons therefor and advising the applicant of the right to appeal to the commissioner within a reasonable period of time.

C. Appeal to commissioner. Any applicant or covered person who is determined by the Association to be ineligible for coverage under the state plan may appeal such determination to the commissioner within a reasonable period of time. Upon receipt of an appeal from a determination of ineligibility, the commissioner may, in his discretion, affirm, reverse, or modify the determination of the Association.

D. Solicitation of eligible persons. The Association shall develop a plan for use by the Association, upon approval by the commissioner, to publicize the existence of the state plan, the eligibility requirements and procedures for enrollment, and to maintain public awareness of and participation in the state plan.

1. The Association shall ~~may~~ prepare and make available ~~distribute~~ certificate of eligibility forms and enrollment instruction forms to insurance solicitors, agents and brokers, and to the general public in Minnesota.

2. The Association shall require the writing carrier to pay a referral fee of $25.00 for any certificate of eligibility accepted by the Association or its writing carrier. The referral fee shall be paid to the licensed agent whose signature appears as the agent on the accepted certificate of eligibility. The referral fee shall be paid from the premium received for the state plan.

FINDINGS

10 4 MCAR §1.3233 MCHA - Selection, Approval and Operations of Writing Carrier(s).

A. Selection and approval of a writing carrier(s).

1. The Association may select a writing carrier or writing carriers on the basis of criteria for selection which shall include but not be limited to:

a. The member's proven ability to handle large group accident and health insurance cases,

b. The efficiency of the member's claim paying capacity,

c. An estimate of total charges for administering the plan, and

d. Other criteria developed by the Association and set forth in its operating rules. ~~or the commissioner.~~

B. Operations of the Writing Carrier.

(4) The writing carrier shall exercise reasonable efforts to advise covered persons, ~~W~~within 15 working days of receipt ~~by the writing carrier~~ of a properly completed and executed proof of loss, ~~the covered person shall, to the extent possible, be advised~~ whether the submitted claim was accepted or rejected by the writing carrier, unless sooner ~~already~~ settled.

. . . .

Based on the foregoing Findings of Fact, the Commissioner makes the following:

CONCLUSIONS

1. That the Insurance Division gave proper notice of the promulgation of the proposed rules.

2. That the Insurance Division has the statutory authority to promulgate the proposed rules as amended.

3. That the Insurance Division has fulfilled all relevant, substantive and procedural requirements of law or rule.

4. That the Insurance Division has demonstrated the need for and the reasonableness of the proposed rules by an affirmative presentation of the facts in record.

5. That the Insurance Division has considered all findings and recommendations of the Hearing Examiner and modifications of the rules as set forth in finding of fact number 1 are not substantial and adequately based upon evidence contained within this record.

Dated: March 2nd, 1979.

J. P. KOLESKI
Acting Commissioner of Insurance

ADMIN-1000 (Rev. 1/78)

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL - Commerce

Office Memorandum

TO : Lee Sheehy
Special Assistant Attorney General

DATE: 4/2/79

FROM : Reynaud L. Harp RLH
Special Assistant Attorney General

PHONE: 9412

SUBJECT: Minnesota Comprehensive Health Insurance Act
Proposed Rules (4 MCAR §§ 1.3200 - 1.3235)

Pursuant to our telephone conversation of today's date, please be advised that the text of 4 MCAR § 1.3233 B 4.b. should be amended as follows:

> 4. The writing carrier shall be paid from time to time as provided in the Association's contract with the writing carrier for its direct and indirect expenses incurred in the performance of its services from the state plan premiums received in an amount not to exceed the lesser of:
>
> . . . .
>
> b. direct and indirect operating and administrative expenses incurred in the performance of its services, ~~and~~ or

RLH:saf

ADMIN 1000 (Rev. 1/78)

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL -INSURANCE

Office Memorandum

TO : LEE SHEEHY
Special Assistant Attorney General

DATE: Mar. 28, 1979

FROM : REYNAUD L. HARP RLH
Special Assistant Attorney General

PHONE: 9412

SUBJECT: MINNESOTA COMPREHENSIVE HEALTH INSURANCE ACT
PROPOSED RULES (4 MCAR §§1.3200 - 1.3235)

Attached herewith are the additional materials which you requested for your review of the above-referenced proposed rules. These materials include:

- Complaint filed in 3M, et al, vs. Heaton, et al, U.S.D.C. Minn., 3-78-479.
- Complaint filed in St. Paul Elec. Wkrs., et al vs. Heaton, et al, U.S.D.C. Minn., 3-78-269.
- Amended Complaint filed in Insurers' Action Council, Inc., et al vs. Heaton, et al, U.S.D.C. Minn., 3-76-440.
- Notice of Intent to Solicit Outside Information regarding promulgation of the subject rules, as published in the State Register at 1 S.R. 1287, 1 S.R. 1526, and 2 S.R. 2357.

Please be advised that 4 MCAR §1.3201 N (Dental Care) contains a typographical error with respect to the statutory reference contained therein. Accordingly, the reference to Minn. Stat. §105.05, subd. 1, contained within the text should be replaced with Minn. Stat. §150A.05, subd. 1, which is the correct statutory citation.

aso
Att.

OFFICIAL NOTICES

Department of Commerce Insurance Division

Implementation of the Minnesota Comprehensive Health Insurance Act of 1976

Notice of Intent to Solicit Outside Opinion

DATED: March 15, 1977

Notice is hereby given that the Department of Commerce, Insurance Division, shall entertain considerations for proposed rules for the implementation of the Minnesota Comprehensive Health Insurance Act of 1976 (Laws of 1976, ch. 296, art. I). All interested individuals or groups are requested to submit their considerations relating to: (1) the administration of the Comprehensive Health Insurance Plan including bid specifications for the selection of a writing carrier, guidelines for the acceptance of reinsurance by the Minnesota Comprehensive Health Association, and selection of policies of accident and health insurance to be offered by the Minnesota Comprehensive Health Association; and (2) criteria to be used by the Commissioner of Insurance in the evaluation of policies of accident and health insurance submitted by insurers for certification pursuant to Section 5 of the Minnesota Comprehensive Health Insurance Act.

All interested or affected persons/or groups are requested to participate. Proposals, information, and comment shall be submitted in writing and may be addressed to:

John T. Ingrassia,
Supervisor, Life and Health Section
Insurance Division
Department of Commerce
500 Metro Square Building
St. Paul, Minnesota 55101

All statements of information and comment must be received within thirty (30) days of the above date.

Berton W. Heaton
Commissioner of Insurance

Department of Finance

Notice of Intent to Solicit Outside Opinion Regarding Selection of State Depository Banks

Notice is hereby given, pursuant to Minn. Stat. § 15.0412, subd. 6 (Supp. 1975), that the Minnesota State Department of Finance will now seek information and opinions preparatory to promulgating and proposing rules governing the selection procedures it utilizes in determining banks eligible for the deposit of state funds.

Minn. Stat. § 16A.27 (1976), directs the Commissioner of the Minnesota Department of Finance to select banks to serve as depositories for state funds by bidding and, in exceptional cases, without recourse to bidding. Such selections are subject to approval by the State of Minnesota Executive Council pursuant to Minn. Stat. § 9.031 (1976). As Minn. Stat. § 15.0412, subd. 3 (1976), requires each agency to adopt rules setting forth the nature and requirements of all formal and informal procedures related to the administration of official agency duties, the Commissioner of the Minnesota Department of Finance has directed that rules be promulgated in the bank depository selection area and, toward that end, that outside opinions be sought.

The rules to be promulgated shall encompass methods of solicitation, specification of bank service requirements, bid evaluation and methods of final selection with respect to the bank depository bid process. Additionally, the rules shall define the exceptional cases in which bids will not be sought and consider the depository award process in such situations.

In order to seek outside information and opinions, representatives of the Minnesota State Department of Finance will be conducting a meeting in St. Paul. The meeting will be held March 24, 1977, from 1:30 to 4:00 p.m., at the St. Paul Holiday Inn (194 & Marion Street).

In addition to the meeting noted above, any and all interested persons may submit oral or written data or views regarding the promulgation of bank depository rules by contacting Mr. Otto V. Byhre, Jr., Director of Banking Activities, Minnesota State Department of Finance, Room 309, State Administration Building, 50 Sherburne Avenue, St. Paul, Minnesota 55155, Telephone: 612-296-5631.

This notice and any written material received by the Minnesota State Department of Finance with respect thereto shall become a part of the rule promulgation hearing record

Hearing Examiner may dispose of this matter adverse to a party failing to appear at the hearing.

The above cited procedural rules are available at the Office of Hearing Examiners or may be purchased from the Documents Section of the Department of Administration, 140 Centennial Building, Saint Paul, Minnesota 55155 (Telephone: 612-296-2874). They provide generally for the procedural rights of the parties including: rights to advance notice of witnesses and evidence, right to a prehearing conference, rights to present evidence and crossexamine witnesses, and right to purchase a record or transcript. Parties are entitled to issuance of subpoenas to compel witnesses to attend and produce documents and other evidence.

Persons attending the hearing should bring all evidence bearing on the case including any records or other documents.

If persons have good reason for requesting a delay of the hearing, the request must be made in writing to the Hearing Examiner at least 5 days prior to the hearing. A copy of the request must be served on the agency and any other parties.

Jim Harrington
Commissioner of Transportation

Notice of Appearance

Date of Hearing: May 10, 1977

Name and Telephone Number of Hearing Examiner:

Mr. Richard DeLong
1745 University Avenue
Saint Paul, Minn. 55104
296-8113

TO THE HEARING EXAMINER:

You are advised that the party named below will appear at the above hearing.

Name of Party: _____

Address: _____

Telephone Number: _____

Party's Attorney or Other Representative: _____

_____

Signature of Party or Attorney: _____

Date: _____

Department of Commerce Insurance Division

Proposal for Adoption of Rules by the Department of Commerce, Insurance Division, Governing the Minnesota Comprehensive Health Insurance Act of 1976. (Laws of 1976, ch. 296, Art. I).

Notice of Intent to Solicit Outside Opinion
Extension of Time for Response

Dated: April 8, 1977.

NOTICE IS HEREBY GIVEN that the Department of Commerce, Insurance Division, will allow additional time for response to its solicitation of proposals for consideration as rules for the implementation of the Minnesota Comprehensive Health Insurance Act of 1976. Notice of solicitation of information was first published in Vol. I, State Register, p. 1287 (March 7, 1977), and pursuant to said notice the initial solicitation period expires on April 15, 1977.

Pursuant to the request of interested parties, additional time is granted for submissions of proposals and the solicitation period is hereby extended to May 15, 1977.

All interested persons or groups are requested to submit their considerations relating to: (1) the administration of the Comprehensive Health Insurance Plan, including bid specifications for the selection of a writing carrier, guidelines for the acceptance of reinsurance by the Minnesota Comprehensive Health Association, and the selection of policies of accident and health insurance to be offered by the Minnesota Comprehensive Health Association; and (2) criteria to be used by the Commissioner of Insurance in the evaluation of policies of accident and health insurance submitted by insurers for certification pursuant to Section 5 of the Minnesota Comprehensive Health Insurance Act.

Proposals, information, and comment shall be submitted in writing and may be addressed to:

John T. Ingrassia
Supervisor, Life & Health Section
Insurance Division
Department of Commerce
500 Metro Square Building
St. Paul, Minnesota 55101

All proposals, information, and comment must be received by May 15, 1977.

BERTON W. HEATON
Commissioner of Insurance and
Chairman, Commerce Commission
500 Metro Square Building
St. Paul, Minnesota 55101

Proposal for Adoption of Rules by the Department of Commerce, Insurance Division, Establishing Arbitration Procedures for Matters Covered by Minn. Stat. § 65B.53 (1976).

Notice of Intent to Solicit Outside Opinion

Dated: April 8, 1977.

NOTICE IS HEREBY GIVEN that the Department of Commerce, Insurance Division, shall entertain consideration for proposed rules establishing arbitration procedures as required by Minn. Stat. § 65B.53, subd. 4 (1976). This provision requires the Commissioner to establish arbitration procedures to enforce the right of indemnity provided in Minn. Stat. § 65B.53, subd. 1 (1976) of the Minnesota No-Fault Automobile Insurance Act. All interested individuals or groups are requested to submit their considerations relating to arbitration procedures that should be adopted by the Commissioner of Insurance.

All interested or affected persons/or groups are requested to participate. Proposals, information, and comment shall be submitted in writing and may be addressed to:

Thomas L. O'Malley
Assistant Commissioner
Insurance Division
Department of Commerce
500 Metro Square Building
St. Paul, Minnesota 55101

All statements of information and comment must be received within thirty (30) days of the above date.

BERTON W. HEATON
Commissioner of Insurance and
Chairman, Commerce Commission
500 Metro Square Building
St. Paul, Minnesota 55101

State Planning Agency Developmental Disabilities Planning Office

1977 U.S. Regional Special Project Grants

The Developmental Disabilities Office, U.S. Department of Health, Education and Welfare (H.E.W.), announced in the *Federal Register* of Monday, March 28, 1977 that applications are now being accepted from public or private/non-profit organizations to compete for grants under its Regional Special Projects program. The purpose of this program is to enhance the scope of quality, and improve the coordination of services provided to persons having a developmental disability (defined as mental retardation, cerebral palsy, epilepsy, or autism). The scope of project operations may range from a community to a statewide focus. The established priority areas are for coordination of state service projects, personal and legal advocacy projects, recreation/leisure projects, projects targeted as sparsely populated areas, training and technical assistance for state/local planning and administration of services for persons having a developmental disability.

It is expected that approximately $700,000 will be allocated for grants in the Region 5 states of Minnesota, Wisconsin, Illinois, Indiana, Ohio, and Michigan. The grant application, evaluation and awards procedures will be conducted by the H.E.W. Office of Human Development in Chicago, Illinois. For specific details on program objectives and priorities, specific application forms and procedures, contact:

Mr. Robert Vogt, Director
Developmental Disabilities Office
Office of Human Development
Dept. of H.E.W. — Region 5
300 S. Wacker Drive
Chicago, Illinois 60607
Tel: 312/353-8416

Grant Application Deadline Extension

The deadline for submittal of applications for public information projects related to the interests of persons having a developmental disability, announced in the March 28, 1977 issue of the State Register (1 S.R. 1439), has been extended from May 31, 1977 to **June 10, 1977.**

OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, an agency, in preparing proposed rules, may seek information or opinion from sources outside the agency. Notices of intent to solicit outside opinion must be published in the *State Register* and all interested persons afforded the opportunity to submit data or views on the subject, either orally or in writing.

The *State Register* also publishes other official notices of state agencies, notices of meetings, and matters of public interest.

Department of Commerce Insurance Division

Notice of Intent to Solicit Outside Information and Opinion Regarding Proposed Rules for Implementation of the Minnesota Comprehensive Health Insurance Act of 1976

Notice is hereby given that the Department of Commerce, Insurance Division, shall solicit nonagency information and opinions in preparation for the adoption of permanent rules for implementation of the Minnesota Comprehensive Health Insurance Act of 1976, Minn. Stat. §§ 62E.01, *et. seq.* (1976).

All interested persons are hereby afforded the opportunity to submit relevant data or views on the subject either in written form or orally. Responses should be directed to:

John T. Ingrassia
Supervisor, Life & Health Section
Insurance Division
Department of Commerce
500 Metro Square Building
St. Paul, Minnesota 55101
(612) 296-2202

June 26, 1978

Thomas L. O'Malley
Assistant Commissioner of Insurance

Department of Education Division of Special Services — Office of Public Libraries and Interlibrary Cooperation

Notice of Intent to Solicit Outside Opinion Regarding Rules for Grants for Public Library Services and Interlibrary Cooperation

The Department of Education, Division of Special Services, Office of Public Libraries and Interlibrary Cooperation is drafting rules to implement Laws of 1978, ch. 546, which permits the State Board of Education to promulgate rules to govern grant programs for public library services and interlibrary cooperation, including application procedures, computation formulas for Establishment Grants and Regional Library Basic System Support Grants, and eligibility criteria for grants.

The Department invites interested persons or groups to provide information, comment and advice on the subject in writing or orally to Mr. William G. Asp, Director, Office of Public Libraries and Interlibrary Cooperation, 301 Hanover Building, 480 Cedar Street, St. Paul, Minnesota 55101.

Written statements will be made part of the public hearing record.

State Planning Agency Health Planning Division

Notice of Availability of State Funds for Health Research

Pursuant to Laws of 1977, ch. 453, § 27, there is made available $1.5 million of state funds for a Health Research Program (HRP). This program will help to maintain biomedical research in Minnesota and will strengthen the state's ability to produce health services research, nonmedical health research, and health policy research and analysis. As mandated by the Minnesota Legislature, the disbursement of these funds is to be directed by the Minnesota Statewide Health Coordinating Council (SHCC).

Three categories of research grants are established, with the total funds to be divided among them as follows:

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

THIRD DIVISION

Minnesota Mining and Manufacturing Company, Minnesota Power & Light Company and Northern States Power Company,

Plaintiffs,

vs.

State of Minnesota and Berton W. Heaton, Commissioner of the Insurance Division of the Department of Commerce of the State of Minnesota,

Defendants.

3-78-479

COMPLAINT

JURISDICTION AND VENUE

1. This action has been commenced pursuant to the provisions of 28 U.S.C. §§ 2201 and 2202, seeking a judgment declaring that certain provisions of the Minnesota Comprehensive Health Insurance Act of 1976, as amended, Minn. Stat. 62E.01-62E.17, have been preempted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001-1381) and as a result of said preemption are not applicable to, nor enforceable against, plaintiffs; plaintiffs seek a temporary and permanent injunction restraining defendants from enforcing

said provisions of the Minnesota Act against them. This Court has jurisdiction of this action under 28 U.S.C. §§ 1331 and 1337, and the Employee Retirement Income Security Act of 1974, § 502(e)(1) and § 502(f) (29 U.S.C. § 1132). Each plaintiff, as regards its activities which are subject to the Employee Retirement Income Security Act of 1974, is engaged in interstate commerce.

2. Venue is proper in this district under 28 U.S.C. § 1391, and the Employee Retirement Income Security Act of 1974, § 502(e)(2) (29 U.S.C. § 1132).

PARTIES

3. Plaintiff, Minnesota Mining and Manufacturing Company (hereinafter referred to as "3M") is a Delaware corporation with its principal corporate offices in Saint Paul, Minnesota.

4. Plaintiff, Minnesota Power & Light Company (hereinafter referred to as "MP&L") is a Minnesota corporation with its principal corporate offices in Duluth, Minnesota.

5. Plaintiff, Northern States Power Company (hereinafter referred to as "NSP") is a Minnesota corporation with its principal corporate offices in Minneapolis, Minnesota.

6. Defendant, Berton W. Heaton, is Commissioner of the Insurance Division of the Department of Commerce for

the State of Minnesota and is charged with the enforcement of the Minnesota Comprehensive Health Insurance Act of 1976, as amended, hereinafter referred to as "State Act" (Minn. Stat. § 62E.01, et seq.).

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

7. The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 to 1381, (hereinafter referred to as "ERISA") was enacted to protect persons participating in employee benefit plans and their beneficiaries by requiring disclosures of information, by requiring that all assets of these plans be used exclusively for providing benefits to participants and beneficiaries, by establishing standards of conduct, responsibility and obligation for fiduciaries of employee benefit plans and by providing for appropriate remedies, sanctions and access to the federal courts.

8. Each plaintiff herein is subject to the provisions of ERISA and has established and now maintains an "employee benfit plan" for the benefit of its employees residing within the State of Minnesota, within the meaning and definition of said terms as used therein.

THE MINNESOTA COMPREHENSIVE HEALTH INSURANCE ACT OF 1976

9. The Minnesota Legislature enacted the State Act. The primary purposes of the State Act were to require

insurers and employers to make available plans of health coverage meeting certain minimum standards and to assure similar coverage for persons who were not otherwise insurable.

10. Each plaintiff herein is an employer and makes available to its employees a "plan of health coverage" as defined in the State Act. Each of said plans of health coverage is an "employee benefit plan" as defined in ERISA.

11. The State Act, as amended, defines "self-insurer" as follows:

> "self-insurer" means an employer or an employee welfare benefit fund or plan which directly or indirectly provides a plan of health coverage to its employees and administers the plan of health coverage itself or through an insurer, trust or agent except to the extent of accident and health insurance premiums, subscriber contract charges, or health maintenance organization contract charges.... (Minn. Stat. § 62E.02, subd. 21).

Each plaintiff is a "self-insurer" as that term is defined in the State Act.

12. The State Act:

(a) creates the Minnesota Comprehensive Health Association (MCHA), a Minnesota corporation. The State Act specifically provides that membership in MCHA consists of all insurers, self-insurers, fraternals and health maintenance organizations licensed or authorized to do business in the State of Minnesota (Minn. Stat. § 62E.10,

subd. 1). Failure to maintain membership in MCHA may result in the loss of the right to do "self-insurance business" in the State of Minnesota (Minn. Stat. § 62E.10, subd. 3). One of the functions of MCHA is to create an insurance fund for the purpose of providing health insurance for individuals who, under customary underwriting standards utilized by private health insurers, are otherwise uninsurable. MCHA is charged with administering and enforcing certain provisions of the State Act and each member of MCHA is required to share in the losses arising from claims expenses of the comprehensive health insurance plan offered by MCHA and also must share in the operating and administrative expenses incurred or estimated to be incurred by it incident to the operation of its affairs (Minn. Stat. § 62E.11, subd. 5);

(b) requires that plans maintained by employers for their employees provide specified health care services and benefits and failure to provide such coverage will result in the loss of income tax deductions of the employer's costs for such health benefits (Minn. Stat. § 62E.03);

(c) requires that each benefit plan of plaintiff be approved as a "qualified plan" by defendant Commissioner of Insurance (Minn. Stat. § 62E.05);

(d) requires that each benefit plan maintained by plaintiff provide conversion privileges to participants leaving the group (Minn. Stat. § 62E.16); and

(e) requires that the employee benefit plans of each plaintiff offer participants option vehicles for receipt of benefits such as through an accident and health insurance policy or through a health maintenance organization contract (Minn. Stat. § 62E.17, subds. 1 and 2).

THE PREEMPTION PROVISION OF ERISA

13. Section 514(a) of ERISA (29 U.S.C. § 1144(a)) specifically provides:

> "... the provisions of this Title and Title IV shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 4(a) and not exempt under Section 4(b)."

14. The plaintiffs herein maintain "employee benefit plans described in § 4(a) and not exempt under § 4(b)

of ERISA. Each of the provisions of the State Act described in paragraph 12 hereof is a "state law" which "relates to ... employee benefit plan[s]" and is preempted by the provisions of ERISA. Pursuant to section 514(a) plaintiffs are not and cannot be required to comply with any of said sections of the State Act.

ACTIONS OF DEFENDANTS

15. Each plaintiff has received a Notice of Assessment from MCHA. A sample of the form of notice is attached as Exhibit A.

16. Plaintiffs 3M and NSP have notified MCHA and defendant Heaton of their intention not to pay the assessment attributable to them for the reason, among others, that ERISA has preempted the field of employee benefit plans, including the provisions of Minn. Stat. § 62E.10. MP&L has paid, under protest, its assessments to date, but intends to refuse to pay future assessments.

17. Defendant Heaton has advised each plaintiff that it must comply with the provisions of the State Act, become a member of MCHA and pay the assessment attributable to it. Defendant Heaton has formally advised plaintiffs that if the full amount of said assessment attributed to them is not paid,

"proceedings will be initiated to revoke your right of doing self-insurance business in Minnesota." A sample copy of defendant Heaton's letter is attached hereto as Exhibit B.

18. The United States Department of Labor, which is charged with administration and enforcement of ERISA, has advised defendants that certain provisions of the State Act have been preempted by ERISA. A copy of said letter is attached hereto as Exhibit C. Notwithstanding said letter, defendants have advised plaintiffs of their opinion that the State Act has not been preempted by ERISA and of their intention to enforce the various provisions of the State Act against plaintiffs. On information and belief, defendants will initiate proceedings to secure compliance with those provisions of the State Act set forth in paragraph 12 hereof.

CLAIM FOR RELIEF

19. Plaintiffs incorporate by reference each and every allegation of paragraphs 1 through 18 of this Complaint.

20. Congress has specifically determined and provided in ERISA, as set forth in paragraph 13 hereof, that ERISA supersedes any state law which relates to any employee benefit plan covered by ERISA.

21. As a result of this federal preemption, defendants are without jurisdiction or authority to enforce the provisions of sections 62E.10; 62E.03; 62E.05; 62E.16; 62E.17, subds. 1 and 2 of the State Act against plaintiffs. Enforcement of said sections would contravene Section VI, Clause 2 and Amendment XIV of the United States Constitution.

22. Unless the declaratory and injunctive relief prayed for herein are granted, defendants will revoke the right of each plaintiff to engage in "self-insurance business" in Minnesota and otherwise require compliance with the State Act.

23. By reason of the foregoing, each plaintiff will suffer irreparable harm and none has an adequate remedy at law.

WHEREFORE, Plaintiffs pray for relief as follows:

1. The Court declare and adjudge that enforcement of provisions of sections 62E.10; 62E.03; 62E.05; 62E.16; 62E.17, subds. 1 and 2 of the Minnesota Comprehensive Health Insurance Act of 1976 against plaintiffs would violate ERISA and Article VI, Clause 2 and Amendment XIV of the United States Constitution.

2. The Court temporarily and permanently enjoin and restrain the defendants and those acting under them

from enforcing, in any manner, the provisions of sections 62E.10; 62E.03; 62E.05; 62E.16; 62E.17, subds. 1 and 2 of the Minnesota Comprehensive Health Insurance Act of 1976 as to plaintiffs, including enjoining said defendants and anyone acting under them from initiating any proceeding against plaintiffs to revoke the right of doing business or doing self-insurance business in Minnesota.

3. The Court award plaintiffs their costs and disbursements herein, reasonable attorneys' fees, and such assessments as each plaintiff has previously paid to MCHA.

4. The Court grant plaintiffs such other and further relief as the Court deems just and equitable.

BRIGGS AND MORGAN

By _____
Leonard J. Keyes

And _____
Richard H. Kyle
Attorneys for Plaintiffs
First National Bank Building
Saint Paul, Minnesota 55101
612-291-1215

MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION
Box 9309 ● Minneapolis, Minnesota 55440 ● 612·372-5410

NOTICE OF ASSESSMENT

In accordance with the Assessment Agreement entered into with the Minnesota Comprehensiv Health Association (Association), and the Minnesota Comprehensive Health Insurance Act o 1976 (Act), as amended, the member of the Association named below is hereby assessed for the amounts indicated. This assessment is based on the ratio of each member's total cos of self insurance, accident and health insurance premium, subscriber contract charges, o health maintenance organization contract charges received from or on behalf of Minnesota residents divided into the total cost of self insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charg received by all Association members from or on behalf of Minnesota residents, as determined by the Commissioner of Insurance for the State of Minnesota. The "Premium Base" shown below is based on each member's reported 1976 experience, unless otherwise determined by the Commissioner. The assessment is calculated at $2.61 per $10,000.00 of premium, contract charge or cost of self insurance ($2.22 for the 1977 Final Assessment and $0.39 for the 1978 Interim Assessment). As required by the Act, this assessment has been approved by the Commissioner.

The Final 1977 Assessment is necessary as a result of deviations in the claim experience of the state plan from the premium payments allocated to the payment of benefits, togeth with the operating and administrative expenses incurred by the Association in that year. Credit is given for the Interim Assessment paid by members in 1977. The Interim 1978 Assessment is for operating and administrative expenses estimated to be incurred by the Association incident to the conduct of its affairs in this current year. Interim Assess ments paid in 1978 will be credited against the 1978 Final Assessment to be made at the end of the year.

This assessment is due and payable within 30 days of the receipt of this notice. Failur to pay the assessment shall be grounds for termination of membership. Termination of membership may mean the loss of privilege of doing accident and health insurance, self insurance or health maintenance organization business in Minnesota. Remit payment to the Association at the above address.

James P. Smith
Treasurer

Premium Base $_____

Assessment:

Final 1977 $_____

Less Interim 1977 $_____

Net 1977 $_____

Interim 1978 $_____

DATE: 3-6-78

Total Due $_____

RETURN ONE COPY OF THIS NOTICE WITH PAYMENT

OCT - 4 1978

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE
ST. PAUL, MINNESOTA 55101

October 3, 1978

TEL. NO. 296-6907

Attention: Chief Executive Officer

Gentlemen:

Re: Delinquent Assessment
Minnesota Comprehensive Health Association

I have been informed by the Minnesota Comprehensive Health Association, of which you are a member, that you have not yet paid your latest assessment of

Pursuant to Minn. Stat. § 62E.10, subd. 1 (1977), unless the Minnesota Comprehensive Health Association receives the full amount of the assessment due from you within 30 days of your receipt of this letter, proceedings will be initiated to revoke your right of doing self-insurance business in Minnesota.

Sincerely,

Berton W. Heaton

BERTON W. HEATON
COMMISSIONER OF INSURANCE

mw
cc: James P. Smith, Treasurer
Minnesota Comprehensive Health Association
1103

U.S. DEPARTMENT OF LABOR
Pension and Welfare Benefit Programs
Washington, D.C. 20216

MAR 24 1977

Mr. Berton W. Heaton
Insurance Commissioner
Department of Commerce
500 Metro Square Building
St. Paul, Minnesota 55101

STATE OF MINNESOTA
MAR 30 1977
DEPARTMENT OF COMMERCE

Re: Minnesota Comprehensive Health Insurance Act of 1976 (Minn. Laws 1976, ch. 296)

Dear Mr. Heaton:

The Department of Labor is charged with administration and enforcement of certain provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1001, et seq. Among such provisions is §514(a) of ERISA, which provides:

EFFECT ON OTHER LAWS

Sec.514.(a) Except as provided in subsection (b) of this section, the provisions of this title and Title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

The effect of this section is to preempt all state laws which relate to employee benefit plans subject to the coverage of Title I of ERISA (Protection of Employee Benefit Rights), whether such state laws conflict with the terms of the federal legislation or would merely supplement the federal scheme. The coverage of ERISA extends to employee benefit plans established or maintained by employers engaged in commerce or in any industry or activity affecting commerce, or by employee organizations representing employees so engaged. ERISA §4(a). The term "employee benefit plan" encompasses both pension plans and welfare plans. Included in the definition of welfare plans found in §3(1) of ERISA are plans established or maintained by employers or employee organizations, or both, for the purpose of providing

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OCT 17 1978
REVIEWED

EXHIBIT C

"medical, surgical, or hospital care or benefits" to their participants and beneficiaries.

Pursuant to the request of interested parties, the Department of Labor has undertaken a review of the Minnesota Comprehensive Health Insurance Act of 1976 for the purpose of determining the extent to which that Act may be preempted under §514 of ERISA.

While much of the Minnesota legislation regulates insurance carriers and is thus specifically excluded from federal preemption pursuant to ERISA §514(b)(2)(A), certain provisions clearly relate to employee benefit plans now subject to the coverage of ERISA. It is the view of the Department of Labor that to the extent that the Comprehensive Health Insurance Act may be applicable by its terms to employee benefit plans, the Act is preempted by §514(a) of ERISA. Moreover under §514(b)(2)(B) of ERISA, an employee benefit plan subject to ERISA may not be deemed to be an insurance company or insurer for the purpose of State laws purporting to regulate insurance companies or insurance contracts. Thus, a state may not obtain power to regulate what is truly an employee benefit plan by deeming it to be in the business of insurance. Such a plan is outside the reach of State regulation.

The reasons for broad preemption of State laws under ERISA were succinctly stated by Senator Javits, a major sponsor and floor manager of the bill, during its final consideration.

> Both the House and Senate bills provided for preemption of State law, but ---with one major exception appearing in the House bill------ defined the perimeters of preemption in relation to the areas regulated by the bill.
>
> Such a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension plans not clearly connected to the Federal regulatory scheme.

> Although the desirability of further regulation - at either the State or Federal level - undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required - but for certain exceptions - the displacement of State action in the field of private employee benefit programs. 120 Cong. Rec. S15751 (daily ed. Aug. 22, 1974).

The major reasons for broad preemption disclosed in these remarks include (1) the need to prevent conflicting regulation over interstate plans, (2) the desire to avoid the litigation that would result from piecemeal preemption, (3) the emergence of a pervasive Federal interest in employee benefit plans, and (4) the existence of a comprehensive federal program for future study (see §3022).

The Comprehensive Health Insurance Act of 1976, insofar as it relates to ERISA-covered plans, includes several provisions of the type subject to preemption by ERISA. These include, among others, the requirement that plans maintained by employers for their employees provide specified health care services and benefits (Sec. 62E. 03, Subd. 1); that such plans be approved ("qualified") by the commissioner (Sec. 62E.05); that plans afford conversion privileges to participants leaving the group (Sec. 62E. 16); and that employers with over one hundred employees cause plans maintained by them to offer participants optional vehicles (insurance, HMO's) for receipt of benefits (Sec. 62E.17, Subds. 1 and 2).

We regard such provisions to be legally indistinguishable from those of California Knox-Keene Health Care Service Plan Act of 1975 (Cal. Health and Safety Code §1340, et seq.) recently held to be preempted by ERISA in Hewlett-Packard Co., et al. v. Barnes, Civil No. C76 1607 CBR (N.D. Cal. 1976). [Copy of opinion enclosed.]

We are aware of the Memorandum and Order entered on December 23, 1976 in Insurers Action Council, Inc., et al., v. Heaton, et al., Civ. 3-76-440 (D. Minn.). The court there denied a preliminary injunction restraining the enforcement of the Minnesota statute during the interval between the hearing and the trial. The merits of the plaintiff's preemption claim and the other questions presented by the litigation are, of course, still before the court so long as the entire law suit is pending and awaits disposition. It is not apparent to us that the plaintiffs in Insurers Action Council presented squarely to the court, at this preliminary stage, the extent to which provisions of the Minnesota statute might affect employee benefit plans which, under ERISA section 514(b)(2)(B), are not to be deemed to be insurance companies. We are also uncertain whether the plaintiffs in that case -- all of whom identify themselves as insurers or associations of insurers -- have standing to present this question. We disagree with the court's statement on pages 9 and 10 of the Memorandum and Order, that "the conflict between the challenged state insurance law and ERISA has to be very clear in order to trigger the preemption provision," to the extent that this analysis is intended to apply to the state law's effect on a health care or other employee welfare benefit plan within the definition of section 3(1) and covered by ERISA.

I hope that this information and the expression of our views will be of assistance to you in your implementation of the Comprehensive Health Insurance Act within the limits of federal law. I would appreciate an expression of your response to the position outlined above.

Sincerely,

J. Vernon Ballard

J. Vernon Ballard
Acting Administrator
Pension and Welfare Benefit Programs

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA, THIRD DIVISION

ST. PAUL ELECTRICAL WORKERS WELFARE FUND, a Trust, ELECTRICAL WORKERS HEALTH AND WELFARE FUND, a Trust, TWIN CITY PIPE TRADES WELFARE FUND, a Trust, SHEET METAL WORKERS 547 WELFARE PLAN, a Trust, MINNESOTA WISCONSIN HEALTH AND WELFARE PLAN, a Trust, ST. PAUL CHAPTER, NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION, a Minnesota Not For Profit Corporation, WEBER ELECTRIC, INC., a Minnesota corporation, THOMAS R. FRANTES and FRANK HORAK, in their own behalf as Trustees of Twin City Pipe Trades Welfare Fund, and CLYDE W. MILLERBERND and JOHN J. GALLES,

Plaintiffs,

vs.

BERTON W. HEATON, Commissioner of the Insurance Division of the Department of Commerce of the State of Minnesota; MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION, a Minnesota corporation, and ARTHUR C. ROEMER, Commissioner of Revenue for the State of Minnesota,

Defendants.

CIVIL NO. 3-78-269

COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

JURISDICTION AND VENUE

1. This is an action for declaratory judgment under the provisions of 28 U.S.C. §§2201 and 2202 that the Minnesota Comprehensive Health Insurance Act of 1976 (as amended) and other Minnesota Statutes as herein set forth do not apply to the plaintiffs, and for a permanent injunction restraining defendants from enforcing the provisions of such Minnesota Statutes as to plaintiffs and each of them. The Court has jurisdiction of this action under 28 U.S.C. §§1331 and 1337, the Employee Retirement Income Security Act of 1974, §502(e)(1), (29 U.S.C. §1132), and the Labor Management Relations Act of 1947, §302 (29 U.S.C. §186(e)). The matter in controversy exceeds, exclusive of interest and costs, the sum of $10,000.00. The plaintiffs, as regards their activities which are the subject of this action, are engaged in interstate commerce.

RECEIVED
JUL 24 1978
ATTORNEY GENERAL
102 STATE CAPITOL
ST. PAUL, MINN. 55155

2. Venue is proper in this district under 28 U.S.C. §1391, the Employee Retirement Income Security Act of 1974, §502(e)(2) (29 U.S.C. §1132) and the Labor Management Relations Act of 1947, §302 (29 U.S.C. §§185 and 186(e)).

PARTIES

3. Plaintiff, St. Paul Chapter, National Electrical Contractors Association is a Minnesota nonprofit corporation and is an association of electrical contractor-employers organized for purposes of collective bargaining (hereinafter referred to as "Chapter") and is here suing in a representative capacity on behalf of its members.

4. Plaintiff, Weber Electric, Inc., is a Minnesota corporation, (hereinafter referred to as "Contractor") is in the business of electrical contracting and is a member of the Chapter and is a party to a collective bargaining agreement between the Chapter and the International Brotherhood of Electrical Workers Local Union No. 110, AFL-CIO.

5. Plaintiff, St. Paul Electrical Workers Welfare Fund, is a trust established pursuant to a collective bargaining agreement between various employers, including those who are members of the Chapter, and the International Brotherhood of Electrical Workers, Local Union No. 110, AFL-CIO. The trust is established pursuant to authority contained in §302 of the National Labor Relations Act, (29 U.S.C. §186) and is administered by a board of eight trustees, four of whom are appointed by the Chapter and four of whom are appointed by the union as parties to the collective bargaining agreement. The trust is here suing on its own behalf and in a representative capacity on behalf of the participants and beneficiaries of the trust.

6. Plaintiff, Twin City Pipe Trades Welfare Fund, is a trust established pursuant to a collective bargaining agreement between various employers, including those who are members of the Twin City Piping Industry Association and Metro-Association of Plumbing-Heating-Cooling Contractors, on behalf of employers, and the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, AFL-CIO, Local Unions #15, #34, #455 and #539, on behalf of the employees. The trust is established pursuant to authority contained in §302 of the National Labor Relations Act, (29 U.S.C. §186) and is administered by a board of eight trustees, four of whom are appointed by the employers and four of whom are appointed by the unions as parties to the collective bargaining agreement. The trust is here suing on its own behalf and in a representative capacity on behalf of the participants and beneficiaries of the trust.

7. Plaintiff, Sheet Metal Workers 547 Welfare Plan, is a trust established pursuant to a collective bargaining agreement between various employers and the Sheet Metal Workers International Association Local Union #547. The trust is established pursuant to authority contained in §302 of the National Labor Relations Act, (29 U.S.C. §186) and is administered by a board of four trustees, two of whom are appointed by the various employers and two of whom are appointed by the union as parties to the collective bargaining agreement. The trust is here suing on its own behalf and in a representative capacity on behalf of the participants and beneficiaries of the trust.

8. Plaintiff, Minnesota Wisconsin Health and Welfare Plan, is a trust established pursuant to a collective bargaining agreement between various employers and the Laundry, Dry Cleaning and Service

Trade Industries Local 150, Laundry and Dry Cleaning Association of Saint Paul, Inc. The trust is established pursuant to authority contained in Section 302 of the National Labor Relations Act, (29 U.S.C. §186) and is administered by a board of four trustees, two of whom are appointed by the Launderers and Dry Cleaners Association of Saint Paul, Inc. and two of whom are appointed by the union as parties to the collective bargaining agreement. The trust is here suing on its own behalf and in a representative capacity on behalf of the participants and beneficiaries of the trust.

9. Plaintiff, Electrical Workers Health and Welfare Fund, is a trust established pursuant to a collective bargaining agreement between various employers, including those who are members of the Twin Ports - Arrowhead Chapter of the National Electrical Contractors Association and the International Brotherhood of Electrical Workers, Local Unions #242-276, and 294, AFL-CIO. The trust is established pursuant to authority contained in Section 302 of the National Labor Relations Act (29 U.S.C. §186) and is administered by a board of ten trustees, five of whom are appointed by the Employers and five of whom are appointed by the unions as parties to the collective bargaining agreement. The trust is here suing on its own behalf and in a representative capacity on behalf of the participants and beneficiaries of the trust.

10. Plaintiff trusts described in Paragraphs 5 through 9 herein are trusts qualified as tax exempt organizations under the Internal Revenue Code of 1954 as amended (26 U.S.C. §501(c)(9)). These trusts are also employee welfare benefit plans within the meaning of Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. §1002(1)). Each of the trusts herein are self-funded, that is, benefits are provided solely

and entirely from contributions made by employers to the respective trust funds as negotiated in collective bargaining agreements between the parties thereto.

11. Plaintiffs, Thomas R. Frantes and Frank Horak (hereinafter "Trustees") are trustees of Twin City Pipe Trades Welfare Fund, whose obligations, responsibilities and liabilities to the employee benefit fund which they administer, with other trustees, are determined by the fiduciary responsibility and other provisions of the Taft-Hartley Act pursuant to which the trust was established, and by the Employee Retirement Income Security Act of 1974. Plaintiff, Thomas R. Frantes, is chairman of the board of trustees and is one of four trustees of Twin City Pipe Trades Welfare Fund selected by and representing contributing employer signatories to the trust agreement, and plaintiff, Frank Horak, is co-chairman of the board of trustees and is one of four trustees selected by and representing signatory unions to the trust agreement. They sue here also as representatives of the other trustees.

12. Plaintiffs, Clyde W. Millerbernd and John J. Galles, are participants and beneficiaries in The St. Paul Electrical Workers Welfare Fund, residing at 399 Blair, St. Paul, Minnesota and 411 South Pascal, St. Paul, Minnesota respectively, and possess certain stated rights to the fund assets under federal law and the trust agreement pursuant to which the fund is established and operates.

13. Defendant, Berton W. Heaton, is Commissioner of the Insurance Division of the Department of Commerce for the State of Minnesota and is charged with the enforcement of the Minnesota Comprehensive Health Insurance Act, as amended, hereinafter referred to as "The Minnesota Act" (Minn. Stat. §62E.01, et. seq.) and certain other Minnesota laws as herein set forth.

14. Defendant, Arthur C. Roemer, is the Commissioner of Revenue for the State of Minnesota and is charged with the enforcement of the Minnesota Income Tax Act (Minn. Stat. §290, et. seq.).

15. Defendant, Minnesota Comprehensive Health Association (hereinafter MCHA) is a Minnesota corporation whose membership is mandated by law (Minn. Stat. §62E.10) to consist of all insurers, self-insurers, fraternals and health maintenance organizations licensed or authorized to do business in the State of Minnesota. One of the functions of the MCHA is to provide an insurance fund for the purpose of providing health insurance for individuals who, under customary underwriting standards utilized by private health insurers, are otherwise uninsurable. In addition, the MCHA is charged with administering and enforcing certain provisions of the Minnesota Comprehensive Health Insurance Act, as amended (Minn. Stat. 62E.01, et. seq.).

BACKGROUND OF CLAIMS AND APPLICABLE LAW

16. Section 302 of the Labor Management Relations Act, also known as the Taft-Hartley Act (29 U.S.C. §186) was enacted by Congress in 1947 under the commerce clause for the purpose of prohibiting, among other things, the payment of money, other than ordinary compensation, by an employer to his employees or their representatives, except for certain purposes. The Act specifically authorizes such payments if made to a trust for the sole and exclusive purpose of providing, among other things, health and welfare benefits to the employees and their families. Such trusts are required to be administered solely by the trustees representing employers and employees equally, exclusively for the benefit of the employees. The plaintiff welfare funds herein are created and maintained pursuant to the authority of this section; the plaintiff trustees herein are appointed and serve pursuant to the authority of this section, individually and as representatives of their respective trusts; and the plaintiff Contractor contributes funds to such trust pursuant to the authority of this section.

17. Section 302 of the Taft-Hartley Act (29 U.S.C. §186) preempts state regulation of welfare funds which would be inconsistent with §302.

18. In 1974, Congress, under the commerce clause, enacted the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 to 1381, (hereinafter referred to as "ERISA") to protect those persons who participate in employee benefit plans and their beneficiaries by requiring disclosures of information to those persons, by requiring that all assets of these plans be used exclusively for providing benefits to participants and beneficiaries, by establishing standards of conduct, responsibility and obligation for fiduciaries of employee benefit plans and by providing for appropriate remedies, sanctions and ready access to the federal courts.

19. Section 514(a) of ERISA (29 U.S.C. §1144(a)) specifically provides:

> "...the provisions of this Title and Title IV shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 4(a) and not exempt under Section 4(b)."

20. The plaintiffs described in Paragraphs 5 through 9 herein are "employee benefit plans" described in §4(a) and not exempt under §4(b) of ERISA.

21. In 1976, the Minnesota Legislature enacted the Minnesota Comprehensive Health Insurance Act of 1976. The 1977 Legislature amended this Act which included an amendment to the definition of "self-insurer" which, as amended, now reads:

> "Self-insurer" means an employer or an employee welfare benefit fund or plan which directly or indirectly provides a plan of health coverage to its employees and administers the plan of health coverage itself or through an insurer, trust or agent except to the extent of accident and health insurance premiums, subscriber contract charges, or health maintenance organization contract charges.... (Minn. Stat. §62E.02, subd. 21)

22. The Minnesota Act as amended creates the MCHA and specifically provides that membership in the MCHA consists of all insurers, self-insurers, fraternals and health maintenance organizations licensed or authorized to do business in the State of Minnesota (Minn. Stat. §62E.10, subd. 1) Failure to maintain membership in the association may result in the loss of the ability to do business in the State of Minnesota (Minn. Stat. §62E.10, subd. 3). In addition, each member of the association is required to share in the losses due to claims expenses of the comprehensive health insurance plan offered by the association and also must share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the operation of its affairs (Minn. Stat. §62E.11, subd. 5).

23. Defendant, Minnesota Comprehensive Health Association, has advised plaintiff trusts that they must comply with the provisions of the Minnesota Act and become members of the association, and that the provisions of ERISA do not supersede the application of the Minnesota Act to regulate plaintiff trusts. There are no administrative procedures which will afford plaintiffs the relief they seek herein.

24. The Minnesota Comprehensive Health Act specifically provides that each employer in this state who provides or makes available to his employees a plan of health coverage shall make available to his employees employed in this state a plan or combination of plans which have been certified by the Commissioner as a number 2 qualified plan. (Minn. Stat. 62E.03, Subd. 1). The failure of an employer to make available such number 2 qualified plan will result in loss of a deduction for the employer's costs for health benefits (Minn. Stat. 62E.03, Subd. 2).

25. Minnesota Statutes 62A.17 provides that certain health care plans providing hospital or medical expenses incurred by

a Minnesota resident must contain a provision which permits every eligible employee whose employment is terminated to elect to continue coverage for himself and his dependents provided that the health care plan remains in force.

26. The Minnesota Comprehensive Health Insurance Act of 1976 as amended specifically provides that every program of self insurance shall include, in addition to the provisions required by Minnesota Statutes 62A.17, the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions if the individual insured leaves the group regardless of the reason for leaving the group (Minn. Stat. 62E.16).

27. Chapter 62A of Minnesota Statutes provides for mandated benefits that must be included in policies of accident and sickness insurance issued or delivered to any person in the State of Minnesota and prescribes certain other provisions which must be included in such policies of accident and sickness insurance issued or delivered to any person in the State of Minnesota. (Minn. Stat. 62A.02, et. seq.). The Minnesota Comprehensive Health Insurance law provides that these mandated benefits must also be included as part of the plan of health coverage to be made available to employees under the law. (Minn. Stat. 62E.03 and 62E.06).

FIRST CLAIM

THE PROVISIONS OF SECTION 302 OF THE TAFT-HARTLEY ACT (29 U.S.C. §186) PREEMPT MINNESOTA STATE LAWS AND REGULATIONS WHICH ARE INCONSISTENT THEREWITH.

28. Plaintiffs incorporate by reference each and every allegation of Paragraphs 1 through 27 of this Complaint.

29. The provisions of Section 302 of the Taft-Hartley Act (29 U.S.C. §186) preempt state laws and regulations which are inconsistent therewith.

30. As a result of the federal preemption by the Taft-Hartley Act, the defendants are without jurisdiction or authority to enforce the provisions of the Minnesota Comprehensive Health Insurance Act and other laws enumerated herein against plaintiffs.

31. Unless a declaratory judgment and a permanent injunction, as prayed for hereinafter, is entered prohibiting defendants from enforcing the Minnesota Comprehensive Health Insurance Act and other related Minnesota Statutes with respect to plaintiffs, plaintiffs have no adequate remedy at law and thus will suffer immediate and irreparable loss and damage as hereinafter set forth.

SECOND CLAIM

ENFORCEMENT OF THE MINNESOTA COMPREHENSIVE HEALTH INSURANCE ACT OF 1976 (AS AMENDED) AND OTHER RELATED MINNESOTA STATUTES AS HEREIN SET FORTH BY DEFENDANTS AGAINST PLAINTIFFS, IS IN VIOLATION OF ERISA SECTION 514(a)(29 U.S.C. §1144(a)).

32. Plaintiffs incorporate by reference each and every allegation of Paragraphs 1 through 27 of this Complaint.

33. Congress has specifically determined and provided in ERISA, as set forth in Paragraphs 19 and 20 hereof, that ERISA supersedes any state law which relates to any employee benefit plan covered by ERISA.

34. As a result of the federal preemption by ERISA, the Defendants are without jurisdiction or authority to enforce the provisions of the Minnesota Comprehensive Health Insurance Act and other related Minnesota Statutes as set forth herein against plaintiffs.

35. Unless a declaratory judgment and a permanent injunction as prayed for hereinafter, is entered prohibiting defendants from enforcing the Minnesota Comprehensive Health Insurance Act and other related Minnesota Statutes with respect to plaintiffs,

plaintiffs have no adequate remedy at law and thus will suffer immediate and irreparable loss and damage as hereinafter set forth.

THIRD CLAIM

ENFORCEMENT OF THE MINNESOTA COMPREHENSIVE HEALTH INSURANCE ACT OF 1976 (AS AMENDED) AND OTHER RELATED MINNESOTA STATUTES AS HEREIN SET FORTH BY DEFENDANTS AGAINST PLAINTIFFS, AS SUCH ENFORCEMENT IS THREATENED BY DEFENDANTS, WOULD VIOLATE THE UNITED STATES CONSTITUTION.

36. Plaintiffs incorporate by reference each and every allegation of Paragraphs 1 through 27 of this Complaint.

37. As a result of the federal preemption by ERISA and the Taft-Hartley Act, the defendants are without jurisdiction or authority to enforce the provisions of the Minnesota Comprehensive Health Insurance Act and other related Minnesota Statutes as set forth herein against plaintiffs and such enforcement violates Section VI, Clause 2 of the United States Constitution.

38. The enforcement by defendants of the Minnesota Statutes herein described would deny the plaintiffs the protections afforded them under the 14th Amendment to the United States Constitution.

39. The definition of "self-insurer" under Minnesota law, as set forth in Paragraph 21 herein, is vague and ambiguous and is, therefore, null and void under the 14th Amendment to the United States Constitution.

40. Enforcement by defendants of the Minnesota Statutes as set forth herein would impair the contractual obligations between plaintiff employers and various unions signatory to collective bargaining agreements establishing plaintiff Trusts all in violation of Article I §10 of The United States Constitution which provides in part:

"No state shall . . . pass any . law impairing the obligation of contracts."

FOURTH CLAIM

ENFORCEMENT OF THE MINNESOTA COMPREHENSIVE HEALTH INSURANCE ACT AND OTHER RELATED MINNESOTA STATUTES AS SET FORTH HEREIN BY THE DEFENDANTS AGAINST PLAINTIFFS, AS SUCH ENFORCEMENT IS PRESENTLY BEING THREATENED BY DEFENDANTS, WOULD IMPOSE INCONSISTENT AND IRRECONCILABLE OBLIGATIONS UPON THE TRUSTEES OF SUCH FUNDS.

41. Plaintiffs incorporate by reference each and every allegation of Paragraphs 1 through 27 of this Complaint.

42. Section 403(a) of ERISA requires that all assets of an employee benefit plan be held in trust by the trustees. The defendants have demanded that the trustees contribute a portion of said trust funds to the Minnesota Comprehensive Health Association. Such contribution constitutes a diversion of trust funds and would be inconsistent with the purposes of the trust, and in violation of §403(a) of ERISA.

43. Section 404(a)(1) of ERISA provides that a fiduciary (each of the trustees) shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the plan. The defendants are attempting to compel the trustees to devote a portion of their time, administrative expenses and trust funds for the interest and benefit of persons other than participants and beneficiaries of the plan, and are attempting to compel the plaintiff trustees to utilize trust funds other than for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the plan, in violation of the trust agreement and the provisions of ERISA.

44. Section 403(c)(1) of ERISA provides that "the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan." The defendants are attempting to compel the trustees to utilize plan assets for a purpose other than providing benefits to participants in the plan and their beneficiaries, and for the purpose of deferring expenses other than those of administering the plan.

45. The Taft-Hartley Act, Title 29 U.S.C. §186, requires that all payments made to the fund on behalf of employees be held in trust for the "exclusive benefit of employees." That section further provides that the trust is to be administered by a board of trustees equally representing employees and employers and payments made out of the trust fund can only be made as specified in a written agreement. The defendants are attempting to interfere in the administration of the fund and compel use of trust assets in a manner not specified in the written trust agreement. Interference by the Minnesota Comprehensive Health Association in the operation of the fund and the enforcement of other Minnesota Statutes as described herein would be inconsistent with, and violative of, the provisions of the Taft-Hartley Act requiring that the fund be administered by equal representation of employers and employees.

46. The provisions of the Taft-Hartley Act pursuant to which the funds are established and operate, require that the funds provide equal benefits to all employees covered by the collective bargaining agreement, without regard to their insurability under standards utilized by private insurers. All of the plaintiff trusts cover 100% of eligible employees, without any exceptions, riders, or other limitations to coverage based upon their state of health. Consequently, membership by the

funds in the Minnesota Comprehensive Health Association would not in any way benefit any of the employee participants or their beneficiaries, since none of the employee participants or their beneficiaries would be referred to the Minnesota Comprehensive Health Association for coverage.

47. Unless a declaratory judgment and a permanent injunction as prayed for hereinafter is entered prohibiting defendants fror enforcing the Minnesota Comprehensive Health Insurance Act and other related statutes as described herein with respect to plaintiffs, plaintiffs have no remedy at law and as a result of the first, second, third and fourth claims enumerated herein, wil suffer immediate and irreparable loss and damage, including:

(a) Plaintiff trusts will be required to pay assessments and fees to the MCHA, which will deplete the funds available in the described benefit plans to provide benefits for participants of their respective plans;

(b) Plaintiff trusts under federal law are required to use their assets for the sole and exclusive benefit of their participants and beneficiaries and cannot deny benefits to any participant or beneficiary because of his being a substandard risk under state law (Minn. Stat. §62E.14, subd. 1). Thus, no participant or beneficiary of any of the plaintiff trusts will become an enrollee of the Comprehensive Health Insurance Plan, and there can be no recompense for any assessments or fees required by state law to be paid to MCHA, the net result being that such assessments and fees charged to plaintiff trusts will be used for the benefit of others;

(c) Plaintiff trusts will be injured in that should they, in good faith, not comply with the Minnesota Comprehensive Health Insurance Act, they will be subject to penalties under the Minnesota Comprehensive Health Insurance Act and they can be prevented from doing business within the State of Minnesota;

(d) Plaintiff trusts will be injured in that compliance with the Minnesota Comprehensive Health Insurance Act and other related Minnesota Statutes as described herein will require a substantial expenditure of employee hours which are not retrievable and for which there can be no recompense; such expenditure of time will result in increased costs to the employee welfare benefit plans which will deplete the funds available to provide benefits to participants of the respective plans.

(e) Plaintiff participants will be injured in that should plaintiff trusts comply with the Minnesota Comprehensive Health Insurance Act and other related statutes, there will be less assets of the trust funds to be utilized for providing benefits to participants and beneficiaries; and

(f) Plaintiff employers will be injured in that they are required by collective bargaining agreements to make stated contributions to employee welfare benefit plans which may not conform with the Minnesota Comprehensive Health Insurance Act, in which case they will suffer a tax penalty under the Act (Minn. Stat. §62E.03, subd. 2) and if they fail to maintain membership in the MCHA, they may risk losing certain rights to do business in the State of Minnesota;

(g) Plaintiff trustees will be subjected to civil and/or criminal penalties for violations of federal law which may occur should plaintiff trustees be made to comply with inconsistent state law;

(h) Plaintiff employers are injured in that enforcement of The Minnesota Comprehensive Health Act would deny to Plaintiff employers the protection afforded them by Article I §10, Article VI Clause 2, and the Fourteenth Amendment to The United States Constitution.

WHEREFORE, Plaintiffs pray:

1. That the court declare and adjudge that any enforcement of the Minnesota Comprehensive Health Insurance Act of 1976 (as amended), and Chapter 62A of Minnesota Statutes, against Plaintiffs would violate ERISA, the Taft-Hartley Act, Article I §10, Article VI, Clause 2 and the Fourteenth Amendment to the United States Constitution.

2. That the court permanently enjoin and restrain the defendants and those acting under them from, in any manner, enforcing the Minnesota Comprehensive Health Insurance Act of 1976 (as amended), and Chapter 62A of Minnesota Statutes, as to plaintiffs.

3. That plaintiffs be awarded their costs of this suit.

4. That plaintiffs have such other and further relief as

the court deems appropriate.

Dated: July 7, 1978.

FELHABER, LARSON, FENLON AND VOGT, P.A.

By _____
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W-1080 First National Bank Building
Saint Paul, Minnesota 55101
612/222-6321

HANSEN, DORDELL BRADT

By _____
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Attorneys for Plaintiffs

ATTORNEY GENERAL
SOLICITOR GENERAL
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A.M. 7 8 9 10 11 12 1 2 3 4 5 6 7 P.M.

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

THIRD DIVISION

Insurers' Action Council, Inc., a Nebraska corporation, Woodmen Accident & Life Company, a Nebraska corporation; Time Insurance Company, a Wisconsin corporation; Mutual of Omaha Insurance Company, a Nebraska corporation; Business Men's Assurance Company of America, a Missouri corporation; The Midwest Life Insurance Company of Lincoln, Nebraska, a Nebraska corporation: Washington National Insurance Company, an Illinois corporation; Mutual Protective Insurance Company, a Nebraska corporation; American Republic Insurance Company, an Iowa corporation; American Home Assurance Company, a New York corporation; Illinois Mutual Life & Casualty Company, an Illinois corporation; Physicians Mutual Insurance Company, a Nebraska corporation, Plaintiffs, vs. Berton W. Heaton, Commissioner of Insurance, and The Minnesota Department of Commerce, Insurance Division, and the Minnesota Comprehensive Health Association, Defendants, and United Cerebral Palsy, Minnesota Epilepsy League, Minnesota Association for Retarded Citizens, Michael L. Berde and Carol T. Berde, Intervenor-Defendants.	3-76 Civ. 440 AMENDED COMPLAINT FOR A DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

Plaintiffs, for their Complaint against defendants, state and allege as follows:

Count I

Identification of Parties

1. Plaintiff, Insurers' Action Council, Inc. (hereinafter "Council"), is a nonprofit corporation organized under the laws of the State of Nebraska. The membership of the Council consists of 24 insurance companies domiciled in

fourteen states (hereinafter "members) that are authorized to write, heretofore have been writing, and now are writing and/or renewing policies of accident and health insurance for insureds who are residents of the State of Minnesota. (All references herein to accident and health insurance shall mean and refer to accident and health insurance as defined by the Minnesota Comprehensive Health Insurance Act, Minnesota Statutes, 1976, Chapter 296, Article I, codified as Minn. Stat. §§ 62E.01, et seq.) Said policies are written both within and without the State of Minnesota. In addition, many of the Council's members write other types of insurance, both within and without the State of Minnesota. A substantial portion of all individual accident and health insurance which has been written by insurers in the State of Minnesota has been written and is being renewed by members of the Council. The Council is authorized to, and hereby does, bring this action on its own behalf and on behalf of its members.

2. Plaintiffs, other than the Council, are insurance corporations and the state of incorporation of each of these plaintiffs is as follows:

Corporation	State of Incorporation
Woodmen Accident & Life Company	Nebraska
Time Insurance Company	Wisconsin
Mutual of Omaha Insurance Company	Nebraska
Business Men's Assurance Company of America	Missouri
The Midwest Life Insurance Company of Lincoln, Nebraska	Nebraska
Washington National Insurance Company	Illinois
Mutual Protective Insurance Company	Nebraska
American Republic Insurance Company	Iowa
American Home Assurance Company	New York
Illinois Mutual Life & Casualty Company	Illinois
Physicians Mutual Insurance Company	Nebraska

Each of these plaintiffs is engaged in interstate commerce, is duly authorized to write accident and health insurance in the State of Minnesota and is at this time engaged in writing and/or renewing policies of accident and health insurance in the State of Minnesota. The plaintiffs listed in this paragraph will hereinafter be referred to as the "named plaintiffs."

3. Defendant, Berton W. Heaton, is the Commissioner of Insurance (hereinafter "Commissioner") of the Department of Commerce for the State of Minnesota. In his capacity as public officer of the State of Minnesota the Commissioner resides in the City of Saint Paul, County of Ramsey.

Pursuant to Minn. Stat. § 60A.03, Subd. 2(1), the Commissioner is generally charged with the duty to enforce all laws of the State of Minnesota relating to insurance, including the provisions of Minnesota Statutes, 1976, Chapter 142 (hereinafter "Chapter 142"). Chapter 142 amends Minn. Stat., Sections 62A.16 and 62A.17. Pursuant to Minn. Stat. § 62E.09, the Commissioner is specifically charged with the administration of the Minnesota Comprehensive Health Insurance Act, Minnesota Statutes, 1976, Chapter 296, Article I (hereinafter "Act"). The Act is codified as Minn. Stat. §§ 62E.01, et seq.

4. Defendant, Minnesota Department of Commerce, Insurance Division (hereinafter "Insurance Division") is the Minnesota State Agency administered by the Commissioner. The Insurance Division's principal office is in the City of Saint Paul, County of Ramsey.

5. Defendant, Minnesota Comprehensive Health Association (hereinafter "Association") is a Minnesota non-profit corporation incorporated on October 14, 1976. The Association's membership, organization, duties and powers are defined and specified in Minn. Stat. §§ 62E.10 - 62E.15.

Purpose and Statutory Authority for Action

6. This action is brought pursuant to Minnesota Statutes, 1949, Chapter 555, relating to declaratory judgments, to obtain a declaration that the Act and Minnesota Statutes Chapter 142 are unconstitutional, or in the alternative for a construction of such parts of said Acts that are found to be valid. This action is also brought pursuant to Rule 65, Minnesota Rules

of Civil Procedure, to obtain permanent injunctive relief against enforcement of those parts of the Act and Chapter 142 that are found to be unconstitutional.

7. Subsequent to the service of the original Complaint in this action, this case was removed by defendants to the United States District Court, District of Minnesota. Consequently, plaintiffs now also bring this action pursuant to 28 U.S.C. § 2201 to obtain a declaration that the Act as amended, and Chapter 142 as amended are unconstitutional or in the alternative for a construction of such parts of said Acts that are found to be valid. The action is also brought pursuant to Rule 65 Federal Rules of Civil Procedure to obtain permanent injunctive relief against enforcement of those parts of the Act and Chapter 142 that are found to be unconstitutional.

Facts

8. The Act was approved April 13, 1976. A copy of the Act is attached hereto as Exhibit "A" and incorporated herein by reference. The effective dates of each section of the Act are set forth in Section 20 of the Act.

On or about May 27, 1977, the Act was amended by Minnesota Statutes, 1977, Chapter 335 (hereinafter "Chapter 335"). On or about June 2, 1977, the Act was further amended by Minnesota Statutes, 1977, Chapter 409 (hereinafter "Chapter 409"). Chapter 335 amending only Minnesota Statutes § 62E.16, became effective August 1, 1977. Chapter 409, amending various sections of Minnesota Statutes including § 62E.01, et seq., became effective June 3, 1977. Copies of said amendments are attached hereto as Exhibits "A-1" and "A-2" and are incorporated herein by reference.

9. The Act purports to define "insurer" as "those companies operating pursuant to Minnesota Statutes, Chapters 62A or 62C and offering or selling policies or contracts of accident and health insurance." [Section 62E.02, Subd. 10]

10. The Act purports to define "accident and health insurance policy" as "insurance or nonprofit health service plan contracts providing benefits for hospital, surgical and medical care. . . ." subject to certain

specified exceptions. [Section 62E.02, Subd. 11]

11. As a consequence of Section 62E.02, Subdivisions 10 and 11, all members of the Council and each named plaintiff may be considered by the defendants to be an "insurer" for purposes of the Act.

12. The Act purports to require all insurers, including members of the Council and each named plaintiff, as a condition of doing business in Minnesota, to offer certain "qualified plans" of accident and health insurance to all eligible applicants. [Section 62E.04]

13. The Act, as amended, also purports to require all insurers, including members of the Council and each named plaintiff to offer certain major medical coverage at the time of application to every applicant for a new "unqualified" policy of accident and health insurance and annually to all persons holding "unqualified" policies of accident and health insurance. [§ 62E.04]

14. The Act, as amended, also purports to require all insurers, including members of the Council and each named plaintiff, as a condition of doing accident and health insurance business in Minnesota, to become members of the Minnesota Comprehensive Health Association. [§ 62E.10]

15. The Act permits insurers, including members of the Council and each named plaintiff, to reinsure with the Association some, but apparently not all, of the "qualified plan" coverages mandated by Section 62E.04. [Section 62E.04, Subd. 6; 62E.10, Subd. 7]

16. The Act also purports to require the Association, through a carrier or carriers, to offer certain types of accident and health insurance, without restriction, to certain persons not otherwise eligible for accident and health insurance because of condition of health. [Sections 62E.11, 12, 13 and 14]

17. The Act also may require all insurers, including members of the Council and named plaintiffs, to share in any losses incurred by the Association as a consequence of the reinsurance by the Association of "qualified plan" coverages written by individual insurers in compliance with Sections 62E.04 and 62E.16. [Section 62E.11, Subd. 5] The Act does not

authorize insurers to recover these losses.

18. The Act also purports to require all insurers, including members of the Council and named plaintiffs, to share in any losses incurred by the Association as a consequence of the issuance by the Association, through the writing carrier or carriers, of policies of accident and health insurance to those persons not previously eligible for accident and health insurance because of condition of health. [Section 62E.10, Subd. 5] The Act unreasonably imposes on insurers and their policyholders, exclusive of the general public and the general revenues of the State of Minnesota, the cost of bearing the resulting losses incurred by the Association. Moreover, the Act does not authorize insurers to recover these losses.

19. The writing of accident and health insurance is a highly technical and specialized field within the insurance industry, requiring special expertise in the writing of policies, the underwriting of policies, the evaluation of health risks, the preparation of applications and the various policy forms required, rate making, the training of agents and other personnel in the writing of this coverage, and in the adjusting of losses.

20. Many insurers, including many members of the Council and some named plaintiffs, do not now possess the technical expertise or the financial resources required to write accident and health insurance on the scale contemplated by the Act. Said insurers must unnecessarily and against their desire spend substantial sums of money in order to attempt to comply with the Act, without any prospect of recovering these developmental costs.

21. Some insurers, including some members of the Council and some named plaintiffs, do have the technical expertise and financial resources to allow them to attempt to comply with the Act. As a consequence of the reinsurance provisions of the Act, however, these insurers will be compelled to absorb losses incurred by other less sophisticated, less efficient and less qualified insurers, without any prospect of recovering these losses. Moreover, even these insurers must unnecessarily and against their desires spend substantial sums of money in attempting to comply with the Act, many of which expenses will be unrecoverable under any circumstances.

Violations of Guarantees of Due Process

22. The Act unlawfully deprives insurers, including members of the Council and named plaintiffs of their property without due process of law in the following manner:

a. By virtue of Section 20 of the Act, Section 62E.04 and each subdivision thereunder as originally enacted purportedly became effective on July 1, 1976. Subdivision 1 purports to require insurers to offer individual "qualified" plans to all eligible applicants for individual coverage. Subdivision 2 purports to require insurers to offer "qualified" medicare supplement plans to each eligible applicant for medical supplement coverage. Subdivision 3 purports to require insurers to offer "qualified" group insurance plans to each eligible applicant for group insurance. Subdivision 4, originally, purported to require the inclusion of major medical coverage in all "unqualified" plans of insurance, unless specifically rejected in writing. Subd. 4, as amended, became effective on June 3, 1977 and purports to require insurers to offer coverage of major medical expenses to applicants for "unqualified" plans and to holders of "unqualified" plans.

b. Section 62E.04, Subd. 5 states:

> "No policy of accident and health insurance may be issued or renewed in this state 180 days after the effective date of this section by an insurer or a fraternal which has not complied with the requirements of this section." (Emphasis added).

c. Plaintiffs believe, and therefore allege that prior to December 28, 1976 many insurers were unable to comply with the provisions of § 62E.04. Moreover, many insurers that did comply, either before or after December 28, 1977 did so by offering "qualified" plans which were certified as the "actuarial equivalent" of "qualified" plans pursuant to § 62E.02, Subd. 4.

d. Many plans certified as "actuarial equivalent" plans contained out-of-pocket expense limitations in excess of $3,000 or maximum lifetime benefits less than $250,000. However, by virtue of § 62E.06, Subd. 1(a) as amended as of June 3, 1977:

> "The $3,000 limitation on total annual out-of-pocket expenses and the $250,000 maximum lifetime benefit shall not be subject to change or substitution by use of an actuarily equivalent benefit."

e. The Act deprives insurers, including members of the Council and named plaintiffs of their property without due process of law to the extent that it prohibits insurers from issuing or renewing policies in Minnesota:

(1) Where the insurer was unable to comply with the provisions of § 62E.04 prior to December 28, 1976;

(2) Where the insurer was able to comply prior to June 3, 1977 but did so by utilizing actuarial equivalent plans that allowed a limitation in excess of $3,000 per person on total annual out-of-pocket expenses and/or a maximum lifetime benefit of less than $250,000.

(3) Where the insurer ceases to issue new policies, but is contractually committed to continue in force policies issued prior to July 1, 1976 which are "guaranteed renewable" or "non-cancellable" or policies referred to in paragraph 30, infra.

(4) Without the right or opportunity to have its right to do accident and health insurance business reinstated or continued upon compliance with the Act at a later date.

23. The Act unlawfully deprives insurers, including members of the Council and named plaintiffs of their property without due process of law in the following manner:

a. Section 62E.8, Subd. 1 as amended provides that the premium to be charged for membership in the comprehensive health insurance plan [hereinafter "state plan"] shall be, for the first eighteen months of operation, ". . . the average of rates charged by the five insurers with the largest number of individuals . . ." in each of the various "qualified" plans. Subdivision 2 as amended provides that for subsequent enrollees or renewals of membership, the schedule of premiums "shall be designed to be self-supporting and based on generally accepted actuarial principles."

b. By basing the state plan premium on an average of premiums charged to fully insurable persons, and by compelling insurers, including all members of the Council and named plaintiffs, unreasonably to bear the losses generated by the operation of the state plan, implementation of the Act will cause all insurers to incur losses and will illegally deprive them

of their assets and property. The rates to be charged for the first eighteen months' operation of the state plan will be confiscatory. Furthermore, to the extent that the state plan is operated in subsequent years with premium rates that will be acceptable to the public, it will necessarily continue to be confiscatory.

c. The Act will require insurers, including members of the Council and named plaintiffs to apply income received from nonresidents of Minnesota for the benefit of Minnesota residents.

24. The Act unlawfully deprives insurers, including members of the Council and named plaintiffs, of their property without due process of law by depriving those insurers who currently have in force guaranteed renewable and non-cancellable policies of accident and health insurance of the right to exercise the independent business decision to cease doing new business in Minnesota to the extent that Section 62E.04, purports to require those insurers with "unqualified", guaranteed renewable or non-cancellable policies in force to offer "qualified" plans or major medical coverage whether or not said insurers have ever issued said coverages and whether or not said insurers have any desire or ability to do so.

25. The Act purports to regulate the group insurance business of insurers, including members of the Council and named plaintiffs, that is conducted beyond the territorial jurisdiction of the State of Minnesota and thereby deprives said insurers of their property without due process of law.

26. In many respects the Act is so vague, ambiguous, unclear and uncertain that insurers, including members of the Council and named plaintiffs, cannot reasonably understand their purported duties under the Act or how its operation will affect them. Enforcement of the Act will thus deprive insurers, including members of the Council and named plaintiffs of their property without due process of law. The following are the most serious unlawfully vague provisions of the Act:

a. Section 62E.04, Subd. 5 which became effective on July 1, 1976, provides:

> "No policy of accident and health insurance may be issued or renewed in this state 180 days after the effective date of this section

by an insurer or fraternal which has not complied with the requirements of this section."

As previously alleged in paragraph 8, supra, the Act was subsequently amended in several material respects in 1977, but Section 62E.04, Subd. 5 was not amended. It is therefore unclear at what point in time policies of accident and health insurance can no longer be issued or renewed by insurers that have not complied with the provisions of Section 62E.04 as amended.

b. The Act, as amended, is unclear as to whether or not an insurer can comply with the provisions of § 62E.04, Subd. 4 by offering coverage that is the actuarial equivalent of the major medical coverage referred to therein.

c. Section 62E.04, Subd. 6 relating to reinsurance of mandated coverage is in apparent conflict with Section 62E.10, Subd. 7, clauses (e) and (f) relating to acceptance of reinsurance by the Association.

d. In an effort to give insurers guidance with respect to compliance with the Act, the Commissioner has issued "Circular Letters" which purport to answer questions relating to the Act. However, evidently because of the time required to promulgate rules and regulations under the Minnesota Administrative Procedures Act, the Commissioner has not adopted formal rules or regulations. Consequently, insurers have no legally enforceable guidelines upon which they can rely in dealing with the insuring public when attempting to comply with the vague and indefinite provisions of the Act.

Violation of Guarantees Against Impairment of Contract

27. Pursuant to § 62E.04, Subds. 1, 2 and 3, insurers must offer "qualified" plans of accident and health insurance to each eligible applicant for such insurance. Pursuant to § 62E.04, Subd. 4, as amended, insurers must offer coverage of major medical expenses to every applicant for each new "unqualified" policy at the time of application and annually to every holder of an "unqualified" policy of accident and health insurance.

28. Section 62E.04 originally became effective on July 1, 1976. [§ 20 of the Act]

29. Prior to July 1, 1976, many insurers, including members of the

Council and named plaintiffs, issued various forms of accident and health insurance policies to residents of Minnesota which said insurers guaranteed to renew. Many of these policies are "unqualified" policies and do not include major medical coverage. Said policies include two distinct types:

a. policies, commonly termed "non-cancellable" or "guaranteed renewable, non-cancellable" which must be renewed by the insurer upon payment of the applicable premium and where the insurer has no power to either refuse to renew the policy or to change the premium;

b. policies commonly termed "guaranteed renewable" wherein the insurer must renew the policy upon payment of the applicable premium, and the insurer may not refuse to renew the policy, but may increase the policy premium on a class basis.

30. Prior to July 1, 1976 many insurers, including members of the Council and named plaintiffs, issued various other forms of accident and health insurance policies to residents of Minnesota, the terms of which prohibit the insurers from refusing to renew said policies on an individual basis. These policies must be renewed upon payment of the applicable premium, (which can be changed on a class basis) unless the insurer elects to non-renew all policies of the same class.

31. The policies referred to in paragraphs 29 and 30, supra, constitute continuing contracts. Insurers issuing such policies do not have the unrestricted right to terminate any of said policies.

32. Pursuant to the terms of the "non-cancellable" policies and the "guaranteed renewable" policies referred to in paragraph 29, supra, and the policies referred to in paragraph 30, supra, the issuing insurer has a contractual obligation to renew said policies but has no contractual obligation to offer new, increased or additional coverages. To the extent that § 62E.04 purports to require said insurers to offer "qualified" plans or major medical coverage when said policies are renewed, the Act, as amended, unlawfully interferes with and impairs these existing contractual obligations.

33. Pursuant to the terms of the "non-cancellable" policies and "guaranteed renewable policies" referred to in paragraph 29, supra, and the policies referred to in paragraph 30, supra, the insured has a contractual

right to have his policy renewed by the issuing insurer. To the extent that § 62E.04, Subd. 5 prohibits insurers who cannot, do not, or have not complied with the provisions of § 62E.04 from renewing said policies, the Act unlawfully interferes with and impairs the existing contractual rights of insurers and insureds. Furthermore, to the extent that § 62E.10, Subd. 3 prohibits insurers that fail to maintain membership in the Association from renewing said policies, the Act unlawfully interferes with and impairs the existing contractual rights of insurers and insureds.

Summary of Count I Constitutional Violations

34. The Act is null, void and unconstitutional for the following reasons, among others:

a. It unlawfully, arbitrarily and unreasonably interferes with the rights of insurers, including members of the Council and named plaintiffs, to transact the business of writing accident and health insurance and wrongfully deprives insurers, including members of the Council and named plaintiffs of their property, all in violation of the due process clause of the Fourteenth Amendment to the United States Constitution and Article I, Section 7 of the Constitution of Minnesota.

b. It unlawfully impairs obligations of contract of accident and health insurers, including members of the Council and named plaintiffs, in violation of Article I, Section 10 of the United States Constitution and Article I, Section 11 of the Minnesota Constitution.

c. It unlawfully regulates activities of insurers, including activities of members of Council and named plaintiffs, beyond the territorial jurisdiction of the State of Minnesota in violation of the due process clause of the Fourteenth Amendment to the United States Constitution.

d. It unlawfully conditions the right of any accident and health insurer, including members of the Council and named plaintiffs, to write any form of insurance on compliance with requirements that are so vague, indefinite and uncertain that no insurer can know what its rights or obligations are under the Act or how it will be affected by its operation, in violation of the due process clause of the Fourteenth Amendment to the United States Constitution

and Article I, Section 7 of the Minnesota Constitution.

COUNT II

35. Realleges each of the allegations contained in the preceding paragraphs.

36. Chapter 142, Minnesota Statutes, 1976 was enacted April 3, 1976 and purportedly became effective on August 1, 1976. A copy of said Chapter is attached hereto as Exhibit "B" and is hereby incorporated by reference.

37. Section 1, Chapter 142 purports to amend Minnesota Statutes, 1974, Section 62A.16 by making the provisions of Sections 62A.16 and 62A.17 applicable "to all group insurance policies . . . providing coverage for hospital or medical expenses incurred by a Minnesota resident employed within this state."

38. Section 3 of Chapter 142 added a subdivision 6 to Minnesota Statutes 1974, Section 62A.17. Said subdivision generally purported to require insurers to offer a guaranteed renewable individual policy of insurance upon termination of employment to certain covered employees, their spouses and dependants who had previously been covered by group accident and health insurance policies which were issued to the employers.

39. Chapter 409, Minnesota Statutes was enacted and purportedly became effective on June 3, 1977. A copy of said Chapter has been attached hereto as Exhibit "A-2" and is hereby incorporated by reference.

40. Section 2 of Chapter 409 purports to amend subdivision 6 of Minnesota Statutes 1976, Section 62A.17. Subdivision 6 as amended, generally purports to require insurers to offer a number one, two and three "qualified" plan of insurance to certain covered employees, their spouses and dependants who had previously been covered by group accident and health insurance policies which were issued to the employers, regardless of the type of the basic group policy. Group conversion policies must generally be renewable at the option of the insured until age 65, regardless of the renewability features of the basic group policy.

41. Many insurers, including members of the Council and named plaintiffs issue group policies of accident and health insurance outside the

State of Minnesota to entities outside the State of Minnesota. Said policies are already regulated by the States where issued. Chapter 142, as amended by Chapter 409, also purports to regulate these contracts of insurance when any individual covered by said policy is employed in and is a resident of Minnesota in violation of the due process clause of the Fourteenth Amendment to the United States Constitution.

Summary of Count II Constitutional Violations

42. Chapter 142, as amended by Chapter 409, is null, void and unconstitutional for the following reasons, among others:

a. It unlawfully, arbitrarily and unreasonably interferes with the rights of insurers, including named plaintiffs and members of the Council, to transact the business of writing accident and health insurance and wrongfully deprives insurers, including named plaintiffs and members of the Council, of property, all in violation of the due process clause of the Fourteenth Amendment to the United States Constitution and Article I, Section 7 of the Minnesota Constitution.

b. It unlawfully attempts to regulate activities of insurers, including activities of the named plaintiffs and members of the Council, beyond the territorial jurisdiction of the State of Minnesota in violation of the due process clause of the Fourteenth Amendment to the United States Constitution.

Irreparable Injury

43. Unless enforcement of the Act and Chapter 142, as amended, is enjoined, insurers, including all members of the Council and all named plaintiffs will be irreparably injured in the following ways, among others:

a. They will be forced to spend substantial sums of money to attempt to comply without being able to recover these investment costs.

b. They will be forced to incur substantial losses without any prospect of recovering these losses.

c. They will risk losing the right to do any further business in the State of Minnesota.

d. They may be subjected to a multiplicity of lawsuits of substantial size by current policy holders.

44. Insurers, including all members of the Council and all named plaintiffs, have no adequate remedy at law.

WHEREFORE, plaintiff prays that:

1. The Act as amended be declared unconstitutional and of no force and effect;

2. The implementation and enforcement of all provisions of the Act as amended be permanently enjoined;

3. Chapter 142 as amended be declared unconstitutional and of no force and effect;

4. The implementation and enforcement of all provisions of Chapter 142 as amended be permanently enjoined;

5. In the alternative, if the Act as amended or Chapter 142 as amended, or any parts thereof are found to be valid, that the Court declare and order:

a. That the Act, as amended does not apply to any policy of accident and health insurance wherein the insurer does not have the unilateral right to refuse to renew the policy on an individual basis, including policies that are (1) non-cancellable, (2) guaranteed renewable, and (3) non-renewable by class.

b. That the Act as amended allows insurers to utilize the concept of actuarial equivalence in complying with the provisions of Section 62E.04, Subdivisions 1, 2, 3 and 4, but that compliance cannot be compelled until at least 180 days after the Commissioner, by rule, establishes an acceptable actuarial equivalent outline.

c. That insurers that do no more than renew policies of accident and health insurance issued prior to July 1, 1976 need not join the Association.

d. That insurers are permitted to raise their Minnesota premium rates in an amount sufficient to offset any assessments by the Association even if said increased premiums bear no relation to the benefits contained in the policies on which premium rates are raised.

e. That neither the Act as amended nor Chapter 142 as amended applies to policies of accident and health insurance issued outside of Minnesota

to a person or entity that neither resides in nor has its principal place of business in Minnesota.

f. That the Association must accept reinsurance of:

(1) Individual "qualified" plans, regardless of the age of the individual insureds;

(2) Group conversions, regardless of the age of the converting insured or the size of the group from which the insured converts;

(3) Qualified medicare supplement plans; and

(4) Major medical coverage issued pursuant to § 62E.04, Subd. 4, regardless of the age of the individual insureds.

and

6. The Court order such other relief as may be appropriate.

DOHERTY, RUMBLE & BUTLER

By Frank Clayborne (RJS)
Frank Clayborne

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#513 Dept of Commerce
Insurance Division

RULES REVIEW CHECKLIST

DATE RULES RECEIVED 3-16 Temporary Rule _____

Resubmitted and Received _____

DUE DATE 4-5

a. Returned to Agency w/o filing w/Secy of State 4-3
b. Approved 4-2 Date Sent Back to Agency _____

- -

•1. Rules as Adopted ✓
•2. Rules as Proposed ✓
3. Certificate of Board's Authorizing Resolution, where applicable N.A.
•4. Order for Hearing ✓
•5. Notice of Hearing ✓
•(i) Sufficiency ✓
•6. Secretary of State's List ✓
•7. Certificate of Acquisition of Secretary of State's List ✓
•8. Affidavit of Mailing ✓
•(i) At least 30 days prior to hearing ✓
•9. Statement of Need and Evidence ✓ Satisfied
•10. Hearing Examiner's Report ✓
•11. Agency's Findings of Fact ✓
•12. Certificate of Board's Resolution Adopting Rules, where applicable [redacted] ✓ ? See M.S. § 45.021
•13. Order Adopting ✓
14. Report of Chief Hearing Examiner ✓
(i) Finding of No Substantial Change ✓
(ii) Permission to Incorporate by Reference, where applicable N.A.
•15. Certificate of Compliance with Rulemaking Procedures ✓
16. Copy of Notice of Intent to Solicit Outside Opinion, where applicable N.A.
17. Petition by Public, where applicable N.A.

STATEMENT OF COMPLIANCE WITH
MANUAL OF RULEMAKING PROCEDURES

I, Special Assistant Attorney General William R. Howard, do hereby declare that I have examined the proposed rules and all related documents and that based on them and my personal familiarity with the applicable procedures, the manual of rule-making procedures has been followed.

Dated: March 2, 1979.

William R. Howard

WILLIAM R. HOWARD
Special Assistant
Attorney General

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE BERTON W. HEATON

COMMISSIONER OF INSURANCE

In the Matter of the Proposed Rules of the Minnesota Department of Commerce, Insurance Division, Relating to the Comprehensive Health Insurance Act, Minn. Stat. ch. 62E

ORDER FOR HEARING

IT IS HEREBY ORDERED that a public hearing on the above-captioned rules be held in the hearing room at 500 Metro Square Building, Seventh and Robert Streets, Saint Paul, Minnesota, on November 1, 1978, commencing at 9:30 a.m., and continuing until all persons have had an opportunity to be heard.

IT IS FURTHER ORDERED that a Notice of Hearing be mailed to all persons or representatives of associations or other interested groups who registered their names with the Secretary of State for that purpose.

IT IS FURTHER ORDERED that the Notice of Hearing be published in the State Register.

Berton W. Heaton

BERTON W. HEATON
Commissioner of Insurance

Dated: September 11, 1978.

STATE OF MINNESOTA)
)ss.
COUNTY OF RAMSEY)

AFFIDAVIT OF SERVICE

Mae V. Wilson, Senior Clerk Stenographer, being first duly sworn, deposes and says:

That on the 29th day of September, 1978, at the City of Saint Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Hearing by depositing in the United States mail, or in the case of State employees, in the inter office mail, at said City of Saint Paul, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the attached Certificate of the Secretary of State as well as to all persons listed on the attached sheets as presently being members of the Minnesota Comprehensive Health Association, members of the Minnesota Legislature, and persons listed on the Insurance Division List and on the Life and Health Section Courtesy List.

Mae V. Wilson

Subscribed and sworn to before me
this 2nd day of October, 1978.

Audrey S. Ostergren

AUDREY S. OSTERGREN
Notary Public, Ramsey Co., Minn.
My Commission Expires
Sept. 30, 1982

STATE OF MINNESOTA)
)ss.
COUNTY OF RAMSEY)

AFFIDAVIT OF RECEIPT OF MAILING LIST

John Gross, being first duly sworn, deposes and says:

1. That he is employed by the Department of Commerce, Insurance Division, as a life and health policy forms analyst.

2. That on September 26, 1978, he did personally receive from the Office of the Secretary of State the Secretary of State's Mailing List of persons who had requested notification of proposed rules hearings to be held by the Department of Commerce, Insurance Division.

FURTHER AFFIANT SAYETH NOT.

John L. Gross

Subscribed and sworn to before me
this 2nd day of October, 1978.

Audrey S. Ostergren

AUDREY S. OSTERGREN
Notary Public, Ramsey Co., Minn.
My Commission Expires
Sept. 30, 1982

STATE REGISTER

STATE OF MINNESOTA

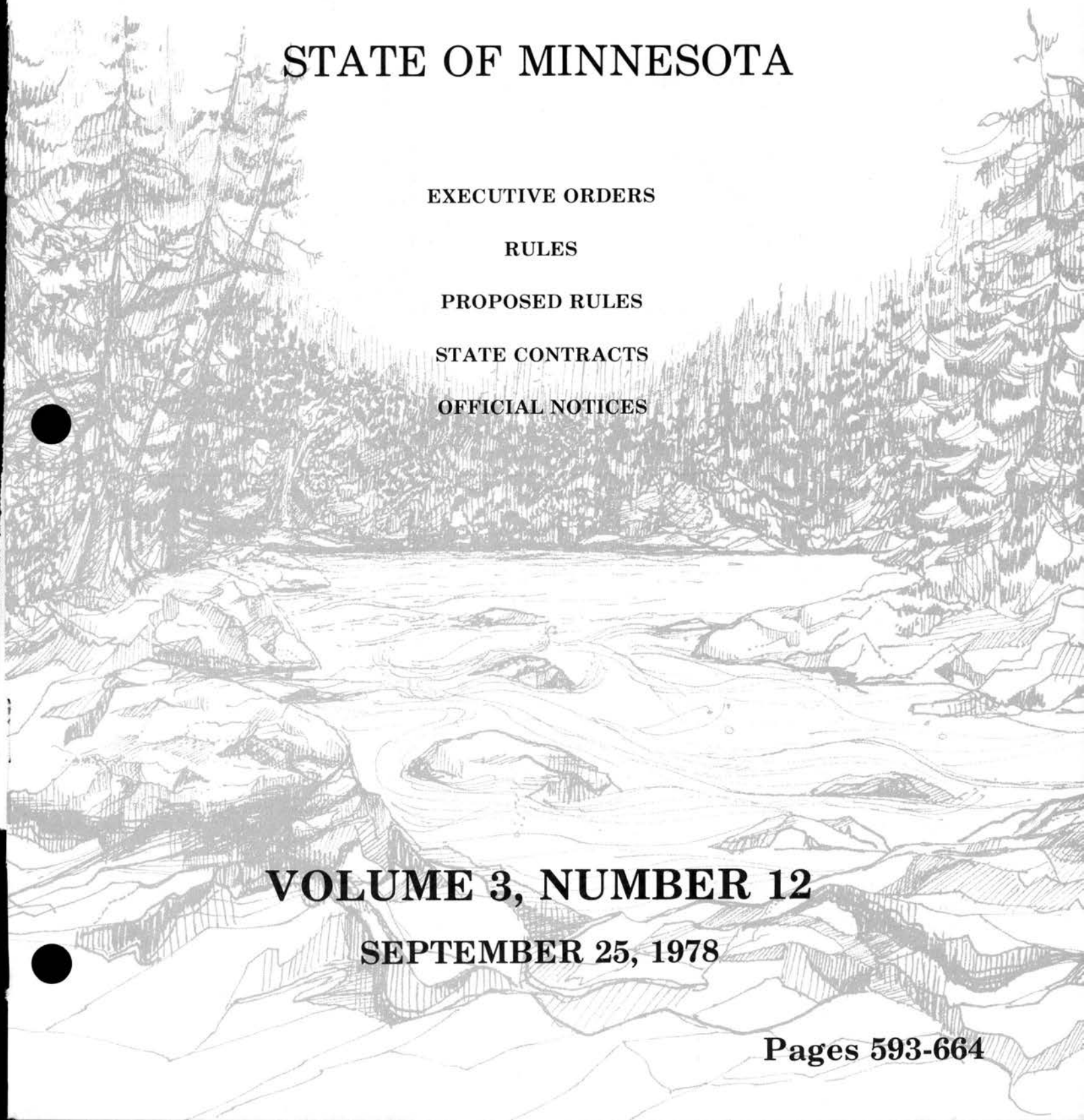
EXECUTIVE ORDERS

RULES

PROPOSED RULES

STATE CONTRACTS

OFFICIAL NOTICES



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SEPTEMBER 25, 1978

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STATE REGISTER

Printing Schedule for Agencies

Issue Number	*Submission deadline for Executive Orders, Adopted Rules and Proposed Rules	*Submission deadline for State Contract Notices and other **Official Notices.	Issue Date
	SCHEDULE FOR VOLUME 3		
13	Monday Sept 18	Monday Sept 25	Monday Oct 2
14	Monday Sept 25	Monday Oct 2	Monday Oct 9
15	Monday Oct 2	Monday Oct 9	Monday Oct 16
16	Monday Oct 9	Monday Oct 16	Monday Oct 23
17	Monday Oct 16	Monday Oct 23	Monday Oct 30

*Deadline extensions may be possible at the editor's discretion; however, none will be made beyond the second Wednesday (12 calendar days) preceding the issue date for rules, proposed rules and executive orders, or beyond the Wednesday (5 calendar days) preceding the issue date for official notices. Requests for deadline extensions should be made only in valid emergency situations.

**Notices of Public Hearings on proposed rules are published in the Proposed Rules section and must be submitted two weeks prior to the issue date.

Instructions for submission of documents may be obtained from the Office of the State Register, Suite 415, Hamm Building, 408 St. Peter Street, St. Paul, Minnesota 55102.

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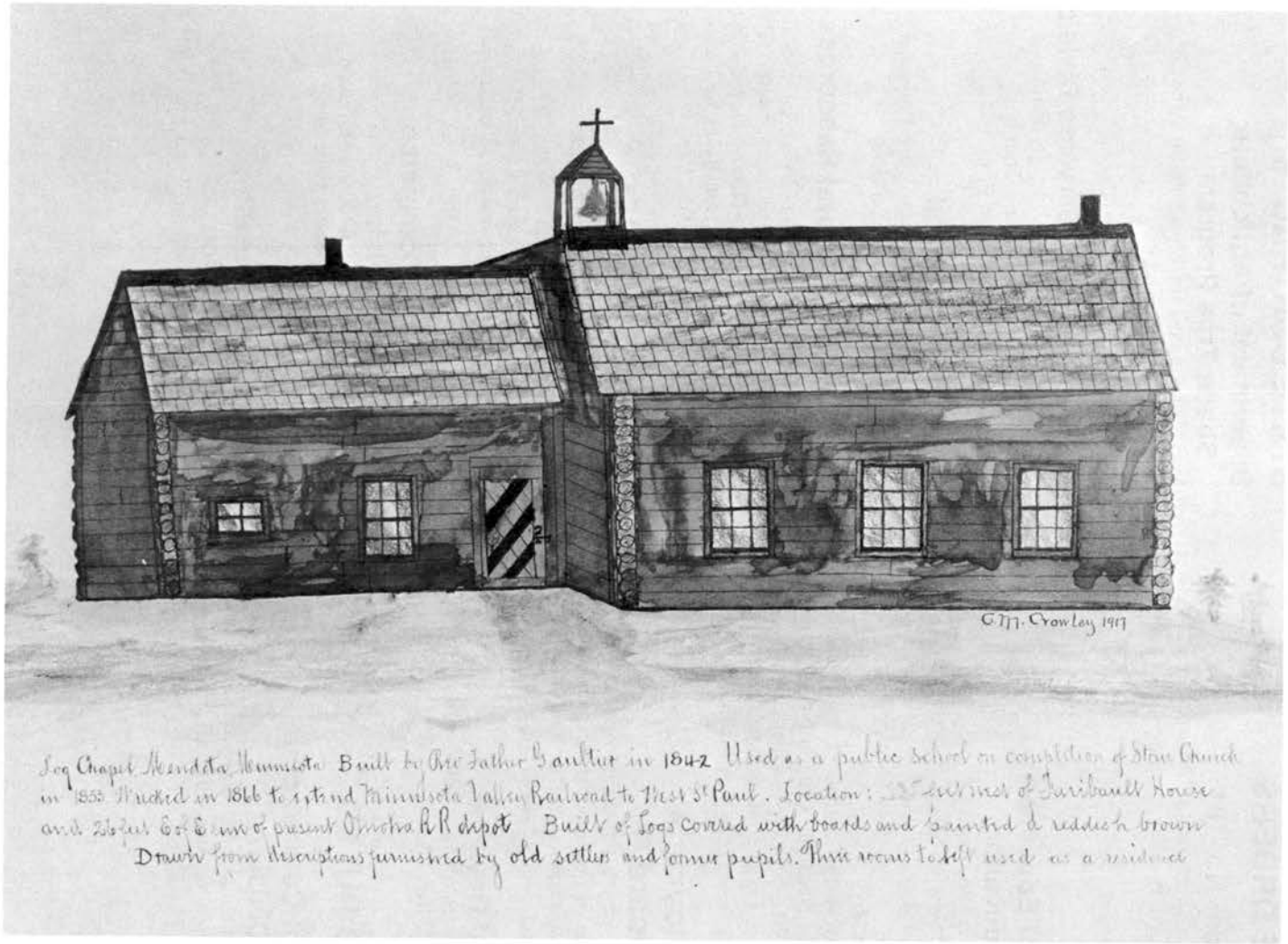

This log chapel was replaced by the brick Mendota Church when its congregation outgrew it in 1853. The oldest operating church in Minnesota, Mendota Church was rededicated on Sunday, September 24. (Courtesy of The Catholic Historical Society of St. Paul housed in the John Ireland Memorial Library at The Saint Paul Seminar)

MCAR AMENDMENTS AND ADDITIONS

The following is a listing of all proposed and adopted rules published in this issue of the *State Register*. The listing is arranged in the same order as the table of contents of the *Minnesota Code of Agency Rules* (MCAR). All adopted rules published in the *State Register* and listed below amend the rules contained in the MCAR set. Both proposed temporary and adopted temporary rules are listed here although they are not printed in the MCAR due to the short term nature of their legal effectiveness. During the term of their legal effectiveness, however, adopted temporary rules do amend the MCAR. A cumulative listing of all proposed and adopted rules in Volume 3 of the *State Register* will be published on a quarterly basis and at the end of the volume year.

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EXECUTIVE ORDERS

Executive Order No. 181

Providing for the Establishment of a Governor's Task Force on Poverty

I, Rudy Perpich, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, more than 400,000 of Minnesota's citizens are poor; and,

Whereas, the causes which place a person or a family in poverty are usually multiple, reflective of racial discrimination, fixed incomes, age, poor health, limited mobility, employment barriers, and other related factors; and,

Whereas, public policies and systemic policies directly affect the well-being of the poor;

Now, therefore, I order:

1. Creation of a Governor's Task Force on Poverty, consisting of 15 members, representative of a broad spectrum of Minnesota citizens and citizen groups.

a. The Commissioner, Minnesota Department of Economic Security, is designated as my representative on the Task Force.

b. The Commissioner, Department of Finance, and the Director, State Planning Agency, shall be ex-officio members and shall act as special resources to the Task Force.

c. All departments and agencies shall make available to the Task Force, upon request, policy and public information related to programs where such affect the poor.

d. Terms of the members shall be one year.

2. The purpose of the Task Force is to review existing state policies affecting the poverty populace to recommend ways to correct the policies that have adverse effect upon them, and to propose to me directions to be taken in state policy development where positive or specific anti-poverty policies do not exist.

3. The Minnesota Department of Economic Security shall provide staff support and shall act as fiscal agent for the Task Force. Pursuant to Minn. Stat. §§ 4.07 and 7.09 (1976), and related statutes, the Task Force may apply for, accept, and utilize any public or private funds to fulfill its responsibilities under this order. The Department of Economic Security is designated as the lead agency and as such may, pursuant to Minn. Stat. § 4.07 (1976), apply for, accept, and expend federal funds available to fulfill its responsibilities under this order.

4. The Task Force shall supply reports to the Governor on a quarterly basis.

Pursuant to Minn. Stat. § 4.035 (1977 Supp.), this order shall be effective 15 days after its

publication in the *State Register* and shall remain in effect until it is rescinded by proper authority or it expires in accordance with Minn. Stat. § 4.035 or § 15.0593 (1977 Supp.)

In testimony whereof, I hereunto set my hand on this 7th day of September, 1978.



RULES



The Oliver H. Kelley Farm is known as the "birthplace of organized agriculture in the United States." Kelley began homesteading in 1850 and organized the National Grange of the Order of the Patrons of Husbandry in 1867. He served as the Grange's executive secretary from 1870 to 1878. The Grange restored the farm in the 1950s and donated it to the Minnesota Historical Society, which plans to develop it as a working farm of the 1860-70 era. It is located two miles southeast of Elk River on U.S. Highways 169, 10 and 52. (Drawing by Ron Hunt reprinted, with permission, from *A Living Past: 15 Historic Places in Minnesota*, copyright 1973, 1978 by Minnesota Historical Society)

The adoption of a rule becomes effective after the requirements of Minn. Stat. § 15.0412, subd. 4, have been met and five working days after the rule is published in the *State Register*, unless a later date is required by statutes or specified in the rule.

If an adopted rule is identical to its proposed form as previously published, a notice of adoption as proposed and a citation to its previous *State Register* publication will be printed.

If an adopted rule differs from its proposed form, language which has been deleted will be printed with strike outs and new language will be underlined, and the rule's previous *State Register* publication will be cited.

A temporary rule becomes effective upon the approval of the Attorney General as specified in Minn. Stat. § 15.0412, subd. 5. Notice of his decision will be published as soon as practicable, and the adopted temporary rule will be published in the manner provided for adopted rules under subd. 4.

Department of Education Board of Education

Adopted Rules Governing Issuance and Renewal of Licenses for School Superintendents and Principals

The rules in regard to the issuance and renewal of licenses for school superintendents and principals, 5 MCAR §§ 1.0552-1.05599, have been adopted and are identical to their proposed form as published in the *State Register*, Volume 2, Number 33, pp. 1540-1548, February 20, 1978 (2 S.R. 1540) with the following amendments:

Rules as Adopted

Chapter Twenty-Eight Issuance and Renewal of Licenses for School Superintendents and Principals

5 MCAR § 1.0553 C. The task force shall consist of ~~eleven~~ fourteen voting and ~~two~~ one nonvoting members as follows:

1. Two elementary school principals;

2. Two secondary school principals;

3. Two school superintendents;

4. One practicing classroom teacher;

5. Two administrators or faculty members in education from colleges with approved school administration programs;

6. One member of a Minnesota school board;

7. One individual employed outside education who has an executive or management position with a level of responsibility similar to that of a superintendent in a large school district;

8. Two members of the public;

9. ~~Two nonvoting members from the department of education staff.~~ One student representative from an approved Minnesota program in school administration;

10. One nonvoting member from the state department of education staff.

5 MCAR § 1.0554 A. Entrance license.

1. Requirements must be met for each administrative area where licensure is sought. An entrance license ~~may be~~ shall be issued to an applicant who has met all of the following requirements. An applicant must:

a. Have had three years of ~~classroom~~ teaching experience while holding licenses valid for the position or positions in which the experience was gained. Elementary school principals must have at least three years of teaching experience ~~in one or more grades, kindergarten through 6.~~ at the elementary level. Secondary school principals must have at least three years of teaching experience ~~in one or more grades, 7 through 12.~~ at the secondary level. Superintendents of schools must have at least three years of teaching experience ~~in one or more grades, kindergarten through 12.~~ at the elementary or secondary level.

b. Complete a specialist or doctoral program, or a program consisting of a master's degree plus 45 quarter credits, in the administrative area for which licensure is sought. Each program to be approved by the commissioner of education must:

(1) Be offered at a regionally accredited Minnesota graduate school.

(2) Include a field experience ~~as follows:~~. Persons taking part in field experiences shall not replace required licensed principals or superintendents.

(a) Programs which prepare elementary school principals and assistant principals must include at least 200 clock hours of field experience, or equivalent, in an elementary school as an administrative aide to a licensed and practicing elementary school principal, or in an administrative placement with a licensed educational administrator appropriate for the elementary school principalship and for the individual. The 200 clock hours must be completed within 12 continuous months from the commencement of the field experience.

(b) Programs which prepare secondary school principals and assistant principals must include at least 200 clock hours of field experience, or equivalent, in a secondary school as an administrative aide to a licensed and practicing secondary school principal, or in an administrative placement with a licensed educational administrator appropriate for the secondary school principalship and for the individual. The 200 clock hours must be completed within 12 continuous months from the commencement of the field experience.

(c) Programs which prepare superintendents of schools and assistant superintendents must include at least 200 clock hours of field experience, or equivalent. The field experience shall be in an administrative placement with a licensed educational administrator appropriate for the superintendency and for the individual. The 200 clock hours must be completed within 12 continuous months from the commencement of the field experience.

B. Continuing license.

1. The first continuing license ~~may be~~ shall be issued to an applicant who has met all of the following requirements. An applicant must:

a. Hold, or have held, an entrance license in the administrative area for which the continuing license is requested.

KEY: RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language. **PROPOSED RULES SECTION** — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material."

b. Provide evidence of at least one year of experience in the administrative area for which the continuing license is requested while holding an entrance license or a one-year, nonrenewable entrance license for that administrative area.

2. The second and subsequent continuing licenses ~~may be~~ shall be issued to an applicant who has met ~~both of~~ the following requirements during the term of the continuing license which is expiring. An applicant must:

a. Provide evidence to the office of the Commissioner of Education of the completion of at least 125 clock hours of approved administrative continuing education.

b. Provide a record, to be on file in the central office of the employing school district or agency, of the completion of at least 75 hours of individual professional development activity related to school administration.

c. In the first five years following the effective date of this chapter, clock hours of approved administrative continuing education and clock hours of individual professional development activity shall be required as follows:

(1) Twenty-five clock hours of approved administrative continuing education and fifteen clock hours of individual professional development activity for renewal of licenses expiring June 30, 1979.

(2) Fifty clock hours of approved administrative continuing education and thirty clock hours of individual professional development activity for renewal of licenses expiring June 30, 1980.

(3) Seventy-five clock hours of approved administrative continuing education and forty-five clock hours of individual professional development activity for renewal of licenses expiring June 30, 1981.

(4) One hundred clock hours of approved administrative continuing education and sixty clock hours of individual professional development activity for renewal of licenses expiring June 30, 1982.

(5) One hundred twenty-five clock hours of approved administrative continuing education and seventy-five clock hours of individual professional development activity for renewal of licenses expiring June 30, 1983.

d. In the first five years following the effective date of this Chapter, renewal units which are earned toward administrative relicensure may be allocated toward clock hours of administrative continuing education. For every one renewal unit earned and verified by the local committee for continuing education, one clock hour of administrative continuing education shall be granted. Provisions B.2.c. and B.2.d. of 5 MCAR § 1.0554 shall remain in effect until July 1, 1983, at which time provisions B.2.c. and B.2.d. shall be repealed without further action by the Board of Education.

Energy Agency

Adopted Rules Governing Contents of Applications for Certificates of Need and Criteria for Assessment of Need for Large Liquefied Gas Storage Facilities, Large Underground Gas Storage Facilities, and Large Gas Pipelines

The proposed rules published at *State Register*, Volume 2, Number 33, pp. 1548-1559, February 20, 1978 (2 S.R. 1548-1559), are adopted as of July 28, 1978. The rules are identical to their proposed form, with the following amendments:

Rules As Adopted

EA 703 Applicability of rules.

A. A petroleum supplier applying for a certificate of need to construct a large liquefied petroleum gas storage facility or large liquefied petroleum gas pipeline shall apply under Minn. Regs. EA 1001 *et seq.*; an energy user shall apply under 6 MCAR § 2.0801 *et seq.*

B. Each utility or pipeline company applying for a certificate of need to construct one of the following types of large energy facilities shall provide all information required by these rules:

1. a new large liquefied gas storage facility;

2. a new large underground gas storage facility;

3. a new large gas pipeline;

4. any project which, within a period of 2 years, would expand the liquefied gas storage capacity of an existing large liquefied gas storage facility in excess of either 20% of capacity or 100,000 gallons, whichever is greater;

5. any project which, within a period of 2 years, would expand the capacity of an existing large gas pipeline in excess of either 20% of rated design throughput or 17,000 Mcf per day (or equivalent Mcf per day), whichever is greater; and

6. any project which, within a period of 2 years, would expand the capacity of an existing large underground gas storage facility in excess of 20% of capacity.

C. Exceptions.

1. Any person who as of the effective date of these rules has begun or has completed construction of a large energy facility shall not be subject to these rules for that facility.

2. An interstate pipeline requiring a certificate of public convenience and necessity from the Federal Energy Regulatory Commission shall not be subject to these rules.

EA 704 Application procedures and timing.

E. A hearing examiner shall be assigned, and a public hearing shall be scheduled to commence no later than eighty days after the receipt of the application, in accordance with Minnesota Energy Agency Rules of Procedure Governing Certificate of Need Program, Minn. Regs. EA 500 *et seq.*, and the Hearing Examiner Rules for Contested Case Procedures, Minn. Regs. HE 201 *et seq.*

H. Prior to the submission of an application, a person shall ~~may~~ be exempted from any data requirement of these rules upon a written request to the director for exemption from specified rules and a showing by that person in the request that the data requirement (1) is unnecessary to determine the need for the proposed facility or (2) may be satisfied by submission of another document. A request for exemption must be filed at least 20 days prior to submission of an application. The director shall respond in writing to each such request within 15 days of receipt including reasons for the decision. The director shall file a statement of exemptions granted and reasons therefor prior to commencement of the hearing.

Public Employment Relations Board

Adopted Rules Governing Fair Share Appeal Procedures, Code of Professional Responsibility for Arbitrators, Arbitrator Selection and Compensation and Board Appeal Procedures

The rules proposed and published at *State Register*, Volume 2, Number 17, October 31, 1977, pp. 931-933 (2 S.R. 933) are adopted and are identical to their proposed form, with the following amendments:

Rules as Adopted

PERB 41 Professional responsibility. In arbitrating disputes concerning terms and conditions of employment pursuant to Minn. Stat. § 179.72, arbitrators shall conform to the standards and procedures set forth in the Code of Professional Responsibility for Arbitrators of Labor-Management Disputes as approved by the ~~Joint Steering Committee of the~~ National Academy of Arbitrators, American Arbitration Association, and Federal Mediation and Conciliation Service on April 28, 1975, incorporated herein by reference, to the extent not inconsistent with the provisions of the Public Employment Labor Relations Act ~~and~~ , PERB 30-40~~.~~ , or other applicable law or rule, provided that:

A. Part 5(B)(1)(c), paragraph 112, of the Code of Professional Responsibility should not be construed as limiting the right of the parties to order a copy of the hearing transcript; and

B. Part 6(A)(1)(b), paragraph 124, of the Code of Professional Responsibility should not be construed as limiting the right of the parties to submit written briefs to the arbitrator.

PERB 55 Professional responsibility. In arbitrating grievances pursuant to Minnesota Statutes, section 179.70, arbitrators shall conform to the standards and procedures set forth in the Code of Professional Responsibility for Arbitrators of Labor-Management Disputes as approved by the ~~Joint Steering Committee of the~~ National Academy of Arbi-

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trators, American Arbitration Association, and Federal Mediation and Conciliation Service on April 28, 1975, incorporated herein by reference, to the extent not inconsistent with the provisions of the Public Employment Labor Relations Act ~~and~~ , PERB 50-54~~.~~ , or other applicable law or rule, provided that:

A. Part 5(B)(1)(c), paragraph 112, of the Code of Professional Responsibility should not be construed as limiting the right of the parties to order a copy of the hearing transcript; and

B. Part 6(A)(1)(b), paragraph 124, of the Code of Professional Responsibility should not be construed as limiting the right of the parties to submit written briefs to the arbitrator.

Department of Revenue

Adopted Rules Governing the Administration of the Sales and Use Tax Law

The following rules published at *State Register*, Volume 2, Number 26, pp. 1289-1339, January 2, 1978 (2 S.R. 1289) are adopted and are identical in every respect to the proposed form: Tax S&U 101 Person; Tax S&U 107 Producing, fabricating, printing or processing of property furnished by consumer; Tax S&U 109 Admissions and use of amusement devices; Tax S&U 115 Reduction in sales price for property taken in trade; Tax S&U 117 Deductions allowable in computing sales price; Tax S&U 202 Application for permit to make retail sales; Tax S&U 204 Revocation of permits; Tax S&U 207 Good faith acceptance of exemption certificates; Tax S&U 208 Content and form of exemption certificate; Tax S&U 302 Collection of tax at time of sale; Tax S&U 404 Gifts — transfers without monetary consideration; Tax S&U 408 Property used in agricultural and industrial production; Tax S&U 411 Isolated or occasional sales; Tax S&U 415 Charitable, religious, and educational organizations; Tax S&U 421 Taconite plant construction and expansion exemptions; Tax S&U 422 Senior citizen organizations; Tax S&U 508 Claim for refund; Tax S&U 510 Penalties and interest; Tax S&U 511 Limitations on disclosure of sales and use tax information; Tax S&U 601 Commercial artists and photographers; Tax S&U 604 Sales and rentals of mobile homes and house trailers; Tax S&U 607 Advertising signs and billboards; Tax S&U 609 Iron mining industry exemptions.

The rule published at *State Register*, Volume 2, Number 26, pp. 1289-1293, January 2, 1978 (2 S.R. 1289) is adopted and is identical to its proposed form, with the following amendments:

Tax S&U 104 Leases.

B. Example 1. Rental Agency, located in Minnesota, leases an automobile to "X." Thereafter, "X" drives the automobile to ~~Minnesota~~ California and returns the automobile to Rental Agency's office in Los Angeles, and there pays the total lease charge of $280.00. The lease charge constitutes a sale in Minnesota, and Rental Agency is required to include the entire $280.00 in its gross receipts subject to tax.

G. Leases to electing ~~common~~ motor carrier. Effective July 1, 1971, ~~common~~ motor carriers may elect under provisions of Minn. Stat. § 297A.211 to pay directly to the Commissioner of Revenue the tax due on the leasing of certain mobile transportation equipment and accessories used in interstate commerce. Lessors of such property need not collect the tax from the electing carriers who have been issued a ~~common~~ motor carrier direct pay certificate. See Tax S&U 212 for rules relating to the ~~common~~ motor carrier direct pay certificate and describing the property for which the payment of tax by the lessee may be deferred.

The rule published at *State Register*, Vol. 2, No. 26, p. 1294-1298, January 2, 1978 (2 S.R. 1294) is adopted and is identical to its proposed form, with the following amendment:

Tax S&U 108 Meals and drinks.

H.1. ~~Holes~~ Holds a Minnesota Sales and Use Tax Permit:

The rule published at *State Register*, Volume 2, Number 26, pp. 1299-1304, January 2, 1978 (2 S.R. 1299) is adopted and is identical to its proposed form, with the following amendment:

Tax S&U 112 Sales of building material, supplies or equipment.

C.3. The transfer of building materials by an exempt entity to its contractor for use in connection with a contract for the erection, alteration, repair or improvement of realty is not deemed a retail sale (and is thus exempt from the sales or use tax) provided: (1) the contract is for labor only; (2) all incidents of ownership to the building materials remain in the exempt entity at all times; (3) the contractor bears no responsibility for inherent defects in the building materials; and (4) the contractor bears no risk of loss of any of the building materials.

~~If the~~ An exempt entity, in addition to contracting with a contractor for the erection of a building or the alteration or

repair of real estate, ~~appoints and designates~~ may appoint and designate the contractor as "purchasing agent" for such exempt entity in connection with the construction contract. In such situations the department will recognize the agency relationship asserted only if the written contract clearly sets forth: (1) that such appointment has been made; (2) that title to all materials and supplies purchased pursuant to such appointment shall immediately vest in the owner or principal at point of delivery; (3) that the risk of loss with respect to such materials and supplies is that of the owner or principal; and (4) that the owner or principal, and not the agent, shall have responsibility for all defective materials and supplies, including those incorporated into realty purchased in such manner. In the event that the contract in question does not specify as to risk of loss, other competent evidence, such as insurance coverage, will suffice.

Any contractor who has been appointed agent for the purchase of materials and supplies, as specified above, shall furnish adequate notification to all vendors and suppliers of such agency relationship and shall make it clear to such vendors that the obligation for payment is that of the owner and not the contractor-agent. All purchase orders and other documents furnished to the vendor shall clearly reflect the agency relationship.

The rule published at *State Register*, Volume 2, Number 26, pp. 1304-1305, January 2, 1978 (2 S.R. 1304) is adopted and is identical to its proposed form, with the following amendments:

Tax S&U 116 Deductions not allowable in computing sales price.

A. Example 3. Lumber dealer sells a carload of lumber to a building contractor at an agreed upon price of $8,000 including the cost of transportation. The lumber is to be ordered ~~and shipped from a point out of state~~ and drop-shipped directly to the purchaser. No exclusion or deduction for cost of transportation is allowed even if the purchaser pays the transportation charges directly to the common carrier and deducts the same from the amount due the seller. The delivered price is the "sales price." ~~The "time of sale" reference in Minn. Stat. § 297A.01, subd. 8 is that point in time when the seller is able to complete performance of his contract by the physical tender of delivery of goods to the customer.~~

B. Cost of material used — labor or service cost. Certain tangible personal property purchased at retail may require either additional material or additional labor or service, ~~including assembly of component parts or materials,~~ in order to be suitable for the purpose for which purchased, or because of a special request made by a customer. The charges for such labor or material may be included in the sale price or may be in addition thereto, depending upon the policy of the retailer or upon the nature of the property purchased and of the modifications required.

Example 1. Customer orders fur coat from Furs, Inc. for $800.00 which includes extensive alterations to be made in accordance with Customer's instructions. The cost of such alterations to Furs, Inc. is $100.00. As no exclusion or deduction for the labor or material involved in the alterations is allowed, the "sales price" is $800.00.

Example 2. TV Dealer sells Customer a color television receiver for $700.00 installed. The installation and adjustments are performed by a service company which charges TV dealer $15.00. No exclusion or deduction for installation or adjustment labor involved is allowed since such charge is not separately stated. Consequently, the "sales price" is $700.00.

Example 3. Customer orders watch from Jeweler for $250.00 and requests that initials be inscribed in diamond chips. Jeweler agrees to do so without charge for labor but charges Customer $50.00 for the diamond chips used. As no exclusion or deduction is allowed for cost of materials used, the "sales price" is $300.00.

~~B. Example 4. Retailer stocks shelving components in unassembled form and sells such property unassembled or assembled. Customer purchases shelving components and requests that retailer also assemble such components. Retailer bills customer $150.00 for the components and $10.00 for labor. The entire charge of $160.00 is subject to tax.~~

The rule published at *State Register*, Volume 2, Number 26, pp. 1313-1314, January 2, 1978 (2 S.R. 1313) is adopted and is identical to its proposed form, with the following amendment:

Tax S&U 211 Direct pay permit procedure.

C. The holder of a Direct Pay Permit shall furnish a copy of this Direct Pay Permit or a statement that heholds Direct Pay Permit number dated to each vendor from whom he purchases tangible personal property on which an exemption is claimed. This shall relieve the vendor from the responsibility of collecting the sales tax on purchases made by such permit holder. Each person issued a Direct Pay Permit must keep a current list of all vendors from whom purchases are made under the direct pay

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method, and, upon request by the Commissioner, shall submit such list for examination.

The holder of a Direct Pay Permit must either issue the permit to all vendors required to collect Minnesota sales and use taxes (except those excluded in (d) below), and accrue all liability as a use tax, or maintain accounting records in sufficient detail to show in summary, and in respect to each transaction, the amount of sales taxes paid to vendors in each reporting period.

If the holder of the permit chooses the latter alternative, then all purchases from any one supplier must be made either "exempt" or "taxable". It is not permissible to request the vendor to assess the sales tax on only selected transactions.

The rule published at *State Register*, Volume 2, Number 26, pp. 1314-1317, January 2, 1978 (2 S.R. 1314) is adopted and is identical to its proposed form, with the following amendments:

Tax S&U 212 Motor ~~Vehicle Common~~ carriers — direct pay.

D.6. Withdrawal of an election to come under the provisions of Minn. Stat. § 297A.211 shall become effective only upon notice of such intent and return ~~to~~ of the ~~Common~~ Motor Carrier Direct Pay Certificate to the Commissioner of Revenue. ~~If such election is withdrawn, subsequent re-election shall be effective only upon approval of the Commissioner of Revenue.~~ If such election is withdrawn, subsequent re-election shall be effective only upon approval of the Commissioner of Revenue. Motor Carriers which do not elect to pay Minnesota Sales and Use Tax under the provisions of Minn. Stat. § 297A.211, shall be governed by the following:

a. Prior to January 1, 1972, carrier shall pay the sales and use tax directly to registered retailers on all purchases of mobile transportation equipment, parts, acces ories, equipment and supplies not exempt under the provisions of the Sales and Use Tax Law. If the retailer is not registered, the carrier shall pay the tax directly to the Commissioner of Revenue.

b. Subsequent to December 31, 1971. "Mobile Transportation Equipment" subject to the motor vehicle excise tax under the provisions of Minn. Stat. ch. 297B is not subject to the Minnesota Sales and Use Tax. A motor vehicle excise tax, equal to the sales and use tax rate, is collected at the time such equipment is registered in Minnesota. On purchase of parts, accessories, equipment and supplies, not exempt under provisions of the Sales and use Tax Law, the carrier shall pay the sales and use tax directly to registered retailers. If the retailer is not registered, the carrier shall pay the use tax directly to the Commissioner of Revenue.

The rule published at *State Register*, Volume 2, Number 26, pp. 1317-1320, January 2, 1978 (2 S.R. 1317) is adopted and is identical to its proposed form, with the following amendment:

Tax S&U 401 Drugs, therapeutic and prosthetic devices.

E. Purchases by doctors of medicine and dentistry. The purchase of materials, supplies and equipment are subject to the sales and use tax unless the particular item purchased is itself an exempt item when purchased by an individual for his own use. For example, the purchase by such professional men for use in their own office of drugs and medicines would not be subject to tax, nor would the purchase of prosthetic devices such as artificial limbs or eyes be subject to tax.

The purchase by doctors of medicine and dentistry of materials such as pumice, tongue depressors and stethoscopes, which are not in and of themselves exempt from the tax, would be subject to tax when purchased by such professional men.

Sales of tangible personal property to dentists, which are to be affixed to the person of his patient as an ingredient or component part of a dental prosthetic device, are exempt from the sales tax. These include artificial teeth and facings, dental crowns, dental mercury and acrylic, porcelain, gold, silver, alloy and synthetic filling material, teeth braces and retainers.

The exemption does not apply to diagnostic equipment such as an x-ray machine, as this equipment is subject to tax.

The rule published at *State Register*, Volume 2, Number 26, pp. 1320-1321, January 2, 1978 (2 S.R. 1320) is adopted and is identical to its proposed form, with the following amendments:

Tax S&U 407 Clothing and wearing apparel.

A. In general. Sales of clothing and wearing apparel are exempt from tax. "Clothing and wearing apparel" means inner and outer wear, footwear, headwear, gloves and mittens, neckwear, hosiery and similar items customarily worn on the human body for general use, and includes fabrics, thread, buttons, zippers and other similar items which are to be directly incorporated into wearing apparel.

"Clothing and wearing apparel" does not include patterns, thimbles, needles, pins and other sewing equipment, jewelry, handbags, cosmetics, articles normally used or worn only in conjunction with the particular sporting or

athletic activity for which they were designed, or equipment designed for use or wear only in connection with a particular work activity of the user.

Minn. Stat. § 297A.25, subd. 1(g) provides that an article made of fur or pelt is not considered to be clothing or wearing apparel and is, therefore, taxable. Articles made of fur or pelt and other materials are exempt only if the retail value of the fur or pelt is less than three times that of the next most valuable material. Clothing made of synthetic fur is exempt from tax.

Example 1. Retailer sells a woman's wool coat which has a mink fur trimming. The retail value of the fur is $40.00; the retail value of the wool material is $90.00. The sale of the coat is exempt from tax.

Examples of Exempt items

aprons (household and shop)
baby blankets (used as babies' clothing)
baby buntings
bathing suits and caps
belts
bibs
blankets, baby and receiving (used as babies' clothing)
boots (not more than knee high)
bridal wear
buntings
caps
corsets and corset laces
costumes (except masks)
diapers, diaper inserts, disposable diapers
footlets
formal wear
garters and garter belts
girdles
gloves (not designed for a specific sport)
hair bows and nets
handkerchiefs
hats
head scarves
hosiery
leotards
mittens
neck scarves
neckties
overshoes
receiving blankets (used as babies' clothing)
roller bonnets
rubber gloves
rubber pants (baby)
scarves, head and neck
sewing materials:
  buttons
  fabric
  lace
  thread
  yarn
  zipper
shoes and shoe laces
shower caps and clogs
slippers
sneakers
suspenders
swimsuits and caps
tennis shoes
tights
uniforms (Scout, Camp Fire Girls, policemen, firemen, etc.)

Examples of Taxable items

bags, overnight, beach, etc.
barrettes
billfolds
cosmetics, hair dyes, etc.
crib blankets, sheets, mattress pads, rubber sheets, etc.
furs on the hide or pelts
hair clips
handbags
iron-on transfers or emblems
jewelry:
  bracelets
  broaches
  cufflinks
  earrings
  necklaces
  pins
  rings
  tie clasps and tacks
lapel pins
money belts
money clips
perfume
pocketbooks
purses
sewing equipment:
  knitting needles
  patterns
  pins
  scissors
  sewing machine
  sewing needles

KEY: RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language. **PROPOSED RULES SECTION** — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material."

tape measure
thimbles
umbrellas
wallets
watchbands
watches
wigs

The rule published at *State Register*, Volume 2, Number 26, pp. 1334-1335, January 2, 1978 (2 S.R. 1334) is adopted and is identical to its proposed form, with the following amendments:

Tax S&U 608 Aircraft registration.

A. In general. Minn. Stat. § 297A.255 require persons who wish to license or register an aircraft in Minnesota to furnish proof to the Department of ~~Aeronautics~~ Transportation, Aeronautics Division that the Minnesota Sales or Use Tax has been paid, or that the purchase of the aircraft was not subject to the Minnesota Sales or Use Tax. The effect of this law is to impose a use tax on occasional or isolated sales of aircraft in those cases involving sales to individuals not in the business of selling aircraft. The law is effective for registrations applied for after June 30, 1973.

The necessary forms (Form UT-1 and Form ST-24) for reporting and paying the use tax or for claiming exemption are available upon request from the Minnesota Department of Revenue and the Minnesota Department of ~~Aeronautics~~ Transportation, Aeronautics Division.

This statute does not affect the exemption provided for purchases of air flight equipment by airlines taxed under Minn. Stat. §§ 270.071 through 270.079.

When the sales tax has not been paid to the dealer as set forth in B.1. below, the Department of Revenue will forward a completed certificate of tax payment or exemption, Form ST-24, to the Department of Transportation, Aeronautics Division.

B. Registration of aircraft by individuals.

1. Minnesota sales tax paid to dealer. When a purchaser pays the Minnesota sales tax to a Minnesota aircraft dealer who holds a Minnesota Sales and Use Tax Permit, the dealer shall furnish the purchaser with a statement showing that the sales tax has been paid. The aircraft dealer will report and pay the sales tax to the Minnesota Department of Revenue as in the past. It is not necessary for the purchaser of the aircraft to obtain a Certificate of Tax Payment or exemption, Form ST-24, from the Minnesota Department of Revenue. The purchaser should present the statement, which he received from the aircraft dealer, directly to the Department of ~~Aeronautics~~ Transportation Aeronautics Division in order to license or register the aircraft.

C. Registration of aircraft by dealers who are licensed in accordance with Minn. Stat. § 360.63. When a licensed dealer purchases an aircraft for resale and places it in a withholding status, no Certificate of Tax Payment or Exemption is required. When a licensed dealer registers an aircraft for commercial use, he must present a Certificate of Tax Payment or Exemption to the Minnesota Department of Trnsportation Aeronautics Division. He will be required to pay a use tax on his purchase price of the aircraft unless he makes application to the Commissioner of Revenue for an Aircraft Commercial Use Permit, Form ST-23, and pays a $20 fee. By obtaining an Aircraft Commercial Use Permit, Form ST-23, a licensed dealer may purchase an aircraft for resale and put it to commercial use such as crop dusting, charter service, freight transportation and flight instruction, for up to one year without paying a sales or use tax on his purchase. When he sells the aircraft, he is required to collect a sales tax. If he keeps the aircraft for more than one year or makes personal use of such aircraft, a use tax is also due on his purchase price. A licensed aircraft dealer who obtains a Commercial Use Permit, Form ST-23, should check the box of Section B of Form ST-24 which indicates that the aircraft was purchased for resale or lease by the holder of a Minnesota Sales and Use Tax Permit.

The rule published at *State Register*, Volume 2, Number 26, pp. 1336-1339, January 2, 1978 (2 S.R. 1336) is adopted and is identical to its proposed form, with the following amendments:

Tax S&U 610 Automatic data processing.

C. Taxable transactions, unless otherwise exempt under Minn. Stat. ch. 297A.

1. Retail sales of new or used data processing equipment are taxable.

2. Leases of equipment are subject to tax. A lease includes a contract by which a lessee secures for a consideration the use of equipment which may or may not be on his premises if the lessee or his employees operate the equipment, or if the equipment is operated under the direction and control of the lessee or his employees. Subleasing receipts are taxable without any deduction or credit for tax paid by the original lessee to his lessor, if the original lessee uses the property in addition to subleasing it. Use of equipment on a time-sharing basis, where access to the equipment is only by means of remote access facilities, is not a taxable leasing of such equipment.

~~3. Prewritten (canned) programs. These are programs prepared, held or existing for general or repeated use, including programs developed for in-house use and subsequently held or offered for sale or lease. The programs may be transferred to the customer in the form of punched cards, data on magnetic tape or by listing the program instructions on eod-~~

~~ing sheets. In some cases they are usable as written. However, in most cases it is necessary that the program be modified, adapted and tested to meet the customer's particular needs. Tax applies to the sale of all tangible personal property, including coding sheets, cards or magnetic tape, on which or into which such prewritten (canned) programs have been coded, punched or otherwise recorded.~~

~~The tax applies whether title to the tape or other property upon which the program is coded, punched or otherwise recorded, passes to the customer, or the program is recorded on tape or other property furnished by the customer. The temporary transfer of possession of a program, for a consideration, for the purpose of direct use or to be recorded by the customer, is a lease of tangible personal property and the tax applies. Where the consideration consists of license fees or royalty payments, all license fees or royalty payments, present or future, whether for a minimum use or for extended periods, are includable in the measure of tax.~~

~~Programming changes to a prewritten program to adapt it to a customer's equipment, including translating a program to a language compatible with a customer's equipment, are in the nature of fabrication or services that are a part of a sale and, as such, are taxable.~~

~~Charges for assembler, compiler, utility and other prewritten programs provided to those who lease or purchase automatic processing equipment are subject to tax whether the charges are billed separately or are included in the lease or purchase price of the equipment.~~

~~4. Custom programs. These are programs prepared to the special order of a customer.~~

~~Effective April 1, 1978, tax applies to the sale of custom programs transferred to the customer in the form of punched cards or in tape, disc, drum or similar form, or in the form of typed or printed sheets to be used as input media in an optical character recognition system. However, tax does not apply to the transfer of these custom programs in the form of written procedures, such as program instructions listed on coding sheets.~~

~~5.~~ 3. Keypunching and keystroke verifying. This item covers situations where a service bureau's agreement provides only for keypunching, keystroke verifying and proof listing of data or any combination of these operations. It does not include contracts under which these services are performed as steps in processing a client's data as discussed in D.1.

Agreements providing (a) solely for keypunching; (b) keypunching and keystroke verification; or (c) keypunching, providing a proof list and/more verifying of data, are regarded as contracts for the fabrication of punched cards and sales of proof lists. Charges therefor are taxable, whether the cards are furnished by the customer or by the service bureau. Data from source documents may also be recorded directly on magnetic tape (off-line). This operation may include keystroke verifying and/or proof listing of data and is comparable to the punch card operation. Charges for this operation are taxable whether the magnetic tapes are furnished by the customer or by the service bureau. Tax also applies to charges for the imprinting of characters on a document to be used as the input medium in an optical character recognition system. The tax applications would be the same even though paper tape or other media were used in the operation.

~~6.~~ 4. Training materials. Persons who sell or lease data processing equipment may provide a number of training services with the sale or rental of their equipment. Training services, per se, are not subject to the tax. Training materials, such as books, furnished to the trainees for a specific charge are taxable.

~~7.~~ 5. Generally tax applies to the conversion of customer-furnished data from one physical form of recordance to another. For example, if all or some data in punched cards is duplicated into another set of cards, charges for this service are taxable.

~~8.~~ 6. When additional copies of records, reports, or tabulations are provided, tax applies to the charges made for the additional copies. ''Additional copies'' are all copies in excess of those produced on multipart carbon paper simultaneous with the production of the original and on the same printer, whether the copies are prepared by rerunning the same program, by using multiple simultaneous printers, by looping a program such that the program is run continuously, by using different programs to produce the same output product, or by other means. Where additional copies are prepared, the tax will be measured by the charge made by the service bureau to the customer. Chares for copies produced by means of photocopying, multi-lithing, or by other means are also subject to tax.

~~9.~~ 7. ~~Sales of mailing lists (including listings in the form of mailing labels produced as a result of a computer run) are taxable.~~ Sales of mailing lists in the form of cheshire tapes, gummed labels and heat transfers produced as a result of a computer run are taxable. However, where the service bureau, through the use of its automatic data processing

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equipment, addresses material to be mailed, with names and addresses furnished by the customer or maintained by the service bureau for the customer, tax does not apply to the charge for addressing. Similarly, where the service bureau prepares labels to be affixed to material to be mailed, with names and addresses furnished by the customer or maintained by the service bureau for the customer, tax does not apply to the charge for producing the labels, when the service bureau itself affixes the labels to the material to be mailed.

F. Non-taxable transactions.

1. Prewritten (canned) programs. These are programs prepared, held or existing for general or repeated use, including programs developed for in-house use and subsequently held or offered for sale or lease. The programs may be transferred to the customer in the form of punched cards, data on magnetic tape or by listing the program instructions on coding sheets. In some cases they are usable as written. However, in most cases it is necessary that the program be modified, adapted and tested to meet the customer's particular needs. The sale of all property including coding sheets, cards or magnetic tape, on which or into which such prewritten (canned) programs have been coded, punched or otherwise recorded is not subject to tax. These items are classified as intangible personal property.

The tax does not apply whether title to the tape or other property upon which the program is coded, punched or otherwise recorded, passes to the customer, or the program is recorded on tape or other property furnished by the customer. The temporary transfer of possession of a program, for a consideration, for the purpose of direct use or to be recorded by the customer, is not a lease of tangible personal property and the tax does not apply. Where the consideration consists of license fees or royalty payments, all license fees or royalty payments, present or future, whether for a minimum use or for extended periods, are not includable in the measure of tax.

Programming changes to a prewritten program to adapt it to a customer's equipment, including translating a program to a language compatible with a customer's equipment, are not in the nature of fabrication or services that are part of a sale, and are not taxable.

Charges for assembler, compiler, utility and other prewritten programs provided to those who lease or purchase automatic processing equipment are not subject to tax.

2. Custom Programs. These are programs prepared to the special order of a customer. This type of program is classified as intangible personal property, and is not subject to tax.

PROPOSED RULES

Pursuant to Minn. Stat. § 15.0412, subd. 4, agencies must hold public hearings on proposed new rules and/or proposed amendment of existing rules. Notice of intent to hold a hearing must be published in the *State Register* at least 30 days prior to the date set for the hearing, along with the full text of the proposed new or amended rule. The agency shall make at least one free copy of a proposed rule available to any person requesting it.

Pursuant to Minn. Stat. § 15.0412, subd. 5, when a statute, federal law or court order to adopt, suspend or repeal a rule does not allow time for the usual rulemaking process, temporary rules may be proposed. Proposed temporary rules are published in the *State Register*, and for at least 20 days thereafter, interested persons may submit data and views in writing to the proposing agency.

Department of Commerce Insurance Division

Proposed Rules Relating to the Comprehensive Health Insurance Act, Minn. Stat. ch. 62E, As Amended

Order for Hearing

It is hereby ordered that a public hearing on the above-captioned rules be held in the hearing room at 500 Metro Square Building, Seventh and Robert Streets, Saint Paul, Minnesota, on November 1, 1978, commencing at 9:30 a.m., and continuing until all persons have had an opportunity to be heard.

It is further ordered that a Notice of Hearing be mailed to all persons or representatives of associations or other interested groups who registered their names with the Secretary of State for that purpose.

It is further ordered that the Notice of Hearing be published in the *State Register*.

September 11, 1978.

Berton W. Heaton
Commissioner of Insurance



The downy woodpecker is a familiar sight in Minnesota forests, orchards and city parks. In winter it moves into suburban areas to visit bird feeders. The male, larger than the female at 7 inches in length, also has a longer, stronger bill which penetrates deeper into trees and posts. Both male and female have a black forehead, white face, and black and white checked wings, but the male is more colorful with a bright patch of red on the back of his neck. These birds most often nest in young deciduous trees or in holes in dead trees. They range from Alaska and northern Canada to the southern border of the United States. (Drawing by Jane Gstalder)

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Notice of Hearing

Notice is hereby given that a public hearing in the above-entitled matter will be held in the hearing room at 500 Metro Square Building, Seventh and Robert Streets, Saint Paul, Minnesota, on November 1, 1978, at 9:30 a.m. and continuing until all representatives of associations or interested groups or persons have had an opportunity to be heard concerning the adoption of the proposed rules captioned above by submitting either oral or written data, statements or arguments. Statements may be made orally and written materials may be submitted at the hearing. In addition, written materials may be submitted by mail to Mr. George A. Beck, State Office of Hearing Examiners, 1745 University Avenue, Room 300, St. Paul, Minnesota 55104, (612) 296-8108, the Hearing Examiner appointed to hear this matter, either before the hearing or within five (5) working days after the close of the hearing. (The Hearing Examiner may order a longer period of time for comments which may not exceed twenty (20) days.)

Proposed rules if adopted would establish standards and procedures for the certification of qualified plans by the Commissioner of Insurance and would clarify the statutory duties of insurers, fraternals, employers, and self-insurers in the offering of qualified plans and major medical coverages. A qualified plan is a plan of health coverage certified by the Commissioner of Insurance as meeting certain statutorily established levels of health insurance benefits. The Comprehensive Health Insurance Act (Minn. Stat. ch. 62, hereinafter "Act") requires all licensed accident and health insurers and fraternals to offer qualified plans to applicants and requires employers to make available certain qualified plans to their employees as a condition of eligibility for state income tax deduction of the employer's health care costs on behalf of its employees. Insurance companies which sell accident and health insurance must make available qualified plans to their prospective insureds or lose their right to transact accident and health insurance business in Minnesota.

The proposed rules further set forth the operational procedures and organizational structure which govern the Minnesota Comprehensive Health Association (hereinafter "Association") in the offering of State Plan coverages to Minnesota residents. Pursuant to the Act, the Association is required to offer State Plan coverages to residents who are otherwise unable to purchase accident and health insurance coverage in the voluntary insurance market. Benefits paid by the Association as a result of the issuance of State Plan coverages are to be funded through premiums collected from persons insured thereunder, and excess costs of the operation of the State Plan are to be borne in part by pro rata assessments against Association members. The proposed rules also set forth the manner in which the Association shall operate as a reinsurance facility upon which individual Association members may rely for the reinsurance of certain designated insurance coverages which the Act requires that individual insurers or fraternals offer to Minnesota residents.

One free copy of the proposed rules in their entirety may be obtained by writing to John T. Ingrassia, Supervisor of the Life and Health Section, Insurance Division, 500 Metro Square Building, St. Paul, Minnesota 55101. Additional copies of the rules will be available at the door on the day of the hearing.

These rules are proposed pursuant to the authority vested in the Insurance Division by the provisions of Minn. Stat. § 62E.09(a).

Notice is hereby given that adoption of these rules may result in the expenditure of public moneys by local public bodies which establish or maintain self-insurance programs providing accident and health insurance benefits to their employees. Such cost would accrue by virtue of statutorily mandated membership in the Minnesota Comprehensive Health Association and the attendant liability of individual members for a pro rata share of assessments, if any, arising from operation of the State Plan. No reasonable estimate of the cost accruing to affected local public bodies is available. However, it is anticipated that the total cost to public bodies will not be in excess of $100,000 in either of the two years immediately succeeding adoption of the rules as proposed.

Temporary rules relating to the subject matter of these proposed rules were promulgated and published in the *State Register*, Volume 2, Number 36, and were effective on April 20, 1978.

Any person may request notification of the date on which the Hearing Examiner's report will be available, after which date the agency may not take any final action on the rules for a period of five (5) working days. Any person may request notification of the date on which the hearing record has been submitted (or resubmitted) to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the Hearing Examiner (in the case of the Hearing Examiner's report), or to the agency (in the case of the agency's submission or resubmission to the Attorney General).

Notice is hereby given that 25 days prior to the hearing, a statement of need and reasonableness will be available for review at the agency and at the Office of Hearing Examiners. This statement of need and reasonableness will include a summary of all of the evidence which will be presented by the agency at the hearing justifying both the need for and the reasonableness of the proposed rule/rules. Copies of the statement of need and reasonableness may be obtained from the Office of Hearing Examiner at a minimal charge.

Minn. Stat. §§ 10A.01-10A.34 requires each lobbyist to register with the Ethical Practices Board within five (5) days after commencing lobbying. Lobbying includes attempting to influence rulemaking by communicating or urging others to communicate with public officials. A lobbyist is defined in Minn. Stat. § 10A.01, subd. 11 as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than § 250, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) Who spends more than $250, not including his own traveling expenses and membership dues, in any year for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, phone number (612) 296-5615.

September 11, 1978.

Berton W. Heaton
Commissioner of Insurance

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4 MCAR § 1.3200 Authority, scope and purpose. These rules are promulgated pursuant to Minn. Stat. § 62E.09(i) relating to qualified comprehensive health insurance plans and the operations of the Minnesota Comprehensive Health Association in particular, and Minn. Stat. §§ 15.0411 to 15.052,

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as amended, relating generally to the promulgation of administrative rules and regulations. These rules and all future changes herein apply to all insurers, (including non-profit health service plan corporations), self-insurers, fraternals, health maintenance organizations and other organizations which are at the time of adoption of these rules, or at any time in the future, licensed or authorized to do business in or otherwise doing business in this state and are subject to the provisions of the Minnesota comprehensive health insurance act of 1976, as amended. These rules are promulgated to carry out the act, as amended, and to facilitate its full and uniform implementation and enforcement.

4 MCAR § 1.3201 Definitions. All terms used herein which are defined in Minn. Stat. ch. 62E shall have the meanings attributed to them therein. For the purpose of Minn. Stat. ch. 62E and these regulations, the terms defined herein shall have the meanings given to them.

A. Accident only coverage. "Accident only coverage" means a policy designed to provide coverage solely upon the occurrence of an accidental injury or death.

B. Act. "Act" means Minn. Stat. §§ 62E.01 to 62E.17, as amended, which shall be cited as the Minnesota Comprehensive Health Insurance Act of 1976.

C. Actuarial equivalence. "Actuarial equivalence" shall be recognized for two plans where, employing the same set of assumptions for the same population, the expected value of benefits provided by the plans is equal. Expected value of benefits will be measured by the probability of the claim for each benefit multiplied by the average expected amount of each of those benefits.

D. Administrative expenses of the pool. "Administrative expenses of the pool" means the actual operating and administrative expenses of the Association incurred directly in the operation of the reinsurance plan including fees to a reinsurance administrator.

E. Association. "Association" means the Minnesota Comprehensive Health Association.

F. Board. "Board" means the board of directors of the Association.

G. Calendar year. "Calendar year" means a twelve month period from January 1, to and including December 31.

H. Certificate of eligibility. "Certificate of eligibility" or "certificate of eligibility and enrollment form" means the document entitled "certificate of eligibility and enrollment form" or any other document which is used to apply for coverage under the state plan.

I. Claims expenses. "Claims expenses" or "payment of benefits" means all payments to covered persons or providers including payments for hospital, surgical and medical care, and reasonable estimates (as determined by the Association and approved by the commissioner) of the incurred but not reported claims of the state plan.

J. Close relative. "Close relative" means the insured person's spouse, brother, sister, parent or child.

K. Commercial reinsurance. "Commercial reinsurance" or "excess of loss reinsurance" means reinsurance arranged by the Association under which the pool pays premiums to a reinsurer which assumes part of the risk of the reinsurance plan.

L. Covered expenses. "Covered expenses" means the usual and customary charges for the services and articles listed in Minn. Stat. § 62E.06, or the actuarial equivalence thereof, when prescribed for a covered person by a physician and when such expenses are incurred during a period in which the state plan policy or contract is in effect.

M. Covered person. "Covered person" means the insured person or an insured dependent.

N. Dental care. "Dental care" means those services which a person licensed to practice dentistry may provide as defined in Minn. Stat. § 105.05, subd. 1.

O. Disabled child. "Disabled child" or a "dependent child of any age who is disabled" means a child, married or unmarried, who is and has been continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap and is financially dependent upon the insured, provided proof of such incapacity and dependency is furnished to the insurer or to the Association within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or the Association but not more frequently than annually after the two year period following the child's attainment of the limiting age.

P. Employee welfare benefit plan. "Employee welfare benefit plan" means any plan, fund, or program through which an employer provides, directly or indirectly, accident and health benefits to its employees through a trust, through the purchase of insurance, or through the provision of benefits for medical, surgical or hospital care.

Q. Financially dependent. A person shall be considered "financially dependent" if that person is chiefly dependent upon the insured person for support and maintenance.

R. Free standing ambulatory surgical center. "Free standing ambulatory surgical center" or "free standing ambulatory medical center" means a surgical or medical center approved as such by the State of Minnesota.

S. Home health agency. "Home health agency" means a public or private agency that specializes in giving nursing service and other therapeutic services in the insured person's home and is approved as such by the State of Minnesota.

T. Hospital. "Hospital" means:

1. An institution which is operated pursuant to law and which is primarily engaged in providing on an inpatient basis for the medical care and treatment of sick and injured persons through medical, diagnostic, and surgical facilities, under the supervision of a staff of physicians and with twenty-four hour a day nursing service, or

2. An institution not meeting all the requirements of (1), but which is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.

3. In no event shall the term "hospital" include a nursing home or any institution or part thereof which is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

U. Hospital indemnity coverage. "Hospital indemnity coverage" means coverage which provides a fixed dollar benefit on the occurrence of the condition precedent that the covered person was confined in a hospital.

V. Illness. "Illness" means disease, injury, or a condition involving bodily or mental disorder of any kind, and including pregnancy.

W. Independent contractor. "Independent contractor" means a person who exercises an independent employment and contracts to do certain work without being subject to the control of his employer except as to the results of the work.

X. Individual insured. "Individual insured" means the covered employee or surviving spouse or surviving dependent of a covered employee as those terms are used in Minn. Stat. § 62A.17, subd. 6.

Y. Insured dependent. "Insured dependent" means an eligible dependent originally named in the policy or contract schedule or otherwise insured subsequent to the effective date of the policy or contract.

Z. Insured person. "Insured person" means the person named in the policy or contract schedule.

AA. Interim reinsurance assessment. "Interim reinsurance assessment" means an assessment at any time other than at the end of a calendar year (or other fiscal year end as determined by the Association) of participating members when pooling payments and payments by reinsurers for the year are not sufficient to fund paid and estimated obligations of the pool and administrative expenses of the pool.

BB. Licensed and tested insurance agent or solicitor. "Licensed and tested insurance agent or solicitor" means an agent or solicitor as defined in Minn. Stat. § 60A.02, subds. 7 or 8, and licensed by the commissioner under Minn. Stat. § 60A.17 to act as an agent or solicitor for accident and health insurance as defined in Minn. Stat. § 60A.06, subd. 1(5)(a).

CC. Losses. "Losses" means all claims expenses.

DD. Major medical expenses. "Major medical expenses" as used in Minn. Stat. § 62E.04 means the covered expenses for services and articles listed in Minn. Stat. § 62E.06, subd. 1, or the actuarial equivalence thereof, provided that the maximum lifetime benefit limit shall not be less than $250,000.

EE. Net gains. "Net gains" means the excess of premiums or contract charges over claims expenses, after the writing carrier's expenses and agent referral fees (not to exceed 12½% of premiums or contract charges) have been paid as provided in 4 MCAR § 1.3233 B.4.

FF. Non-qualified policy. "A non-qualified policy" or "unqualified policy" or "unqualified plan" means a policy, contract, or plan which has not been certified by the commissioner as qualified pursuant to the terms of the act.

GG. Nursing home. "Nursing home" means an institution meeting the following requirements: (1) it is operated pursuant to law and is primarily engaged in providing the following services for persons convalescing from illness: room, board, and twenty-four hour a day nursing service by one or more professional nurses and such other nursing personnel as are needed to provide adequate medical care; (2) it provides such services under the full-time supervision of a proprietor or employee who is a physician or a registered nurse; and (3) it maintains adequate medical records and has available the services of a physician under an established agreement if not supervised by a physician.

HH. Operating and administrative expenses of the Association. "Operating and administrative expenses of the Association" means expenditures reasonably necessary to the operation and administration of the Association including but not limited to rents, stationery, telegraph and telephone charges, salaries and expenses of office employees, investigators or

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adjusters, and legal expenses, as well as expenses of directors of the board of the Association relating to the conduct of or attendance at meetings. The operating and administrative expenses of the Association do not include the operating and administrative expenses of the writing carrier.

II. Out-of-pocket expenses. "Out-of-pocket expenses" means any cost or charge in a calendar year for a health service or article which is included in the list of covered services and articles under the qualified plan, qualified medicare supplement plan, policy or contract of major medical coverage, or state plan policy or contract under which the person is a covered person, and which is not paid or payable if claim were made under any plan of health coverage, medicare, or other governmental program.

JJ. Participating members. "Participating members" means insurer and fraternal members of the Association which elect to reinsure risks of issuing certain coverages required under the act through the Association under its reinsurance plan.

KK. Per diem policies. "Designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis" means policies which provide benefits upon the occurrence or existence of a condition precedent, without reference to expenses incurred or services provided, for hospital, surgical or medical care.

LL. Policies or contracts of accident and health insurance. "Policies or contracts of accident and health insurance" means accident and health insurance policies as defined by Minn. Stat § 62E.02, subd. 11.

MM. Pooling payment. "Pooling payment" means the amount each participating member pays the Association or its reinsurance administrator during a given period of time as determined by the Association or its reinsurance administrator based on pooling rates and volume of policies and contracts reinsured by the participating member in each category.

NN. Pooling rates. "Pooling rates" means unit rates approved by the Association and used as the basis for pooling payments.

OO. Pre-existing condition. "Pre-existing condition" means an injury, illness or other physical or mental condition of a covered person which existed prior to the issuance of the covered person's policy or contract.

PP. Pre-existing conditions limitation. "Pre-existing conditions limitation" means a limitation excluding coverage for an injury, illness or other physical or mental condition of an applicant which existed prior to the issuance of the applicant's policy or contract.

QQ. Professional services. "Professional services" means only services rendered by a physician or at the physician's direction by a private duty, licensed, registered nurse or an allied health professional. Professional services shall not include a service rendered by a close relative.

RR. Reasonable benefits in relation to the cost of covered services. "Reasonable benefits in relation to the cost of covered services" means reasonable benefits in relation to premium charged for coverage under a policy as determined by the minimum anticipated loss ratio requirement of Minn. Stat. § 62A.02, subd. 3.

SS. Reimbursable services. "Reimbursable services" means eligible services under medicare.

TT. Reinsurance administrator. "Reinsurance administrator" means an entity with which the Association contracts for administration of its reinsurance plan.

UU. Reinsurance assessment. "Reinsurance assessment" means a calendar year end (or other fiscal year end as determined by the Association) assessment of participating members when pooling payments and payments by reinsurers for the year are not sufficient to fund paid and estimated obligations of the pool and administrative expenses of the pool.

VV. Reinsurance plan. "Reinsurance plan" means any mechanism by which the Association undertakes to reinsure the risks which Minn. Stat. § 62E.10 subd. 7 authorizes the Association to reinsure.

WW. Reinsurance pool. "Reinsurance pool" or "pool" means the pool or fund into which the Association or the reinsurance administrator deposits pooling payments, interim reinsurance assessments and reinsurance assessments paid to the Association or its reinsurance administrator by insurer or fraternal members wishing to reinsure certain risks, as well as claims paid by reinsurers under contract for commercial reinsurance with the Association, and other receipts, and from which the Association or its reinsurance administrator pays premiums for commercial reinsurance, administrative expenses of the pool, and reimbursement for claims paid by insurer or fraternal members which have reinsured all or any portion of risks covered under policies or contracts which have been reinsured pursuant to a reinsurance pooling agreement with the Association.

XX. Reinsurance pooling agreement. "Reinsurance pooling agreement" means the agreement between the Association and participating members which establishes a reinsurance plan.

YY. Reinsurer. "Reinsurer" means the commercial reinsurance company which contracts with the Association

to provide excess of loss coverage for the risks which participating members reinsure through the Association.

ZZ. Rejection. "Rejection" means refusal by any Association member to issue a qualified plan to a person who completes an application for coverage under such qualified plan, as determined by the board.

AAA. Renewal date. "Renewal date" means the date specified in a policy or contract on which renewal occurs. In the absence of a specified renewal date in a policy or contract renewal date shall be determined in reference to the anniversary date specified in the policy or contract and shall occur in intervals of no greater than 12 months duration as determined in reference to the date on which the policy or contract became effective. Renewal of a policy or contract shall be deemed to occur upon the expiration of a renewal date if coverage under the policy or contract is continued.

BBB. Resident of Minnesota. "Resident of Minnesota" means a person who is an actual resident of Minnesota, having there his or her principal and permanent abode.

CCC. Restrictive rider. "Restrictive rider" means a document or contractual provision adding certain conditions to the policy's or contract's coverage, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk.

DDD. Student. "Student" means any unmarried child under the age of 25 who during the calendar year is enrolled in and attends an educational institution as a full-time student and who is financially dependent upon an insured person.

EEE. Total cost of self insurance. "Total cost of self insurance" includes any direct and indirect administrative expenses incurred which are related to the operation of a plan or self-insurance, plus the sum of any payment made to or on behalf of Minnesota residents for costs or charges for health benefits by an employer which is a self-insurer under a plan of health coverage, regardless of the amount incurred or relationship of the cost to an insured or partially insured plan of heatlh coverage, which is not counted as premium by an insurer, except to the extent of such payments made for coverage of the types described in clauses 1 through 8 of Minn. Stat. § 62E.02, subd. 11.

FFF. Usual and customary charge. "Usual and customary charge" for the purpose of the state plan means the normal charge, in absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a like service or supply. A "like service" is of the same nature and duration, requires the same skill and is performed by a provider of similar training and experience. A "like supply" is one which is identical or substantially equivalent. "Area" means the municipality (or, in the case of a large city, a subdivision thereof) in which the service or supply is actually provided or such greater area as is necessary to obtain a representative cross-section of charges for a like service or supply.

Part I — Qualified Comprehensive Health Insurance Plan

4 MCAR § 1.3202 — Duties of employers.

A. Duty to make available a qualified plan. An employer shall be deemed to have made available a qualified plan to its employees as required in Minn. Stat. § 62E.03, subd. 1 when participation under a number 2 or number 3 qualified plan or a health maintenance plan is offered to the employee directly or through an insurer or health maintenance organization and without regard to whether the cost of such participation is paid directly or indirectly by the employer or by the employee or by their joint payment.

B. Effect of collective bargaining on duty to make available a qualified plan. An employer whose employees are represented by one or more exclusive bargaining representatives shall be deemed to have complied with the provisions of Minn. Stat. § 62E.03, subd. 1 with respect to all employees within each unit for collective bargaining if the employer makes available qualified plans of health coverage to the exclusive bargaining representatives.

1. Such employers shall be deemed to have complied with requirements of Minn. Stat. § 62E.03, subd. 1 for each accounting period utilized by the employer for Minnesota income tax purposes during the entire term of any collective bargaining agreement executed after an offer of qualified health coverage has been made.

2. Nothing in this section shall require the employer to renegotiate any collectively bargained agreement solely for the purposes of compliance with this act.

C. Frequency of required offer. Except as provided in 4 MCAR § 1.3202 B., an employer shall be deemed to have complied with the requirements of Minn. Stat. § 62E.03, subd. 1 of the act if he makes available to his employees a plan of health coverage which is certified as a number 2 or number 3 qualified plan or a health maintenance plan at least once during each accounting period utilized by the employer for Minnesota income tax purposes.

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4 MCAR § 1.3203 — Duties of insurers and fraternals.

A. Exception of definition of "accident and health insurance policy." The exception provided by Minn. Stat. § 62E.02, subd. 11 (4) shall apply with respect to hospital indemnity coverage sold by an insurer to an applicant who is, at the time of application for hospital indemnity coverage, covered by a qualified plan, notwithstanding the possibility that the applicant may subsequently terminate coverage under a qualified plan.

1. The exclusion of Minn. Stat. § 62E.02, subd. 11 (4) shall also apply to a hospital indemnity coverage which is sold by an insurer to an applicant who is then currently covered by a health maintenance plan.

2. Insurers shall be entitled to conclusively rely upon the written statement of an applicant for hospital indemnity coverage that such applicant is, at the time of the application, covered by a qualified plan or a health maintenance plan.

B. Timing of required offer of a qualified plan or qualified medicare supplement plan.

1. The offer of each type of qualified plan (that is a number 1, number 2, and number 3 qualified plan) which is required when an insurer or fraternal is offering an individual policy of accident health insurance shall occur no later than the date of delivery of such policy to the applicant.

2. The offer of a qualified medicare supplement plan which is required when an insurer or fraternal is offering a medicare supplement policy shall occur no later than the date of delivery of such policy to the applicant.

3. The offer of each type of qualified plan (that is a number 1, number 2, or number 3 qualified plan) required when an insurer or fraternal is offering a group policy of accident and health insurance shall occur no later than the date of delivery of such policy to the applicant.

4. "Each person who applies" and "applicant" for the purposes of Minn. Stat. § 62E.04 and this section of the rules shall be deemed to be only the individual making an initial application for an individual policy or in the case of a group policy, the corporation, partnership, proprietorship, association or other qualified entity making application for a group policy.

5. Minn. Stat. § 62E.04, subds. 1, 2 and 3 shall not be deemed to require an insurer or fraternal to offer a qualified plan or qualified medicare supplement plan at the time a policy is subject to renewal.

C. No duty to offer a particular category of insurance. For the purposes of the act, individual accident and health insurance, group accident and health insurance, individual medicare supplement plans and group medicare supplement plans are recognized as separate and distinct categories of insurance. Nothing in Minn. Stat. § 62E.04, subds. 1, 2 and 3 shall be construed as requiring an insurer or fraternal to engage in the business of offering or issuing a particular category of accident and health insurance policy or medicare supplement plan which it does not otherwise offer or issue in this state.

D. Duty to offer major medical coverage. Each insurer and fraternal shall affirmatively offer, subject to its underwriting standards, coverage of major medical expenses to every applicant for a new unqualified policy at the time of application and annually thereafter to every holder of an unqualified policy of accident and health insurance as required by Minn. Stat. § 62E.04, subd. 4. "Affirmatively offer" shall mean written advice to the applicant for, or the holder of, an unqualified policy of accident and health insurance, of the availability of coverage for major medical expenses. Such written advice of the availability of the coverage for major medical expenses may be satisfied by a contractual provision in the unqualified policy which gives the insured the contractual right to apply to the insurer or fraternal for a policy or rider which provides coverage for 80% of the covered expenses for services listed in Minn. Stat. § 62E.06, subd. 1 or the actuarial equivalence thereof subject to a $5,000 deductible for out-of-pocket expenses, subject to the insurer's or fraternal's underwriting requirements.

E. Effect on foreign contracts. No provision of the act shall be construed to require any insurer or fraternal to alter or amend any policy or contract issued outside the state of Minnesota.

F. Exclusion of certain foreign conversion policies. The issuance of individual group conversion policies or contracts in Minnesota pursuant to Minn. Stat. § 62A.17 or Minn. Stat. § 62E.16 shall not, in and of itself, constitute the transaction of accident and health insurance business by an insurer or fraternal which has relinquished prior authority to transact such business in Minnesota and which is not otherwise currently issuing policies or contracts in Minnesota.

G. Exceptions to duties for certain policies and contracts.

1. The continuation in force of a policy or contract under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend or change the terms, conditions or premium rate of the policy or contract in any way, shall not be considered a renewal for the purposes of Minn. Stat. § 62E.04 and 4 MCAR § 1.3225 A.1. if the policy or contract:

a. was issued prior to July 1, 1976, or

b. was designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis and was issued prior to June 3, 1977.

2. The issuance or renewal by an insurer or fraternal on or after June 3, 1977, of the policy or contract which is designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis, shall not be subject to Minn. Stat. § 62E.04, except for policies and contracts sold by an insurer to provide payments on a hospital indemnity basis if such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue.

H. Sanction for failure to comply with duties of insurers and fraternals. Any insurer or fraternal not in compliance with Minn. Stat. § 62E.04 shall cease and desist from transacting accident and health insurance business in the State of Minnesota. Nothing in this section shall prohibit such an insurer or fraternal no longer meeting the definition of insurer in Minn. Stat. § 62E.02, subd. 10 or fraternal in Minn. Stat. § 62E.02, subd. 19 from continuing to maintain in force any policies or contracts described in 4 MCAR § 1.3203 G.1.

4 MCAR § 1.3204 — Qualified plan pre-existing conditions. A qualified plan may include provisions consistent with generally accepted underwriting practices which provide that any pre-existing condition for any person covered under the policy which was diagnosed prior to the effective date of the policy, and for which medical care or treatment was rendered or prescribed during the 90 days immediately prior to the application for such policy, shall not be covered or eligible for the payment of any benefits for care or treatment rendered during a period of time beginning on the effective date of the policy and ending 24 months after the policy has been continuously in force.

4 MCAR § 1.3205 — Minimum benefits of qualified medicare supplement plans. The minimum benefits of qualified medicare supplement plans shall be as provided in Minn. Stat. § 62E.07 and as described for the purposes of the state plan in 4 MCAR § 1.3230 C.

4 MCAR § 1.3206 — Certification of qualified plans.

A. Application for certification. The application of an insurer, fraternal, or employer for certification by the commissioner of a plan of health coverage as a qualified plan or a qualified medicare supplement plan under Minn. Stat. § 62E.05 shall include the qualification number of the plan for which certification is sought pursuant to the procedures specified in the actuarial equivalence tables set forth in Appendix I of these rules.

B. Certification by the commissioner. An accident and health insurance policy or plan is deemed certified as a qualified plan or qualified medicare supplement plan for the purpose of Minn. Stat. § 62E.05 if it meets the requirements of these regulations and other relevant laws of the state upon the expiration of 90 days after receipt of the request for certification by the commissioner, unless earlier rejected or certified by the commissioner. In the event the commissioner rejects such request, he shall give written notice of the grounds for rejection to the person submitting the plan, and the insurer, fraternal or employer has the same rights in the event of such rejection as provided in Minn. Stat. § 62A.02.

C. Required benefits under the act. On or after June 3, 1977, each plan of health coverage, in order to be certified as a number 1, number 2 or number 3 qualified plan, shall provide a limitation of $3,000 per person on total annual out-of-pocket expenses and a maximum lifetime benefit of not less than $250,000, and shall provide all other benefits required under the act which are not subject to substitution of actuarially equivalent benefits, under Minn. Stat. § 62E.06.

D. Certification of an employer's plan of health coverage. For purposes of certification of an employer's plan of health coverage pursuant to Minn. Stat. § 62E.03, any plan of health coverage which constitutes a qualified plan at the time of issue shall continue to be a qualified plan until the later of the next renewal date of the plan of health coverage or the expiration of an applicable collective bargaining agreement, if any.

4 MCAR § 1.3207 — Termination of coverage: conversion privileges.

A. Eligibility for conversion upon termination. A person whose employment has terminated may elect to exercise the right provided by Minn. Stat. § 62A.17 for continued coverage under the group insurance policy, group subscriber contract, health maintenance contract, or plan of health coverage which is self insured or, at the employee's option, may exercise the right provided by Minn. Stat. § 62E.16 to convert to an individual coverage qualified plan. If the employee elects to continue coverage under Minn. Stat. § 62A.17, such employee may not exercise the right of conversion under Minn. Stat. § 62E.16 until the continua-

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tion coverage obtained pursuant to Minn. Stat. § 62A.17 is terminated, and if the employee elects to convert to an individual qualified plan, the employee may not elect to continue group coverage pursuant to Minn. Stat. § 62A.17.

B. Duty to offer conversion policy or contract.

1. For the purposes of Minn. Stat. § 62E.16 and Minn. Stat. § 62A.17, an insurer, health maintenance organization, or self insurer shall not be required to offer a conversion policy or contract to a person who is then covered by a qualified plan or eligible for medicare.

2. An insurer, health maintenance organization, or self insurer shall not be required to renew a conversion policy or contract issued to a person who, during the prior policy or contract year, became covered by a qualified plan or became eligible for medicare.

3. An insurer, health maintenance organization or self insurer which is required to offer conversion coverage to a terminated employee must offer, at the employee's option, a number 1, number 2 or number 3 qualified plan. A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, spouse or a dependent in lieu of the optional coverage otherwise required by Minn. Stat. §§ 62A.17, subd. 6, and 62E.16.

C. Due notice of cancellation or termination. An insurer, health maintenance organization or self insurer shall be deemed to have provided "due notice of cancellation or termination" as required in Minn. Stat. § 62E.16 if the insurer, health maintenance organization or self insurer notifies in writing those employees at their respective addresses as provided the insurer, health maintenance organization or self insurer by the employer pursuant to the terms of Minn. Stat. § 62E.16.

4 MCAR § 1.3208 Revision of actuarial equivalence tables. The commissioner shall periodically, no less frequently than biennially, review the actuarial equivalence tables set forth in Appendix I of these rules, and shall require that the relative point values set forth therein be actuarially updated when required to more accurately reflect changes in the relative values of benefits (including copayments). Any revision of relative point values which the commissioner shall make shall be published in the *State Register*, together with justification therefor, and shall take effect upon publication. Following revision of the actuarial equivalence tables pursuant to this section, recertification of existing plans of health coverage may be required subject to the provisions set forth in 4 MCAR §§ 1.3202, 1.3203, and 1.3206.

4 MCAR § 1.3209-1.3224 Reserved for future use.

PART II — Minnesota Comprehensive Health Association

4 MCAR § 1.3225 MCHA — Membership in the Association.

A. Mandatory membership. As a condition of doing accident and health insurance business, self insurance business or health maintenance organization business in Minnesota, all insurers, self insurers, fraternals and health maintenance organizations licensed or authorized to do business in this state shall become members of the Association and maintain their membership therein.

1. "Accident and health insurance business" means the issuance or renewal of any accident and health insurance policy as defined in Minn. Stat. § 62E.02, subd. 11.

a. An insurer is engaged in accident and health insurance business during the period in which any policy or contract which has been issued or renewed remains in effect.

b. Such business shall not include the issuance or renewal of policies or contracts providing coverage which is:

(1) limited to disability or income protection coverage for a specified period of time;

(2) limited to automobile insurance which provides coverage for medical payments as defined and authorized under Minn. Stat. § 60A.06, subd. 1(12);

(3) supplemental to liability insurance, as defined and authorized in Minn. Stat. § 60A.06, subd. 1(13);

(4) limited to policies or contracts issued prior to July 1, 1976 under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend or change the terms, conditions or premium rate of the policy or contract in any way; provided that all policies and contracts designed solely to provide payments on a per diem, fixed indemity or non-expense incurred basis issued prior to June 3, 1977 under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend or change the terms, conditions or premium rate of the policy or contract in any way, are also excluded;

(5) designed solely to provide payment on a per diem, fixed indemnity or nonexpense incurred basis except that all policies and contracts designed solely to provide payments on a hospital indemnity basis issued or renewed by an insurer on or after June 3, 1977 are included to the extent that such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue;

(6) Limited to credit accident and health insurance, meaning insurance on a debtor to provide indemnity

for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy, as authorized by Minn. Stat. ch. 62B;

(7) designed solely to provide dental or vision care;

(8) limited to blanket accident and sickness insurance as defined in Minn. Stat. § 62A.11; or

(9) limited to accident only coverage issued by a licensed and tested insurance agent or solicitor and which provides reasonable benefits in relation to the cost of covered services.

2. "Self insurance business" means the provision, directly or indirectly, of a plan of health coverage by a self insurer. "Self insurance business" does not include the direct provision of health care services to employees at no charge to them by an employer engaged in the business of providing health care services to the public, nor does it include provision of benefits which, if provided by an insurer doing accident and health insurance business, would be excluded under 4 MCAR § 1.3225 A.1.b. (1)-(9) of these rules. "Directly or indirectly" for the purposes of this section of the rules means that the employer or employee welfare benefit plan funds the plan of health coverage in any amount or collects any employee contributions which are used to pay for the plan of health coverage.

3. "Health maintenance organization business" means the operation of a nonprofit corporation licensed and operated as provided in Minn. Stat. ch. 62D.

4. "Licensed or authorized to do business" means:

a. licensed by the commissioner to conduct business under Minn. Stat. chs. 62A, 62C, or 64A, or by the Commissioner of Health under Minn. Stat. ch. 62D, or

b. authorized by the Secretary of State to carry on any business in the state of Minnesota or otherwise doing business in this state and acting as an insurer, self insurer, fraternal or health maintenance organization.

B. Assessment agreement. Each member shall enter into an assessment agreement with the Association for a one year term, renewable annually thereafter as required by the act. Signing this assessment agreement shall fulfill the requirement that members enter into a reinsurance contract with the Association under Minn. Stat. § 62E.10, subd. 5. The agreement shall be signed by an officer of the member who is authorized to enter into contracts on behalf of the member, shall be in a form adopted by the board of directors of the Association and approved by the commissioner, and shall include but not be limited to provisions regarding the members' obligation to:

1. share proportionately in funding the operating and administrative expenses of the Association in accordance with 4 MCAR § 1.3225 C. and D. below;

2. share proportionately in the losses of the Association in accordance with 4 MCAR § 1.3225 C. and D. below;

3. pay all fiscal year-end assessments which shall be due within 30 days after the end of the Association's fiscal year (December 31 unless the Association establishes a different fiscal year end) and shall be payable 30 days after receipt of a written assessment notice.

C. Assessments. Members, according to the assessment agreement, will be assessed for their proportionate share of the operating and administrative expenses of the Association, incurred or estimated to be incurred, together with losses, if any, incurred by the Association as a result of operation of the state plan. The total amount of operating and administrative expenses and losses:

1. shall be determined annually by the board at each fiscal year end;

2. may, at the recommendation of the board, subject to the approval of the commissioner, consist of a reasonable estimate of the operating and administrative expenses of the Association for the succeeding fiscal year, which amount shall be adjusted at the end of the succeeding fiscal year to the amount of actual operating and administrative expenses, and members shall be entitled to credit for any excess or shall be assessed for any deficit in these expenses in the next annual fiscal year end assessment.

D. Levy of assessments. The Association may levy assessments following each fiscal year end.

1. The Association may also, upon approval of the commissioner, levy interim assessments when deemed necessary to assure the financial capability of the Association to meet the incurred or estimated operating and administrative expenses of the Association and losses resulting from the state plan. Interim assessments shall be due and payable within 30 days of receipt by a member of a written interim assessment notice.

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2. The Association shall levy each member's share of the total assessment based on the ratio of:

a. the member's total accident and health insurance premium, subscriber contract charges or health maintenance organization contract charges (the preceding defined as charges for business defined in 4 MCAR § 1.3225 A.1. and 3. above) received from or on behalf of residents of Minnesota, or total cost of self insurance, as determined by the commissioner, to

b. the total for all members of premiums, contract charges and benefit plan costs reported in 4 MCAR § 1.3225 D.2.a.

3. The costs and charges referred to in the ratio in 4 MCAR § 1.3225 D.2.a. and b. shall, to the extent possible, be determined by reference to a form issued by the Association or the commissioner which all members shall submit to the commissioner annually for the preceding calendar year.

a. If the required information is not available to the commissioner when necessary to levy an assessment the commissioner may estimate the member's share based on other available information relative to its experience, including but not limited to the annual statement which all insurers are required to transmit to the commissioner under Minn. Stat. § 60A.13.

b. The commissioner shall have the authority to audit the accounts and records of any member and any agent, trust, third party administrator or other entity administering all or any portion of a plan of health coverage with or on behalf of a self insurer for the purpose of obtaining information necessary to levy an assessment.

4. The board may, in its discretion, decline to levy assessments against members which owe up to $5.00 or less in a given year.

E. Failure to execute assessment agreement or to pay assessments. The names of all insurers, self insurers, fraternals and health maintenance organizations which are required under the act to be members of the Association, but which fail to execute an assessment agreement, will be forwarded by the Association to the commissioner for appropriate action within the discretion of the commissioner. Any members which fail to pay annual or interim assessments when such assessments become payable will be reported by the Association to the commissioner for appropriate action within the discretion of the commissioner.

4 MCAR § 1.3226 MCHA — organization and approval. The Association shall operate pursuant to the provisions of Minn. Stat. ch. 62E, with all the powers of a corporation formed under Minn. Stat. ch. 317, except that if the provisions of the two chapters conflict, ch. 62E shall govern.

A. Amendments to the articles of incorporation. Amendments to the articles of incorporation shall be submitted to and approved by the commissioner before filing with the Secretary of State.

B. Amendments to the by-laws. All Amendments to the by-laws of the Association shall be submitted to and approved by the commissioner before they become effective.

C. Operating rules. The board is authorized to adopt and to amend from time to time reasonable operating rules which are not inconsistent with the act and these regulations for the operation of the Association, and upon submission to and approval by the commissioner, these operating rules shall become effective.

4 MCAR § 1.3227 MCHA — board of directors.

A. Composition. The management of the Association shall be vested in a board of seven directors who shall be representative of the membership of the Association, and be officers, employees or agents of members of the Association during their terms of office, and shall automatically be removed for failure to meet this qualification.

B. Election. The board shall be elected by members at the annual meeting of the Association in accordance with the by-laws of the Association, to the extent that such by-laws are consistent with the provisions of Minn. Stat. chs. 317 and 62E, and in accordance with the provisions relating to voting rights as outlined in 4 MCAR § 1.3228.

1. Prior to the election, the Association may submit the names of proposed board members to the commissioner for approval, which may be granted according to criteria as determined by the commissioner.

2. After the annual meeting, the results of the election shall be certified and submitted to the commissioner for approval.

C. Duties. The duties of the board shall include management of the Association in furtherance of its purposes as provided in the act, and as authorized in the articles of incorporation and by-laws of the Association.

1. Members of the board may be reimbursed by the Association for expenses incurred by them in attending board or board committee meetings and for other reasonable expenses incurred within the scope of their activities as directors and within guidelines established by the board and approved by the commissioner, but shall not otherwise be compensated for their services.

D. Officers and committees. The board may elect officers and establish committees as provided in the by-laws of the Association. These officers and committees shall be charged with such duties as authorized by the board in accordance with the by-laws of the Association.

4 MCAR § 1.3228 MCHA — determination of member's voting rights.

A. Meetings. Every member is entitled to vote at the annual meeting and at any special meeting of the members.

B. Weighted vote. A member's vote shall be a weighted vote based on the member's cost of self-insurance, accident and health insurance premiums, subscriber contract charges or health maintenance contract charges derived from or on behalf of residents of Minnesota in the previous calendar year, as determined by the commissioner.

1. To the extent possible, this figure shall be determined by reference to the annual reporting form submitted to the commissioner in accordance with 4 MCAR § 1.3225 D.3.

2. If the necessary information is not available to the commissioner on the form described in 4 MCAR § 1.3228 B. at the time that voting rights must be determined, the commissioner may estimate the member's weighted vote based on other information available to the commissioner.

C. Voting procedures. Members are entitled to vote in person, by proxy, or by mail as determined by the board.

1. When a member elects to vote in person at a members' meeting, the representative casting the vote shall present credentials as may be required by the board.

2. When a member elects to vote by proxy, the proxy statement, as approved by the board and by the commissioner, shall be returned on or before the date indicated in the meeting notice sent to the members.

3. Voting by mail may be permitted as authorized by the board, provided that the meeting notice to members so indicates.

4 MCAR § 1.3229 MCHA — meetings of the Association.

A. Annual meeting. An annual meeting of the members shall be held for the purpose of electing directors as provided in 4 MCAR § 1.3227 B. and for the purpose of transacting any other appropriate business of the membership of the Association.

1. The meeting shall be held in the second calendar quarter of each year unless otherwise determined by the board, and shall occur at such date, time and place as the board determines.

2. "Appropriate business" includes any activities related to the powers and duties of the Association under Minn. Stat. chs. 62E or 317.

3. Notice and quorum requirements shall be as provided in the articles of incorporation or by-laws of the Association or as otherwise authorized by the board.

B. Special meetings. Special meetings of the members shall be held at the request of the commissioner and may otherwise be held as provided by the articles of incorporation or by-laws of the Association for the purpose of conducting any appropriate business of the Association.

1. A special meeting may be held at such date, time and place designated in the notice of the meeting.

2. Notice and quorum requirements shall be as provided in the articles of incorporation or by-laws of the Association or as otherwise authorized by the board.

C. Open meetings. All meetings of the Association membership, board and any committees established in accordance with 4 MCAR § 1.3227 D. shall be held in compliance with the provisions of the open meeting law (Minn. Stat. § 471.705).

4 MCAR § 1.3230 MCHA — minimum benefits of Comprehensive Health Insurance Plans.

A. Duty to offer. The Association shall offer a number 1 and number 2 qualified plan, and a qualified medicare supplement plan to eligible persons. The Association shall offer health maintenance plans in areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier in accordance with 4 MCAR § 1.3233 A. The Association may provide for coverage for eligible dependents.

B. Benefits of a number 1 and number 2 qualified plan. Benefits shall meet or exceed the requirements of Minn. Stat. § 62E.06 or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables set forth in Appendix I of these rules, except where substitution

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of an actuarially equivalent benefit is not permissible under the act.

1. The minimum benefits shall be equal to at least 80% of the charges for covered expenses in excess of the annual deductible which shall not exceed:

a. $500.00 for a number 2 qualified plan,

b. $1,000.00 for a number 1 qualified plan.

2. Coverage shall include an annual (calendar year) limitation of not more than $3,000.00 per covered person on total out-of-pocket expenses, which out-of-pocket expenses shall include the deductible under the state plan policy or contract, and which benefit (copayment) is not subject to substitution of an actuarially equivalent benefit (copayment).

3. Coverage shall be subject to a maximum lifetime benefit of not less than $250,000.00 per covered person, less any amount paid to or on behalf of the covered person under any other state plan policy or contract. This benefit is not subject to substitution of an actuarially equivalent benefit.

C. Benefits of a qualified medicare supplement plan. Benefits of a qualified medicare supplement plan shall meet or exceed the following minimum standards or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables set forth in Appendix I of these rules.

1. The plan shall provide benefits to covered persons who are 65 years of age or older by supplementing medicare through provision of 50% of the deductible and copayment required under medicare.

2. The plan shall provide 80% of the covered charges for expenses as provided in Minn. Stat. § 62E.06 or the actuarial equivalence thereof, which charges are not paid or payable under medicare or would not have been paid or payable had the covered person who is or was entitled or eligible to enroll in medicare been so enrolled.

3. Coverage shall include an annual limitation of $1,000.00 total out-of-pocket expenses per covered person for covered expenses.

4. Coverage may not be subject to a maximum lifetime benefit of less than $100,000.00.

D. Benefits of a health maintenance plan. Benefits of a health maintenance plan shall include those comprehensive health maintenance services required by Minn. Stat. ch. 62D and rules thereunder.

E. Pre-existing conditions. No person who obtains coverage under a policy or contract of the state plan shall be covered for any pre-existing condition during the first six months of coverage under the state plan if such covered person was diagnosed or treated for that condition during the 90 days immediately preceding the filing of a completed certificate of eligibility.

4 MCAR § 1.3231 MCHA — approval of state plan.

A. Submission of proposed state plan. Members of the Association may submit to the Association policies or contracts which have been approved by the commissioner for selection by the Association as the state plan.

B. Approval of policies or contracts by the Association. The Association shall select policies or contracts to constitute the state plan from among the proposals submitted by the members or from proposals developed by the Association or others. These policies and contracts, or parts thereof, may be used to develop specifications for bids from members which wish to be selected as a writing carrier to administer the state plan.

C. Approval of the state plan. The policies or contracts approved by the Association as the state plan shall be approved by the commissioner prior to issuance.

4 MCAR § 1.3232 MCHA — solicitation, application and enrollment of eligible persons in the state plan.

A. Open enrollment. The state plan shall be open for enrollment by eligible persons at all times.

1. "Eligible person" means a resident of Minnesota who submits or on whose behalf is submitted a complete certificate of eligibility and enrollment form to the Association or its writing carrier and who is not already covered by another state plan policy or contract.

a. A complete certificate of eligibility and enrollment form may, at the discretion of the Association, provide:

(1) name, address, age, sex, and length of time as a resident of Minnesota,

(2) name, address, and age of eligible dependents, if any, if they are to be insured;

(a) "eligible dependent" means the insured person's spouse who has not reached age 65 or unmarried child, excluding:

(i) a legally separated spouse;

(ii) a child who is nineteen years old or older unless that child is a student or disabled child;

(iii) a spouse or child who has applied for an individual state plan policy or contract pursuant to any conversion privilege granted to such eligible dependent under the insured person's state plan policy or contract; and

(iv) a spouse or child on active duty in any military, naval or air force of any country.

(3) evidence of rejection, or a requirement of a restrictive rider or pre-existing conditions limitation on a qualified plan the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, by at least two Association members within six months of the date of application. "Substantially reduce coverage from that received by a person who is considered a standard risk" includes any restriction on coverage as a result of an illness, condition, or risk which the Association deems substantial, any increase in rates for an applicant based on an illness, condition or risk, which the Association deems substantial; and any pre-existing conditions limitation which the Association deems substantial.

b. Before a person is determined to be an eligible person, the board may, in its discretion, require that any items listed in 4 MCAR § 1.3232 A.1.a. or other information deemed necessary by the board be submitted to the association or its writing carrier and may also investigate the authenticity of information submitted as a part of the certificate of eligibility.

c. If a covered person, upon reaching age 65, wishes to purchase a state plan qualified medicare supplement plan, the requirement that the person obtain two rejections from members of the Association within the preceding six months may be waived by the board.

d. A person who is age 65 or older shall be eligible for coverage only under the state plan's qualified medicare supplement plan and when an insured person under a qualified plan reaches age 65, the board may, in its discretion, terminate or refuse to renew coverage under the qualified plan.

e. An applicant or any person proposed to be covered under the state plan who has previously been covered by a state plan policy or contract and who has exhausted the maximum lifetime benefit under the state plan shall not be an eligible person for coverage under the state plan, and if such person has exhausted $100,000.00 of the maximum lifetime benefit under the state plan, such person shall not be an eligible person for coverage under a qualified medicare supplement policy or contract of the state plan.

f. When a covered person under the state plan no longer meets one or more of the requirements for eligibility for coverage under the state plan, the board may, in its discretion, terminate or refuse to renew coverage under the state plan.

B. Association's response. Within 30 days of receipt of a complete certificate of eligibility and application pursuant to 4 MCAR § 1.3232 A.1.a. and b., the Association or the writing carrier shall accept the certificate of eligibility or shall reject the certificate of eligibility for failure to meet the eligibility requirements.

1. If the Association or its writing carrier accepts the certificate of eligibility, it shall forward a notice of acceptance, billing information and a policy or contract (or certificate) which shall evidence coverage under the state plan.

a. Such policy or contract (or certificate) of coverage shall include but not be limited to:

(1) a statement that the person is covered under the state plan from the effective date contained therein,

(2) specification of the type of state plan under which the person is covered,

(3) a statement that the plan is provided by the Association.

(4) a description of the benefits provided by the plan, conditions for eligibility, and exclusions and limitations of coverage, and

(5) provision for an identification card for each insured person indicating the type of state plan and also that coverage is being provided by the Association.

b. When the state plan premium is received by the Association or its writing carrier for the first billing period (and accepted in accordance with 4 MCAR § 1.3232 B.) the coverage shall be effective retroactive to the date of receipt by the Association or its writing carrier of the completed certificate of eligibility pursuant to 4 MCAR § 1.3232 A.1.a. and b. unless otherwise requested by the insured person and approved by the board.

2. If the Association does not accept the certificate of eligibility the applicant shall be informed of the reason for the rejection and shall have the opportunity to submit additional information to substantiate eligibility for coverage under the state plan and to request reconsideration of the

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decision. The board may establish a review mechanism for reviewing requests for reconsideration of rejected certificates of eligibility. The Association shall give notice of a final determination of ineligibility to the applicant stating the reasons therefor and advising the applicant of the right to appeal to the commissioner within a reasonable period of time.

C. Appeal to commissioner. Any applicant who is determined by the Association to be ineligible for coverage under the state plan may appeal such determination to the commissioner within a reasonable period of time. Upon receipt of an appeal from a determination of ineligibility, the commissioner may, in his discretion, affirm, reverse, or modify the determination of the Association.

D. Solicitation of eligible persons. The Association shall develop a plan for use by the Association, upon approval by the commissioner, to publicize the existence of the state plan, the eligibility requirements and procedures for enrollment, and to maintain public awareness of and participation in the state plan.

1. The Association may prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance solicitators, agents and brokers, and to the general public in Minnesota.

2. The Association shall require the writing carrier to pay a referral fee of $25.00 for any certificate of eligibility accepted by the Association or its writing carrier. The referral fee shall be paid to the licensed agent whose signature appears as the agent on the accepted certificate of eligibility. The referral fee shall be paid from the premium received for the state plan.

4 MCAR § 1.3233 MCHA — selection, approval, and operations of writing carrier(s).

A. Selection and approval of a writing carrier(s).

1. The Association may select a writing carrier or writing carriers on the basis of criteria for selection which shall include but not be limited to:

a. the member's proven ability to handle large group accident and health insurance cases,

b. the efficiency of the member's claim paying capacity,

c. an estimate of total charges for administering the plan, and

d. other criteria developed by the Association or the commissioner.

2. The writing carrier selected by the Association shall be approved by the commissioner prior to the establishment of a contract with the Association and prior to the commencement of its duties pursuant to Minn. Stat. § 62E.13 and 4 MCAR § 1.3233 B.

3. The writing carrier shall serve for a period of three years, unless the commissioner approves an earlier termination at the request of the writing carrier or the Association in accordance with the terms of its contract with the writing carrier.

a. The commissioner shall approve or deny a request for termination within 90 days of receipt of such request.

b. Failure to make a determination within 90 days of receipt of such request shall be deemed to be an approval.

4. If termination is approved by the commissioner, the writing carrier shall serve for up to six months from the date of the writing carrier's request for termination, at the discretion of the Association, to allow the Association to select another writing carrier.

5. Six months prior to the expiration of each three year period of service by a writing carrier, the Association shall invite insurer and health maintenance organization members, including the current writing carrier(s), to submit bids to serve as writing carrier for the succeeding three year period.

B. Operations of the writing carrier.

1. The writing carrier shall perform all administrative and claims payment functions relating to the state plan.

a. The writing carrier shall establish a premium billing procedure for collection of premiums from insured persons.

(1) Billings shall be made on a periodic basis as determined by the board.

(2) The amount of the premium shall be as determined from time to time by the board pursuant to Minn. Stat. § 62E.08.

b. The writing carrier shall perform all necessary functions to assure timely payment of benefits to covered persons under the state plan.

(1) The writing carrier shall make available information relating to the proper manner of submitting a claim for benefits under the state plan and shall distribute forms upon which submissions shall be made.

(2) The writing carrier shall evaluate the eligibility of the claim for payment under the state plan.

(3) The writing carrier shall determine the usual and customary charges for professional services, supplies or institutional care for which a claim is made under the state plan policy or contract.

(4) Within 15 working days of receipt by the writing carrier of a properly completed and executed proof of loss, the covered person shall, to the extent possible, be advised whether the claim was accepted or rejected by the writing carrier, unless already settled.

(5) The writing carrier shall establish an appeals procedure approved by the board to review claims which are denied in whole or in part. When a claim or any portion thereof is denied, the writing carrier shall inform the covered person of the existence of the procedure, including the right to appeal to the commissioner within a reasonable period of time.

2. The writing carrier shall submit monthly reports to the commissioner and the board on the operation of the state plan. The content and form of the report shall be as determined by the board and approved by the commissioner.

3. The writing carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the state plan. If the writing carrier's payments for claims expenses exceed the portion of the state plan premiums allocated by the board for payment of claims expenses, the Association shall provide to the writing carrier additional funds for payment of claims expenses. Not less than 87½% of the state plan premium, as determined by the board, shall be used to pay claims expenses, and not more than 12½% of the state plan premium shall be used to pay agent referral fees (authorized by Minn. Stat. § 62E.15, subd. 3) and to pay the writing carrier's direct and indirect expenses (as defined and authorized in Minn. Stat. § 62E.13, subd. 7 and described in 4 MCAR § 1.3233).

4. The writing carrier shall be paid from time to time as provided in the Association's contract with the writing carrier for its direct and indirect expenses incurred in the performance of its services from the state plan premiums received in an amount not to exceed the lesser of:

a. 12½% of the state plan premium, less agent referral fees payable under 4 MCAR § 1.3232 C.1.b.,

b. direct and indirect operating and administrative expenses incurred in the performance of its services, and

c. an amount agreed upon by the board and the writing carrier.

5. "Direct and indirect expenses" shall include that portion of the carrier's actual administrative, printing, claims administration, management, building overhead expenses and other actual operating and administrative expenses approved by the board as allocable to the administration of the state plan.

6. The board shall approve cost accounting methods of the writing carrier, which shall be consistent with generally accepted accounting principles.

7. The board shall have the authority to conduct periodic audits to verify the accuracy of financial data and reports submitted by the writing carrier.

C. Appeal to commissioner. Any covered person where claim for benefits under the state plan is denied, in whole or in part, may appeal such determination to the commissioner within a reasonable period of time. Upon receipt of an appeal from a claim denial, the commissioner may, in his discretion, affirm, reverse or modify the determination of the Association.

4 MCAR § 1.3234 MCHA — reinsurance.

A. Authority to make available reinsurance. The Association may provide for reinsurance of risks incurred by insurer or fraternal members resulting from such members' issuance of all or any of the following categories of coverage as provided in the act:

1. individual qualified plans (but not including group conversions),

2. individual qualified medicare supplement plans (but not including group conversions),

3. group conversions on qualified plans,

a. "group conversions" means the conversion policies or contracts required to be issued under Minn. Stat. §§ 62A.16-62A.17 or § 62E.16;

4. group qualified plans which cover fewer than 50 employees or insured persons,

5. group qualified medicare supplement plans with fewer than 50 employees or insured persons,

6. individual major medical coverage, and

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7. group major medical coverage.

A member may make a separate election to reinsure each of the above categories of coverage.

B. Reinsurance plan. The Association may enter into reinsurance pooling agreements with insurer and fraternal members to establish a reinsurance plan for risks of categories of coverage described in 4 MCAR § 1.3234 A. The reinsurance plan may provide for a reinsurance pool.

1. Insurer or fraternal members wishing to participate in the pool shall apply to the Association for participation in the pool, specifying the categories of coverage which the member desires to reinsure.

a. Members entering into a reinsurance pooling agreement for a particular category or categories of coverage shall offer to place in the pool all policies and contracts that it issues in the category or categories listed in 4 MCAR § 1.3234 A. which it wishes to reinsure.

b. Only policies and contracts acceptable to the Association or its reinsurance administrator may be accepted for reinsurance. The Association is under no obligation to accept any but standard risks in the reinsurance plan.

2. The Association may obtain commercial reinsurance to reduce the risk of loss through the pool to insurer or fraternal members entering into reinsurance pooling agreements. Any contract for commercial reinsurance entered into between the Association and a commercial reinsurer shall be binding on any insurer or fraternal member entering into a reinsurance pooling agreement.

3. The Association may administer the pool directly or through a reinsurance administrator.

a. The Association or its reinsurance administrator may establish underwriting standards with which participating members shall comply and may perform reinsurance underwriting on all policies or contracts submitted for reinsurance.

b. The Association or its reinsurance administrator may perform benefit calculation (claims processing) for all claims eligible for reimbursement to participating members. Only claims paid by participating members and approved by the Association or its reinsurance administrator shall be eligible for reimbursement by the Association or its reinsurance administrator in accordance with the reinsurance pooling agreement.

c. Except for underwriting and claims processing functions, the Association or the reinsurance administrator shall have no responsibility for other administration functions for any member's reinsured policies or contracts unless otherwise agreed to by the Association.

4. Participating members shall have the duties established in the reinsurance pooling agreement, including but not limited to:

a. submitting reports which provide all information deemed necessary by the Association or its reinsurance administrator for performance of reinsurance, underwriting, and claims processing functions;

b. paying all pooling payments; and

c. paying all reinsurance assessments and interim reinsurance assessments as required by the board.

C. Pooling payments. The Association may require pooling payments from all participating members, to provide for reimbursement to participating members for claims paid under reinsured policies and contracts and for payment of administrative expenses of the pool incurred or estimated to be incurred during the period for which the pooling payment is made. Pooling payments shall be established by the Association to provide at least 110% of total anticipated expenses for reinsurance and for administration of the policies or contracts which are reinsured.

D. Assessment of participating members.

1. At the end of each calendar year (or other fiscal year end established by the Association) the board may assess participating members on the basis of the formula established in or as a part of the reinsurance pooling agreement.

2. The board may also levy interim reinsurance assessments to assure the financial ability of the Association to reimburse participating members for claims paid under reinsured policies and contracts and operating and administrative expenses incurred or estimated to be incurred in the operation of the reinsurance plan until the calendar year end (or other fiscal year end established by the Association) reinsurance assessment.

a. Interim reinsurance assessments shall be due and payable within 30 days of receipt by a participating member of an interim reinsurance assessment notice.

b. Interim reinsurance assessments shall be credited to each participating member in the year end reinsurance assessment calculation.

3. Each participating member's reinsurance assessment (net after credit for any interim reinsurance assessment) shall be billed to the member by the Association following each calendar year end (or other fiscal year end established by the Association) and shall be due and payable

within 30 days of receipt by the member of the reinsurance assessment notice.

E. Excess receipts. If pooling payments, reinsurance assessments and other receipts by the Association or its reinsurance administrator as a result of the reinsurance plan exceed actual reinsurance losses and administrative expenses of the pool, such excess shall be held at interest and used by the Association to offset losses (including but not limited to reserves for incurred but not reported claims) due to claims expenses of the state plan or allocated to reduce state plan premiums.

4 MCAR § 1.3235 MCHA — severability. If any section or provision of these rules is declared unconstitutional or void by any court of competent jurisdiction or its applicability to any person or circumstances is held invalid, the constitutionality or validity of the remainder of the rules and applicability to other persons and circumstances are not affected, and to this end, the sections and provisions of these rules are declared to be severable.

4 MCAR §§ 1.3236-1.3250 — Reserved for future use.

APPENDIX I

Minnesota Comprehensive Health Insurance Act of 1976
Actuarial Equivalence of Qualified Plans and
Qualified Medicare Supplement Plans

I. How to Use the Test

A. Basic and Comprehensive Major Medical Plans.

1. List the Plan benefits, ignoring deductibles and coinsurance.

2. For each benefit, find the appropriate Table of Equivalent Points for Basic and Major Medical Plans.

3. Extract the appropriate point value for the benefit from the Table, interpolating as necessary or indicated, and place it opposite the listed benefit.

4. Ignore benefits for which no Table exists.

5. List deductible, coinsurance and plan maximum if the Plan is a Comprehensive Major Medical Plan.

6. Find Table(s) of points for deductible, coinsurance and plan maximum.

7. Extract the appropriate point values for deductible, coinsurance and plan maximum, usually negative, interpolating as necessary, and place the values in the list of points.

8. Add algebraically the list of points.

9. Refer the result to the Test For Actuarial Equivalence to determine Qualification.

B. Superimposed Major Medical Plans.

1. Follow steps A.1 through A.4 for Basic Health Plan Benefits.

2. Total the points for the Basic Plan.

3. Enter Tables 21, 22 and 23 of the Tables of Equivalent Points to determine the point value of a Qualified Plan superimposed over the Basic Plan with the Deductible and Benefit Period of the Plan at hand, interpolating as necessary. Put the points in the point column.

4. Compare the benefits in the Superimposed Major Medical Plan with the benefit structure of a Qualified Plan:

a. $250,000 Lifetime Maximum.

b. 80/20 Coinsurance.

c. $3,000 annual per person out-of-pocket maximum.

d. Eligible Expenses are Usual and Customary Expenses For:

(1) Hospital Services.

(2) Physician Care.

(3) Prescription Drugs.

(4) Nursing-Home Care of up to 120 days in one year commencing within 14 days of hospitalization of at least three days.

(5) Home Health Care.

(6) Radium and Radioactive Therapy.

(7) Oxygen.

(8) Anesthetics.

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(9) Prostheses.

(10) Rental or purchase of durable medical equipment.

(11) Diagnostic X-Rays and laboratory tests.

(12) Oral surgery on impacted teeth, teeth roots and gums and tissues, not in connection with tooth extration.

(13) Physical therapy.

(14) Maternity same as any illness.

(15) Minnesota statutorily mandated benefits.

(16) Coordination of Benefits.

5. Consult the Tables for point adjustments (usually negative) for Qualified Plan benefits not in the Superimposed Major Medical Plan being tested. Put the adjustments in the point column.

6. Add algebraically the points for the Basic Plan (B.2.), the Superimposed Major Medical Plan (B.3.) and the adjustments (B.5.).

7. Refer the result to the Test for Actuarial Equivalence to determine Qualification.

C. Medicare Supplement Plans.

1. Follow the rules for Basic and Comprehensive Major Medical Plans but use the Tables of Equivalent Points for Medicare Supplement Plans and the Medicare Supplement Table of Actuarial Equivalence.

II. Benefit Variations Not Covered by Tables.

Only those plan variations that are most common are recognized. For instance, Comprehensive Plan coinsurance was assumed to normally not exceed 20%. Therefore, no points are shown for 25%. However, points for such missing benefit variations can be extrapolated or estimated.

III. Use of Tables.

Any insurer, self insurer, or policyholder may use the Test for Actuarial Equivalence as a Guide. However, to obtain certification of any plan of health benefits as "Qualified", it must be submitted to the commissioner. If an uninsured plan description or a policy form number or policy identification number is sent to the commissioner, together with a statement of its total Equivalent Point Value from the Tables, and with a certification by a principal or officer of an insurer, or by a Member of the Academy of Actuaries for plans submitted by employers, that the plan is Qualified by virtue of the Test of Actuarial Equivalence as either a Plan 1, 2 or 3 or a Medicare Supplement Plan, the plan will be deemed certified as filed. If the Test does not qualify a plan or does not result in qualification for the Plan (i.e., 1, 2 or 3) desired by the insurer or self insurer, the filing must include the plan document or policy, the Equivalent Point Calculation and a statement of specific reasons for the desired qualification. Such plan will not be qualified until and unless so certified by the commissioner.

IV. Update of Tables.

Periodically, the Tables may be revised as health care cost change. The commissioner may re-evaluate actuarial equivalence of any plan or policy at any time as he believes appropriate. Annual re-evaluation of plans is therefore suggested. When a plan is re-evaluated and its qualification status changes, the filing procedures in III, above, will be followed.

V. Mis-Use of Tables.

The tables of Equivalent Points are not intended for any other use, especially not for premium calculations. Thev represent a composite of dat, adjusted to be useable for testing actuarial equivalence. No other use is contemplated.

VI. Why the Test was Developed.

Minn. Stat. § 62E.02 defines Qualified Plans and Qualified Medicare Supplement Plans as health benefit plans that provide the benefits required in Minn. Stat. §§ 62E.06 or 62E.07, "or the actuarial equivalent to those benefits"; Minn. Stat. § 62.06 describes three Qualified Plans and Minn. Stat. § 62E.07 describes a Qualified Medicare Supplement Plan. These statutes require all plans of health coverage to be labelled as Qualified or Non-Qualified. The commissioner may be requested to determine whether a plan is qualified and he may take up to 90 days to make that determination.

The composite point values for a Qualified Plan number 3 and the point values for the Qualified Medicare Supplement Plan are as shown herein.

Composite Point Values For
Minnesota Qualified Plan No. 3
Arbitrary Radix = 1,000 Points

Points	Benefit
395	Hospital Room and Board — unlimited days, semi-private.
485	Hospital Extras (i.e., Hospital Services, Hospital Miscellaneous, Hospital Special Services, or Ancillary Services) including anesthesia.
210	Surgery, including oral surgery but no tooth repair or extraction.

220	Home and Office Physician Care — unlimited.
55	Physician Care in Hospital — unlimited.
75	Obstetrics — unlimited.
125	Hospital maternity — unlimited.
90	X-Rays and Laboratory tests — outpatient and out of hospital.
90	Prescription Drugs and Medicine — outpatient and out of hospital.
20	Emergency Accident Care.
15	Radioactive Therapy — outpatient and out of hospital.
20	Nursing or Convalescent Facility.
10	Home Health Agency Care.
10	Physical Therapy.
20	$3,000 annual "out of pocket" expense limit.
−75	Coordination of Benefits.
−45	Non-Duplication with No-Fault.
−430	$150 Deductible.
−290	20% Coinsurance.
1,000	Total

Note: When setting up the above table, some minor benefits (e.g., student dependents to age 25, oxygen, etc.) specified in the Statute were overlooked. All have extremely nominal point value so no re-calculation has been made for them at this time.

Composite Point Values For
Minnesota Qualified Medicare Supplement Plan
Arbitrary Radix = 100 Points

Points	Benefit
26.13	Hospital Room and Board — unlimited days, semi-private, reasonable and customary — Net of Medicare payments.
3.90	Skilled Nursing Home — Net of Medicare Payments.
.15	Blood and Blood Plasma (In Hospital) — Not provided by Medicare.
45.78	*Surgery, including oral surgery but no tooth repair or extraction.
104.66	*Home and Office Physician Care — unlimited.
22.70	*Physician Care in Hospital — unlimited.
57.58	*X-Rays and Laboratory tests — outpatient and out of hospital.
5.00	*Radioactive Therapy — outpatient and out of hospital.
3.75	*Home Health Agency Care.
1.48	*Miscellaneous.
48.67	Drugs and Medicine — outpatient and out of hospital.
5.00	Private duty nursing.
−158.89	Part B Medicare payments credit.
−54.64	50% of Medicare Coinsurance and Deductibles.
−11.27	20% of expenses not covered by Medicare.
100.00	Total

*Gross expense — before Medicare payment under Part B.

Plan Name _____ Plan No. _____

WORKSHEET
Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other then Medicare Supplement Plans

			Major Medical	
Table	Benefit	Basic	Superimposed	Comprehensive
21-23	Superimposed Major Medical	XXX		XXX
1.	Hospital Room and Board			
2.	Hospital Extras			
3	Surgery			
4.	Physician Care — Home, Office			
5.	Physician Care — Hospital			
15-18	Benefits In Full			

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6.	Maternity			
7.	Diagnostic X-Ray and Lab			
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident			
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility			
13.	Home Health Care			
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents			
24.	Limit on Out of Pocket			
25.	Maximum Benefit	XXX		
XX.	Subtotal			
26.	COB/No-Fault			
19-20	Coinsurance/Deductible	XXX		
XX.	Total			
XX.	Combined Basic and Superimposed		XXX	XXX

Equivalent to Minnesota Qualified Plan Number _____ Non-Qualified ☐

Date _____ By _____

Plan Name _____ Plan No. _____

WORKSHEET
Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

B. Medicare Supplement Plan

Table	Benefit	Days	Daily Benefit	Factor	Product
27.	Hospital — Defined daily benefit				
		1		9.59	
		2-60		83.56	
		61-90		1.50	
		91-150		.61	
		151 & Over		1.02	
		Total	XXX		
		Divisor			
		Quotient			
		Multiplier			
		Product			
27.	Hospital — Usual and customary charges not paid by Medicare				
	A. Medicare Deductible and Coinsurance				
	B. Benefits not covered by Medicare				
28.	Skilled Nursing Facility				
29.	Blood				
30.	Surgery				
31.	Physician Care — Home and Office				
32.	Physician Care — Hospital				
33.	Home Health Care				
34.	Diagnostic X-Ray and Laboratory				
35.	Radioactive Therapy				
36.	Drugs and Medicine				
37.	Private Duty Nursing				
38.	Miscellaneous				
41.	Comprehensive Major Medical				
XX.	Subtotal				
39.	Medicare Part B Payments				
40.	Medicare Part B Deductible not Eligible				
XX.	Total				

Equivalent to Minnesota Qualified Medicare Supplement Plan: Yes ☐ No ☐

Date _____ By _____

Test For
Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. For Plans Other Than Medicare Supplement Plans

If the Point Value of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualified Plan No.:
1,000 + points	3
700 + points	2
550 + points	1
Less than 550 points	Non-Qualified

B. For Medicare Supplement Plans

If the Point Value of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualified Plan No.:
100 + points	Minnesota Medicare Supplemental Plan

Location of Tables
of
Equivalent Points

A. Basic and Major Medical Health Plans

Table	Name
1.	Hospital Room and Board
2.	Hospital Extras
3.	Surgery
4.	Home and Office Physician Care
5.	In Hospital Physician Care
6.	Maternity
7.	Diagnostic X-Ray and Laboratory
8.	Drugs and Medicine
9.	Emergency and Supplemental Accident
10.	Radioactive Therapy
11.	Student Dependents
12.	Nursing or Convalescent — Home Care
13.	Home Health Care Agency Service
14.	Physical Therapy
14.	Oxygen
14.	Prostheses
14.	Durable Medical Equipment
15.	Hospital Room and Board in Full
16.	All Hospital Charges in Full
17.	All Hospital and Surgical Charges in Full
18.	All Hospital, Surgical and In-Hospital Physicians Care in Full
19.	Coinsurance and Deductibles
20.	Combined Dental and Health Insurance Deductible
21.	Superimposed Major Medical
22.	Superimposed Major Medical
23.	Superimposed Major Medical
24.	Limit on ''Out of Pocket'' Expenses
25.	Major Medical Maximums
26.	Coordination and Non-Duplication of Benefits

B. Medicare Supplement Plans

27.	Hospital Room and Board and Extras
28.	Skilled Nursing Facility
29.	Blood
30.	Surgery
31.	Home and Office Physician Care
32.	In-Hospital Physician Care
33.	Home Health Care
34.	Diagnostic X-Ray and Laboratory
35.	Radioactive Therapy
36.	Drugs and Medicines
37.	Private Duty Nursing
38.	Physical Therapy
38.	Oxygen
38.	Prostheses
38.	Durable Medical Equipment
39.	Medicare Part B Payments
40.	Medicare Part B Deductible
41.	Comprehensive Major Medical

Table of Equivalent Points For Basic and Major Medical Health Plans
(Not To Be Used For Medicare Supplement Plans)

1. Hospital Room and Board.

Maximum Days	Semi-Private Room at $81.00 Per Day	Deduct for Each $10/Day Less than Semi-Private
31	330	40
70	370	46
120	380	48
365	390	49
Unlimited	395	50

Additional Points Per $1.00
Excess of Private over Semi-Private 2

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2. Hospital Extras (i.e., Hospital Services, Special Hospital Services, Ancillary Services, Hospital Therapeutics, etc.)

Maximum Amount	Anesthesia	
	Included	Not Included
$ 250	250	245
500	335	305
1,000	410	265
2,000	450	400
5,000	475	415
Unlimited	485	425

3. Surgery.

Limit	Assistant Surgeon Included	Anesthesia	
		Included	Not Included
1957 Intercompany			
a. $420 Maximum	No	100	85
b. $900 Maximum	No	195	170
Prevailing Fee*	No	230	200
Deduct for each "$1.00 per 1964 CRVS Unit" less than Prevailing Fee		25	22
Prevailing Fee*	Yes	240	210
Deduct for each "$1.00 per 1964 CRVS Unit" less than Prevailing Fee		25	22

*Equivalent to $9.00 per 1964 CRVS Unit.

4. Home and Office Physician Care.

Annual Maximum	First Visit Accident	
	First Visit Sickness	Third Visit Sickness
$ 100	115	65
200	140	75
500	170	95
Unlimited	220	120

5. In-Hospital Physician Care.

Maximum Number of Visits	Prevailing Fee at Average $15.50/Day/Visit	Deduct for Each $1.00 Per Day Per Visit Less Than Prevailing Fee
31	40	3
70	46	3
120	49	3
365	52	4
Unlimited	55	4

6. Maternity.

A. Complications only:

a.	Limited to some specified list	20
b.	Any complications	25

B. Full Maternity (including complications):

Limit	Deductible	Flat Maternity	Obstetrics	Hospital Maternity
$ 150	None	—	25	30
300	None	55	50	60
500	None	90	70	90

1,000	None	170	—	—
Unlimited	None	200	75	125
Unlimited	$500	100	—	—
Unlimited	$1,000	30	—	—

7. X-Rays and Laboratory Tests (Out of Hospital).

Maximum	Scheduled (Any Schedule)	Unscheduled
$ 50	40	50
100	55	70
200	60	80
Unlimited	65	90

8. Prescription Drugs and Medicine (Out of Hospital).

Deductible Per Prescription	
$ 2.00	60
1.00	75
None	90

9. Emergency and Supplemental Accident (Basic Plans Only).

Maximum	Emergency	Supplemental
$ 25	10	—
50	15	20
150	—	30
300	—	35
500	—	40
Unlimited	20	—

10. Radioactive Therapy (Out of Hospital).

Scheduled (Any Schedule)	10
Unscheduled	15

11. Student Dependents.

Student Extension Beyond Age 19	
None	0
To Age 21	2
To Age 23	4
To Age 25	5

12. Nursing or Convalescent Home Care (Within 14 days of hospital confinement of at least three days).

Maximum Days	
120 or More	20
Less than 120	0

13. Home Health Care Agency Services

Maximum Visits/Year	
180 or More	10
Less than 180	0

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14. Miscellaneous (Out of Hospital).

A. Physical Therapy	10
B. Oxygen	5
C. Prostheses	5
D. Durable Medical Equipment Rental or Purchase	5

15. Hospital Room and Board in Full to Indicated Limit (Basic and Comprehensive Major Medical Plans) — Use in leiu of Room and Board points in Number 1, above.

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Limit $1,000	Limit $2,000	Limit $5,000	Limit Unlimited
Basic	0	100%	300	325	365	395
Comprehensive	0	20%	455	460	470	475
Comprehensive	$ 50	20%	480	485	500	505
Comprehensive	100	20%	495	505	520	530
Comprehensive	150	20%	510	520	535	550

16. All Hospital Charges in Full to Indicated Limit (Basic and Comprehensive Major Medical Plans) — Use in lieu of Room and Board and Hospital Extras in Numbers 1 and 2, above.

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Limit $1,000	Limit $2,000	Limit $5,000	Limit Unlimited
Basic	0	100%	615	710	805	880
Comprehensive	0	20%	1005	1025	1045	1060
Comprehensive	$ 50	20%	1050	1080	1100	1130
Comprehensive	100	20%	1090	1125	1150	1180
Comprehensive	150	20%	1120	1160	1195	1225

17. All Hospital and Surgical Charges In Full to Indicated Limit (Basic and Comprehensive Major Medical Plans) — Use in lieu of Room and Board, Hospital Extras and Surgery points in Numbers 1, 2 and 3, above.

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Hospital Surgery	$1,000 $5 CRVS	$2,000 $6 CRVS	$5,000 $8 CRVS	Unlimited Unlimited
Basic	0	100%		740	855	955	1090
Comprehensive	0	20%		1240	1265	1295	1310
Comprehensive	$ 50	20%		1295	1330	1370	1400
Comprehensive	100	20%		1340	1385	1440	1465
Comprehensive	150	20%		1375	1425	1480	1515

18. All Hospital, Surgical and In Hospital Physicians Care In Full to Indicated Limit (Basic and Comprehensive Major Medical Plans) — Use in lieu of Room and Board, Hospital Extras, Surgical and In Hospital Physician Care points in Numbers 1, 2, 3 and 5, above.

Plans	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Hospital Surgical Physician	$1,000 $5 CRVS $5/Day	$2,000 $6 CRVS $6/Day	$5,000 $8 CRVS $8/Day	Unlimited Unlimited Unlimited
Basic	0	100%		750	865	1015	1145
Comprehensive	0	20%		1290	1320	1350	1375
Comprehensive	$ 50	20%		1355	1390	1430	1465
Comprehensive	100	20%		1400	1440	1490	1530
Comprehensive	150	20%		1440	1485	1540	1585

19. Coinsurance and Deductibles (Comprehensive Major Medical Plans).

Deductible	Coinsurance: Insured Pays Designated Percent of Expense in Excess of Deductible		
	0%	10%	20%
$ 0	0	−170	−375
50	−170	−325	−520
100	−310	−455	−630
150	−410	−520	−720
200	−520	−640	−790
500	−820	−910	−1020
1,000	−1010	−1080	−1170

20. Combined Dental and Health Insurance Deductible (Comprehensive Major Medical Plans).

Deductible	Added Points
$ 50	90
100	75
150	65
200	40
500	35
1,000	15

21. Superimposed Major Medical Plans — Over Basic Health Plans With Less than 500 Points.

1. Calculate point value of a Comprehensive Major Medical Plan using deductible $100 greater than actual.

2. Add Basic Health Plan points.

22. Superimposed Major Medical Plans — 80/20 Coinsurance — Over Basic Health Plans With 500-799 Points.

Deductible:	Add to Basic Plan Points			
	Calendar Year Plan		2 Year Benefit Period Plan	
	Individual	2 × Family	Individual	2 × Family
A. Corridor				
$ 50	740	780	745	765
100	665	705	680	700
150	615	655	630	650
200	575	615	590	610
500	365	405	380	400
B. Integrated				
$ 500	615	635	650	670
1,000	515	525	535	545

NOTE: Points assume Major Medical contains Minnesota Qualified Plan Number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

23. Superimposed Major Medical Plans — 80/20 Coinsurance — Over Basic Health Plans With 800 or More Points.

Deductible:	Add to Basic Plan Points			
	Calendar Year Plan		2 Year Benefit Period Plan	
	Individual	2 × Family	Individual	2 × Family
A. Corridor				
$ 50	505	535	515	525
100	445	475	455	465
150	405	435	415	425
200	365	395	375	385
500	205	235	215	225

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B.	Integrated				
	$ 500	505	525	530	550
	1,000	405	415	420	430

NOTE: Points assume Major Medical contains Minnesota Qualified Plan Number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

24. Limit on "Out of Pocket" Expenses (i.e., maximum Co-payment and Deductible per benefit year) — Comprehensive and Superimposed Major Medical Plans.

Out of Pocket Limit	Deductible: Coinsurance:	$50 20%	$150 20%	$500* 20%	$1,000 20%
$ 500		80	100	200	—
1,000		36	40	55	60
3,000		20	20	22	25
5,000		10	10	11	13
10,000		5	5	5	6

*Use this column for Superimposed Major Medical Plans

25. Major Medical Maximum (Comprehensive and Superimposed Plans).

Maximum	Add (+) or Subtract (−)
$ 10,000	−50
20,000	−40
50,000	−20
100,000	− 7
250,000	0
Unlimited	+ 5

26. Coordination and Non-Duplication of Benefits (All Plans)		Deduct the Following Percentage of Total Points Before Crediting Points For Deductible and Coinsurance
a.	With other health plans	4.0%
b.	With No Fault	2.5%
c.	With both a. and b.	6.5%
d.	With neither	0

TABLES OF EQUIVALENT POINTS
FOR MEDICARE SUPPLEMENT

27. Hospital Room and Board and Extras

During a spell of illness, Medicare Part A pays all expenses except for the deductible and coinsurance amounts for hospital services during the first 90 days of hospitalization. If hospitalization continues, Medicare will pay the expenses greater than the coinsurance amount until the life-time reserve of 60 days is reached.

Use the following procedure to obtain the Equivalent Point value for a benefit which pays a certain amount if the individual is hospitalized a specified number of days:

a. Multiply the benefits provided by the policy by the appropriate adjustment factors given below and sum.

b. Calculate value of Medicare Deductible and Coinsurance — Multiply the current Medicare deductible and coinsurance amounts by the appropriate adjustment factors and sum. (Calculated below for July 1, 1976 deductible and coinsurance — recalculate each time Medicare changes deductible and coinsurance.)

c. Divide the value from step (a) by step (b).

d. Multiply step (c) by 23.78

	Value of July 1, 1976 Medicare Deductible and Coinsurance		
Days In Hospital	Adjustment Factor	Medicare Deductible and Coinsurance	Value
1	09.59	$104	997.36
2-60	83.56	0	0.00
61-90	1.50	26	39.00
91-150	.61	52	31.72
151	1.02	0	0.00
Total			1068.08

Since the Medicare Deductible and Coinsurance provisions change annually, policies using the defined benefit approach should be re-evaluated annually.

If the policy does not pay a defined benefit during hospitalization but pays all usual and customary charges for hospital inpatient services not paid by Medicare, then use 23.78 and 2.35 as the Equivalent Point value for the benefits providing for the Medicare Deductible and Coinsurance amounts and for the benefits not covered by Medicare respectively.

28. Skilled Nursing Facility

Medicare Part A pays the usual and customary expenses of a qualified Skilled Nursing Facility exclusive of a coinsurance amount after twenty days of confinement up to a maximum of 100 days per spell of illness.

Payment of the Coinsurance Amount (currently $13) up to 100 days	3.50
Payment of reasonable and customary expenses 100 to 120 days	.30
Payment of reasonable and customary expenses after the 120th day	.10

29. Blood

Medicare does not pay for the first 3 pints of blood while in the hospital. If the policy covers this, then the Equivalent Point value is .15.

30. Surgery

	Assistant Surgeon Included	Anesthesia Included	Anesthesia Not Included
Prevailing Fee*	No	48.70	43.60
Deduct for each "1.00 per 1964 CRVS Unit" less than Prevailing Fee		5.05	4.60
Prevailing Fee*	Yes	50.45	45.78
Deduct for each "$1.00 per 1964 CRVS Unit" less than Prevailing Fee		5.05	4.60

*Equivalent to $9.00 factor on the 1964 CRVS

31. Physician Care — Home and Office

	First Visit Accident		
	First Visit Sickness	Third Visit Sickness	
Unlimited	104.46	74.50	

32. Physician Care — Hospital

Maximum Number of Visits	Prevailing Fee at Average 14.50/Day/Visit	Deduct for each 1.00 Per Day Per Visit Less than Prevailing Fee
31	17.51	1.21
70	19.10	1.32
120	20.30	1.40
365	21.46	1.48
Unlimited	22.70	1.57

33. Home Health Care*

Maximum Visits/Year	
180 or More	3.75
Less than 180	0

*Excludes Home Health Care after individual is discharged from a hospital after a stay of at least 3 days.

34. Diagnostic X-Ray and Laboratory (Outpatient or out of hospital)

	Scheduled	Unscheduled
Unlimited	40.60	57.58

35. Radioactive Therapy (Outpatient or out of hospital)

Scheduled	3.00
Unscheduled	5.00

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36. Drugs and Medicines (Outpatient or out of hospital)

Deductible Per Prescription	
2.00	30.00
1.00	38.75
None	48.67

37. Private Duty Nursing (Either RN or LPN) 5.00

38. Miscellaneous (In Clinic or as Outpatient) 1.48

a. Physical Therapy
b. Oxygen
c. Prostheses
d. Durable Medical Equipment (Rental or Purchase)

39. Medicare Part B Payments

Deduct 158.89

40. Medicare Part B Deductible ($60)

Deduct if not eligible 28.50

41. Comprehensive Major Medical Plans

Type	Equivalent Points
a. With C.O.B. against Medicare A and B, Maximum of $50,000 or more, Deductible of $100 or less, and Coinsurance of 20% or less.	100
b. Other, including "Medicare Carve Out" Plans	*

*File with Commissioner.

EXAMPLE I

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesota Qualified Plan?

Deductible:	$100
Coinsurance:	80/20
Maximum:	$10,000
Maternity:	Any Complications
Student Dependents:	To 23
Limits on Specified Benefits:	Outpatient Mental limited to Minnesota Required Benefits
Excluded Care:	Home Health Care
Out of Pocket Limit:	$5,000 per year
Coordination of Benefits	Yes, but no COB with No-Fault

II. Answer (calculated January 1, 1977): Test result is 919 points
This Plan is a Minnesota Qualified Plan Number 2.

Plan Name Comprehensive Plan Plan No. Example I.

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

			Major Medical	
Table	Benefit	Basic	Superimposed	Comprehensive
21-23	Superimposed Major Medical	XXX		XXX
1.	Hospital Room and Board			395
2.	Hospital Extras			485
3.	Surgery			240
4.	Physician Care — Home, Ofice			210
5.	Physician Care — Hospital			55
15-18	Benefits In Full			—
6.	Maternity			25
7.	Diagnostic X-Ray and Lab			90
8.	Drugs and Medicine			90
9.	Emergency/Supplemental Accident			0
10.	Radioactive Therapy			15
12.	Nursing/Convalescent Facility			20
13.	Home Health Care			0
14.	Physical Therapy			10
14.	Oxygen			5
14.	Prostheses			5
14.	Durable Medical Equipment			5
11.	Student Dependents			4
24.	Limit on Out of Pocket			10
25.	Maximum Benefit	XXX		–50
XX.	Subtotal			1614
26.	COB/No-Fault			–65
19-20	Coinsurance/Deductible	XXX		–630
XX.	Total			919
XX.	Combined Basic and Superimposed		XXX	XXX

Equivalent to Minnesota Qualified Plan Number 2 Non-Qualified ☐

Date _____ By _____

EXAMPLE II
Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesota Qualified Plan?

Hospital:	$70 per day, 365 days, $2,000 Extras
Surgery:	$7 CRVS, an assistant surgeon
In Hospital Physicians Calls:	$10 per day, 365 days
Maternity	Specified complications only
Coordination of Benefits	No

II. Answer (calculated January 1, 1977): Test result is 1016 points.

This Plan is a Minnesota Qualified Plan Number 3.

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Plan Name Basic Plan Plan No. Example II

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

			Major Medical	
Table	Benefit	Basic	Superimposed	Comprehensive
21-23	Superimposed Major Medical	XXX		XXX
1.	Hospital Room and Board	336		
2.	Hospital Extras	450		
3.	Surgery	180		
4.	Physician Care — Home, Office	30		
5.	Physician Care — Hospital	20		
15-18	Benefits In Full			
6.	Maternity			
7.	Diagnostic X-Ray and Lab			
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident			
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility			
13.	Home Health Care			
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents			
24.	Limit on Out of Pocket			
25.	Maximum Benefit	XXX		
XX.	Subtotal			
26.	COB/No-Fault			
19-20	Coinsurance/Deductible	XXX		
XX.	Total	1016		
XX.	Combined Basic and Superimposed		XXX	XXX

Equivalent to Minnesota Qualified Plan Number 3 Non-Qualified ☐

Date _____ By _____

EXAMPLE III

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesoda Qualified Plan?

Hospital:	$30 per day, 70 days, $500 Extras
Surgery:	$420 Intercompany
Superimposed Major Medical:	
Deductible	$100 corridor
Coinsurance:	80/20
Maximum:	$10,000
Maternity	Any complications
Student Dependents:	No
Out of Pocket Limit:	None
Excluded Care:	Home Health Care
	Nursing Home Care

Limits on Specified Benefits:	Maximum Eligible Charges as follows:
1. Room & Board	$50, less Basic Benefit
2. Hospital Extras:	$2,000 less Basic Benefit
3. Surgery:	$7.00 per CRVS unit.
Coordination of Benefits	yes, including No/Fault

II. Answer (calculated January 1, 1977): Test result is 611 points.

This Plan is a Minnesota Qualified Plan Number 1.

Plan Name Basic and Superimposed Plan No. Example III

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

			Major Medical	
Table	Benefit	Basic	Superimposed	Comprehensive
21-23	Superimposed Major Medical	XXX	665	XXX
1.	Hospital Room and Board	135	–143 (3.1 times 46)	
2.	Hospital Extras	335	–95 (402 less 305)	
3.	Surgery	85	–50 (2 times 25)	
4.	Physician Care — Home, Office			
5.	Physician Care — Hospital			
15-18	Benefits In Full			
6.	Maternity		–175 (200 less 25)	
7.	Diagnostic X-Ray and Lab			
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident			
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility		–20	
13.	Home Health Care		–10	
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents		–4	
24.	Limit on Out of Pocket		–20	
25.	Maximum Benefit	XXX	–50	
XX.	Subtotal	555	98	
26.	COB/No-Fault	–36	–6	
19-20	Coinsurance/Deductible	XXX		
XX.	Total	519	92	
XX.	Combined Basic and Superimposed	611	XXX	XXX

Equivalent to Minnesota Qualified Plan Number 1 Non-Qualified ☐

Date _____ By _____

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EXAMPLE IV

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to any Minnesota Qualified Plan?

Hospital:	First $3,000 of all Hospital Charges in Full
Surgery:	$420 Intercompany
Emergency Accident:	$25
Superimposed Major Medical:	
Deductible:	$500 Integrated
Coinsurance:	80/20
Maximum:	$25,000
Maternity:	Full
Student Dependents:	No
Out of Pocket Limits	None
Excluded Care:	Home Health Care
Coordination of Benefits:	Yes, Other Health and No Fault Plans

II. Answer: (Calculated January 1, 1977). Test result is 1290 points.

This Plan is a Minnesota Qualified Plan Number 3.

Plan Name Basic With Benefits In Full and Comprehensive Plan No. Example IV

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

A. Other than Medicare Supplement Plans

			Major Medical	
Table	Benefit	Basic	Superimposed	Comprehensive
21-23	Superimposed Major Medical	XXX	615	XXX
1.	Hospital Room and Board			
2.	Hospital Extras			
3.	Surgery	85		
4.	Physician Care — Home, Office			
5.	Physician Care — Hospital			
15-18	Benefits In Ful	741 (710 plus 33% of 95)		
6.	Maternity			
7.	Diagnostic X-Ray and Lab			
8.	Drugs and Medicine			
9.	Emergency/Supplemental Accident	10		
10.	Radioactive Therapy			
12.	Nursing/Convalescent Facility			
13.	Home Health Care		−10	
14.	Physical Therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable Medical Equipment			
11.	Student Dependents		− 5	
24.	Limit on Out of Pocket		−22	
25.	Maximum Benefit	XXX	−35	
XX.	Subtotal	836	543	
26.	COB/No/Fault	−54	−35	
19-20	Coinsurance/Deductible	XXX		
XX.		782	508	508
XX.	Combined Basic and Superimposed	1290	XXX	XXX

Equivalent to Minnesota Qualified Plan Number 3 Non-Qualified ☐

Date _____ By _____

EXAMPLE V.

Use of Actuarial Equivalence Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to a Minnesota Qualified Medicare Supplement Plan?

Hospital Benefit	$100 first day $21 61 to 90 days
Skilled Nursing Home	$13 100 days
Blood	3 pints in hospital
Surgery	$1.50 CRVS with anesthesia, no assistant surgeon
Physician Care — In Hospital	$4 per day, 90 days
Drugs and Medicines	$2 deductible per prescription

II. Answer: (calculated January 1, 1977): Test result is 72.1 points. This Plan is not a Minnesota Qualified Medicare Supplement Plan.

Plan Name Medicare Supplement Plan No. Example V

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

B. Medicare Supplement Plan

Table 27. Benefit: Hospital — Defined daily benefit

Days	Daily Benefit	Factor	Product
1	100	9.59	959.00
2-60	0	83.56	
61-90	26	1.50	39.00
91-150		.61	
151 & Over		1.02	
Total	XXX		998.00
Divisor			1068.08
Quotient			.9344
Multiplier			23.78
Product			22.22

27.	Hospital — Usual and customary chanrges not paid by Medicare	
	A. Medicare Deductible and Coinsurance	
	B. Benefits not covered by Medicare	
28.	Skilled Nursing Facility	3.50
29.	Blood	.15
30.	Surgery	10.82
31.	Physician Care — Home and Office	
32.	Phycician Care — Hospital	5.41
33.	Home Health Care	
34.	Diagnostic X-Ray and Laboratory	
35.	Radioactive Therapy	
36.	Drugs and Medicine	30.00
37.	Private Duty Nursing	
38.	Miscellaneous	
41.	Comprehensive Major Medical	

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XX. Subtotal	72.10
39. Medicare Part B Payments	
40. Medicare Part B Deductible not Eligible	
XX. Total	72.10

Equivalent to Minnesota Qualified Medicare Supplement Plan: Yes ☐ No ☒

Date _____ By _____

EXAMPLE VI

Use of Actuarial Test
Minnesota Comprehensive Health Insurance Act of 1976

I. Question: Is the following Plan actuarially equivalent to a Minnesota Qualified Medicare Supplement Plan?

Benefit: (a) 100% of reasonable and customary hospital and nursing home expenses in excess of Medicare Part A.

(b) 20% of reasonable and customary charges for medical services after $60 deductible applied to expenses eligible under Part B of Medicare.

II. Answer (Calculated January 1, 1977): Test result is 84.3 points.

The Plan is not Qualified.

Plan Name Medicare Supplement Plan No. Example VI

WORKSHEET

Test for Actuarial Equivalence
Minnesota Comprehensive Health Insurance Act of 1976

B. Medicare Supplement Plan

Table Benefit

27. Hospital — Defined daily benefit

Days	Daily Benefit	Factor	Product
1		9.59	
2-60		83.56	
61-90		1.50	
91-150		.61	
151 & Over		1.02	
Total	XXX		
Divisor			
Quotient			
Multiplier			23.78
Product			

27.	Hospital — Usual and customary charges not paid by Medicare	
	A. Medicare Deductible and Coinsurance	23.78
	B. Benefits not covered by Medicare	2.35
28.	Skilled Nursing Facility	3.90
29.	Blood	.15
30.	Surgery	10.09 (=20%)
31.	Physician Care — Home and Office	20.89 (=20%)
32.	Physician Care — Hospital	4.54 (=20%)
33.	Home Health Care	.75 (=20%)
34.	Diagnostic X-Ray and Laboratory	11.52 (=20%)

35.	Radioactive Therapy	1.00 (=20%)
36.	Drugs and Medicine	9.73 (=20%)
37.	Private Duty Nursing	1.00 (=20%)
38.	Miscellaneous	.30 (=20%)
41.	Comprehensive Major Medical	
XX.	Subtotal	90.00
39.	Medicare Part B Payments	
40.	Medicare Part B Deductible Not Eligible	−5.70 (=20%)
XX.	Total	84.30

Equivalent to Minnesota Qualified Medicare Supplement Plan: Yes ☐ No ☒

Date _____ By _____

Department of Transportation

Proposed Rules Governing the Mn/DOT Plan

Notice of Hearing

Notice is hereby given that public hearings in the above-entitled matter will be held at several locations throughout the state commencing on October 31, 1978 and continuing until December 4, 1978. The hearings shall be conducted as follows:

October 31, 1978 — Region 7E
Mora City Library
200 West Maple Avenue
Mora, Minnesota
7:00 p.m.

November 1, 1978 — Region 6W
Appleton Civic Center
323 West Schlieman
Appleton, Minnesota
7:00 p.m.

November 2, 1978 — Region 1
N.W. Regional Development Comm.
425 Woodland Avenue
Crookston, Minnesota
7:00 p.m.

November 9, 1978 — Region 11
Hennepin County Govt. Ctr.
Auditorium Level — "A"
Minneapolis, Minnesota
10:00 a.m.

November 13, 1978 — Region 5
North Campus of the Area
Vocational-Technical Institute
Auditorium
North of the Airport
Staples, Minnesota
7:00 p.m.

November 14, 1978 — Region 2
J. W. Smith Elementary School
18th Street and America Avenue
Bemidji, Minnesota
7:00 p.m.

November 15, 1978 — Region 3
Holiday Inn
Grand Rapids, Minnesota
7:00 p.m.

November 16, 1978 — Region 3
First United Methodist Church
Skyline Parkway & Central Entrance
Duluth, Minnesota
7:00 p.m.

November 20, 1978 — Region 4
Fergus Falls Community College
Room 209 — Science Building
Fergus Falls, Minnesota
7:00 p.m.

November 21, 1978 — Region 7W
St. Cloud City Hall Annex
24th Avenue South
St. Cloud, Minnesota
7:00 p.m.

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November 28, 1978 Region 8
Murray County Courthouse Annex
Slayton, Minnesota
7:00 p.m.

November 29, 1978 Region 9
Minnesota Valley Regional Library
Auditorium
100 E. Main
Mankato, Minnesota
7:00 p.m.

November 30, 1978 Region 10
Rochester Community College
South room of college center
Rochester, Minnesota
7:00 p.m.

December 4, 1978 State Office Building
Room 83
St. Paul, Minnesota
10:00 a.m.

December 5, 1978 Region 6E
Kandiyohi County Office
905 West Litchfield Avenue
Willmar, Minnesota
7:00 p.m.

The hearings shall commence at the indicated times and continue until all persons have had an opportunity to be heard.

All interested or affected persons will have an opportunity to participate. Statements may be made orally and written materials may be submitted at the hearing. In addition, written material may also be submitted by mail to Mr. Bernard Singer, Office of Hearing Examiners, Room 300, 1745 University Avenue, St. Paul, Minnesota 55104, (612) 296-8110, either before the hearings or within five (5) working days after the close of the hearings or for a longer period not to exceed twenty (20) days if so ordered by the Hearing Examiner (in the course of the hearing).

Any person may request notification of the date on which the hearing examiner's report will be available after which date the agency may not take any final action on the rules for a period of five (5) working days. Any person may request notification of the date on which the hearing record has been submitted (or resubmitted) to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearings. After the hearings, you may request notification by sending a written request to the Hearing Examiner (in the case of the Hearing Examiner's report) or to the agency (in the case of the agency's submission or resubmission to the Attorney General).

A copy of the proposed rules is attached hereto. These rules have been modified from those published in the draft version of Mn/DOT PLAN, based on comments received from agency personnel and based on the need to otherwise clarify some of the language contained therein.

One free copy of the proposed rules may be obtained by writing to the Department of Transportation, Bureau of Policy & Planning, Office of Plan Management, Transportation Building, Room 820, St. Paul, Minnesota 55155. Additional copies will be available at the door on the date of the hearings.

The Commissioner of Transportation's authority to promulgate the proposed rules is contained in Minn. Stat. § 174.03, subd. 1(d). Notice is hereby given that 25 days prior to the hearing, a statement of need and reasonableness will be available for review at the agency and at the Office of Hearing Examiners. This statement of need and reasonableness will include a summary of all of the evidence which will be presented by the agency at the hearing justifying both the need for and the reasonableness of the proposed rules. Copies of the statement of need and reasonableness may be obtained from the Office of Hearing Examiners at a minimal charge.

The proposed rules, if adopted, would govern the Department of Transportation in its transportation planning and decision making processes as well as the Department's program management activities. Mn/DOT PLAN will also serve as the basis for a revision of the Action Plan which is a Federal requirement that governs the highway planning and project development process. The relationship of Mn/DOT PLAN to the Action Plan requirements will be discussed and comments will be accepted from interested persons.

Please be advised that Minn. Stat. ch. 10A (1976) requires each lobbyist to register with the Ethical Practices Board within five days after he commences lobbying. A lobbyist is defined by Minn. Stat. ch. 10A.01 (1976), subd. 11 as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) Who spends more than $250, not including traveling expenses and membership dues, in any year for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute in question provides certain exceptions. Questions should be directed to the Minnesota Ethical Practices

Board, 41 State Office Building, St. Paul, Minnesota 55155, telephone (612) 296-5615.

September 11, 1978

Jim Harrington
Commissioner of Transportation

Rules as Proposed

Chapter One §§ 1.0001-1.0004 Authority, Purpose, Jurisdiction and Effect, and Definitions

14 MCAR § 1.0001 Authority. The State Department of Transportation is authorized to adopt, as a rule, a statewide transportation plan and priorities pursuant to the provisions of Minn. Stat. ch. 174.03 (1976).

14 MCAR § 1.0002 Purpose. The purpose of the statewide transportation plan and priorities shall be to provide the basis for determining how best to meet the present and future transportation needs of the public, and to promote the more efficient use of resources for transportation purposes.

14 MCAR § 1.0003 Jurisdiction and effect. The statewide transportation plan and priorities as adopted by the Commissioner of Transportation shall govern transportation decisions made by the Commissioner and the Public Service Commission.

14 MCAR § 1.0004 Definitions. The following terms, as they appear in these rules, shall have the indicated meanings:

A. "Capital Improvement" means the expenditure of funds for the establishment or betterment of facilities and equipment.

B. "Criterion" means a standard upon which a decision may be based.

C. "Critical Areas" means those geographic areas as defined by the Critical Areas Act of 1973, Minn. Stat. ch. 116 G. (1976).

D. "Environment" means the total of external conditions and influences that affect human life, e.g., aesthetic, ecological, social, economic.

E. "Grant-in-Aid" means the distribution of funds from one agency to another agency or group for the establishment, continuation, or improvement of facilities, equipment, or service.

F. "Improvement type" means a group of projects showing common traits or characteristics.

G. "Intermodal" means the relationship between or among the modes and may include a physical contact point, i.e., transfer point between modes.

H. "Major studies" means special, intensive studies of large, complex transportation problems, systems, subsystems, and projects.

I. "Master plan" means a comprehensive plan designed to be implemented by a target year.

J. "Metropolitan Council" means the comprehensive planning agency for the Twin Cities Metropolitan area created pursuant to Minn. Stat. ch. 473 (1976).

K. "Metropolitan Development Guide" means the comprehensive development plan for the Twin Cities metropolitan area prepared by the Metropolitan Council pursuant to Minn. Stat. 1976, ch. 473.145.

L "Minimal projects" means the most simple, least complex construction projects that have little or no effect on the environment, require little or not additional right-of-way, and have no adverse effects on abutting real property.

M. "Mn/DOT transportation planning process" means the general process Mn/DOT will use for transportation planning, programming, and design for the various modes.

N. "Moderate projects" means construction projects with the potential for causing alterations to the local environment, normally consisting of the expansion or realignment to upgrade an existing facility and typically requiring additional right of way.

O. "Policy" means a set of principles that help guide management in making decisions.

P. "Preliminary planning" means the phase of the Mn/DOT transportation planning process undertaken to analyze issues, needs, and problems and arrive at a consensus among the community and professional people on a preferred solution.

Q. "Process" means the procedure by which decisions are made.

R. "Program development process" means a procedure

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used to match the objectives of a specific program with the list of candidate projects and available funds.

S. "Project" means a specific proposal(s) for improvements to transportation facilities or services that leads directly to implementation (that is, the completion of grants or construction).

T. "Prospectus" means a document developed as one of the requirements of the federal government's Urban Transportation Planning Regulations. A "Prospectus" provides a description of the major elements of an urbanized area's transportation planning process as it relates to highway and transit planning and implementation.

U. "Regional Development Commission" means a comprehensive planning agency created pursuant to the Regional Development Act of 1969, Minn. Stat. ch. 462 (1976).

V. "Regional Transportation Policy Plans" means the plans required to be prepared by the Metropolitan Council pursuant to Minn. Stat. ch. 473.146 (1976) and by the Regional Development Commissions pursuant to Minn. Stat. ch. 174.03 (1976).

W. "Schedule of authorized public transportation expenditures" means the allocation of funds by program.

X. "Standard Project Development Process" means the procedure by which a routine project is developed. This procedure includes the processing of grants from established grant programs and the design of minimal and moderate construction projects.

Y. "Statewide significance" means that an issue (1) impacts on a state transportation system; (2) impacts on the operation of a modal system on a statewide basis; (3) affects geographic areas in the state determined by the federal or state governments to be of statewide significance; or (4) may negatively affect the quality of the state's naturalresources.

Z. "Sub-system" means a part of a larger system.

AA. "System" (physical) means a group of interrelated transportation facilities such as traveled ways and terminals. There are different kinds of transportation systems depending upon to what analytical or administrative use they will be put. Examples of different systems, which can overlap one another are: systems based on the role or function of transportation facilities (such as the principal arterial system), the source of funds (such as Federal Aid Urban roadway system), or the agency having administrative control over the facilities (such as state trunk highway system).

BB. "System planning" means the process by which transportation systems of various kinds are planned.

CC. "Urbanized area" means the geographic area as defined by the Bureau of the Census. It generally consists of a city or group of contiguous cities with a population of 50,000 or more, together with adjacent densely populated land (i.e., land having a population density of at least 1000 persons per square mile).

Chapter Three § 1.0005 Statewide Transportation Plan and Priorities

14 MCAR § 1.0005 Statewide transportation plan and priorities.

A. The statewide transportation plan (Mn/DOT/PLAN) shall contain Mn/DOT's decision making processes.

1. These rules specify the procedures to be used in making decisions relating to the transportation needs of the state.

2. The procedures set forth herein shall incorporate:

a. federal and state law;

b. the transportation planning requirements of the federal government;

c. the statutorily defined roles of the Regional Development Commissions and the Metropolitan Council;

d. advisory task forces to the commissioner as appropriate.

B. Transportation decisions made consistent with the provisions of Mn/DOT/PLAN shall also reflect agreement with certain established planning priorities:

1. Administrative procedures consistent with Mn/DOT/PLAN shall be established to aid in transportation decision making and program management.

2. The transportation decision making process shall operate to ensure participation by individual citizens, various organizations and groups, elected officials and other government agencies.

3. Emphasize the maintenance of existing services and facilities within the states' transportation system.

4. Providing of information as requested.

5. Recognize the role of the private sector and individuals in transportation decision making.

6. Recognize intermodal impacts and relationships in transportation planning and decision making.

7. Recognize environmental, social, economic, and energy factors in transportation planning and decision making.

8. Assign priority to those projects where significant resources have already been expended, providing those projects are consistent with Mn/DOT/PLAN provisions.

9. Modify Mn/DOT/PLAN as necessary.

10. Mn/DOT shall conduct annual meetings in each region to assist the commissioner in identifying issues of regional and local concern.

11. Mn/DOT shall contact state legislators annually to receive their input as to the status of the state transportation system and to inform them of Mn/DOT's planned activities in its role of managing the state transportation system.

Chapter Four §§ 1.0006-1.0010 Planning Process; icy Making Process

14 MCAR § 1.0006 Planning process. This planning process shall provide a framework for resolving transportation issues and making transportation decisions.

14 MCAR § 1.0007 Policy making process. Mn/DOT's position on a specific issue, shall be developed consistent with the appropriate procedure as herein indicated:

A. Reaffirmation of an appropriate existing position.

B. No existing position; application of procedure and criteria from Mn/DOT/PLAN or other systems plans.

C. No applicable procedure or set of criteria; analysis of the category to develop procedure and criteria for position development.

D. Revised or newly developed positions shall be incorporated into Mn/DOT/PLAN or appropriate supporting documents.

E. Position statements shall be developed on issues relating to actions, programs, plans or positions within the legal responsibility and authority of Mn/DOT.

1. Issues relating to transportation needs, services, or funding administered by Mn/DOT.

2. Issues concerning transportation rules.

3. Issues regarding Mn/DOT's decision making processes.

4. Resolution of inconsistencies between Mn/DOT Plan and regional or local plans.

F. Agreements shall be negotiated with the Regional Development Commissions and Metropolitan Council specifying their involvement in the policy making process.

14 MCAR § 1.0008 Issues requiring Mn/DOT action.

A. An issue shall require action by Mn/DOT if:

1. Mandated by federal law or regulation.

2. Mandated by state law or rule.

3. The issue is of major statewide significance for transportation.

B. An issue shall be found to be of statewide significance if:

1. The issue impacts on a state transportation system.

2. Impacts on geographic areas of statewide significance.

3. Impacts negatively upon the state's natural resources.

14 MCAR § 1.0009 Determination of Mn/DOT funded transportation services or needs. A transportation service or need shall be funded by Mn/DOT if:

A. Federal laws or regulations require Mn/DOT to fund.

B. State laws or rules require Mn/DOT to fund.

C. Mn/DOT policies, directives or system plans so identify the transportation need or service.

D. A service or need which transcends local boundaries or affects a significant segment of the population shall be determined to be essential to the transportation system based on new policy statements, directives, or amended system plans with the state being determined to be the best means of funding the service.

14 MCAR § 1.0010 Rules necessary to properly administer the use of the state transportation system. Mn/DOT shall develop rules when:

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A. Federal laws or regulations require regulation by Mn/DOT.

B. State laws or rules require regulation by Mn/DOT.

C. Safety considerations, protection of the state's investment in transportation facilities, or economic considerations so require.

Chapter Five §§ 1.0011-1.0014 Transportation Planning Process, Relationship to Transportation Planning by Other Agencies, Standard Project Development, Major Studies

14 MCAR § 1.0011 General provisions of the transportation planning process.

A. The transportation planning process shall:

1. Incorporate the various modes of transportation.

2. Apply to program development, grant administration, project development, and major studies.

B. The transportation planning process shall reflect the following considerations:

1. Modal aspects shall be considered in planning decisions.

2. Environmental aspects shall be addressed throughout the planning process.

3. The transportation planning process shall address local concerns by:

a. involving citizens, elected officials, and other agencies;

b. utilizing small scale system planning;

c. use of informal methods of public participation;

d. analyzing the effects of proposed actions on different segments of the community;

e. including consideration of local concerns and conditions.

4. The transportation planning process shall consider alternative solutions to transportation problems.

14 MCAR § 1.0012 Relationship to transportation planning by other agencies. Mn/DOT's transportation planning process shall attempt to accommodate the transportation planning efforts of other organizations by:

A. Complying with existing federal requirements relating to transportation planning, especially the FHWA requirement for an Action Plan.

B. Complying with existing federal requirements which define the state's role, through Mn/DOT, of cooperating in the transportation planning efforts of the Metropolitan Planning Organizations.

C. Complying with federal requirements relating to local agencies receiving federal funds.

D. Recognizing the statutorily defined role of the Regional Development Commissions.

E. Recognizing the statutorily defined role of transit authorities.

14 MCAR § 1.0013 Standard Project Development. The Standard Project Development Process shall include grant related activities as well as the planning and design, physical facilities.

A. Minimal and moderate projects as well as grant-in-aid programs shall be subject to this general process.

1. The transportation planning process, as applied to this category of projects, shall include:

a. identification of issues, needs, and proposals for changes in services or physical facilities from:

(1) individual citizens;

(2) various organizations and groups;

(3) elected officials;

(4) agency staff members;

(5) surveillance of the system by Mn/DOT staff.

b. Preliminary planning resulting in the development of a recommended project proposal and the related technical information.

c. Programming, which shall result in an evaluation of grant applications and proposed construction projects to determine those which are to be implemented. The detailed process is included in 14 MCAR §§ 1.0015 through 1.0018. New grant programs proposed by Mn/DOT may require the completion of a major study.

d. Detail design and/or grant processing shall involve the processing of grant applications and preparation of detailed construction plans and specifications.

2. Grant-In-Aid programs shall be a means of resolv-

ing transportation problems by providing the grants in aid to organizations, other than Mn/DOT, who shall then provide the transportation service or construct a transportation facility. The general transportation planning process is adapted to these projects in that:

a. Mn/DOT and the grant agency jointly review issues, needs, and proposals.

b. If a new grant program is determined to be required within the preliminary planning phase, a major study may be undertaken as decided within the programming phase.

c. Legislative authority shall be sought for new grant programs if necessary following completion of the major study phase.

d. Preliminary applications are submitted during the programming phase. Eligible applicants then shall have the opportunity to submit final applications from which grant projects are selected and scheduled.

e. Mn/DOT shall conduct a financial audit of the implemented grant program and may otherwise evaluate the effectiveness of the grant program.

B. Proposed projects shall be deferred or dropped at specified points within the process. The project category involved shall determine at what point such a decision may be made.

1. Minimal projects. The decision to drop or defer a project may be made during step 4, which shall involve project design approval, environmental assessment and capital improvement programming.

2. Moderate projects. The decision to drop or defer a project may be made during:

a. Step 4: project justification approval, environmental assessment, preliminary programming

b. Step 8: project design approval, capital improvement programming

3. Major projects. The decision to drop or defer a project may be made during:

a. Step 4: study outline approval, environmental assessment programming of major study.

b. Step 6: approval and adoption of the draft environmental document.

c. Step 9: approval and adoption of the final environmental document.

d. Step 11: project design approval and capital improvement programming.

C. Public input to the transportation planning process shall consist of receipt of comments by Mn/DOT, the conducting of public meetings, affording the opportunity for public hearings, and conducting public hearings.

1. The opportunities for public input shall relate to the project classification.

2. All proposed projects shall be initiated with the opportunity for public input to:

a. offer transportation based issues, needs or proposals, and

b. identify preliminary alternatives and impacts.

3. Minimal projects shall allow for public input during Step 3 when alternatives and impacts are being analyzed including an environmental assessment, resulting in a recommended proposal.

4. Moderate projects shall allow for public input during four steps:

a. Step 3: preparation of the project justification and environmental assessment, resulting in a preliminary programming request.

b. Step 5: development of alternative concepts and project designs including an impact analysis.

c. Step 6: a public hearing shall be held if requested.

d. Step 7: project design recommendation and request for capital improvement programming.

5. Major projects shall allow for public input during five steps:

a. Step 3: Preparation of study justification, environmental assessment and detailed study outline as well as a request for the programming of a major study.

KEY: RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language. **PROPOSED RULES SECTION —** Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material."

b. Step 5: Development of alternative concepts and project designs, analysis of impacts and preparation of draft environmental document.

c. Step 7: a public hearing shall be held if requested.

d. Step 8: reconsideration of alternative concepts and project design, preparation of final environmental document.

e. Step 10: Refining of project design, development of design (layout) recommendation, and request for capital improvement programming.

6. All projects shall allow for public input during the final planning stage which is Step 5 for minimal projects, Step 9 for moderate projects and Step 12 for major projects and involves the preparation of construction plans and acquisition of right of way.

14 MCAR § 1.0014 Major studies. Major studies shall result in a custom-designed study process for each study or project that is subjected to this phase of transportation planning.

A. The development of major studies shall be distinguished from the standard project development process in that:

1. The preliminary planning phase shall relate to the proposed means of conducting the study including resources required.

2. The programming phase shall result in a determination of which major studies are to be conducted and when.

3. The major study shall be defined within the detailed study outline developed during the preliminary planning phase and approved during the programming phase.

B. Long range system planning shall be conducted by Mn/DOT in the major study phase, resulting in review of the long range impact of current programs, trends, and activities and the identification of alternative futures resulting from these current transportation programs, trends, and activities.

C. Sub-system planning as an aspect of major studies will be utilized to assure coordination between system planning and individual project development.

D. Major construction projects as distinguished from minimal and moderate construction projects shall be handled as major studies. The planning phase shall be adopted as appropriate for each individual project but generally varies from minimal and moderate projects in that:

(1) Mn/DOT shall prepare a detailed study justification and outline including a general assessment of alternatives and request for programming of the study.

(2) An EIS shall be developed when required.

Chapter Six §§ 1.0015-1.0018 The Program Development Process

14 MCAR § 1.0015 General provisions of the program development process.

A. The program development process shall apply to capital improvements on the state trunk highway system and to grant programs administration by Mn/DOT with the exception of state-aid and federal-aid-urban programs.

B. The capital improvement and grant-in-aid program shall be developed by Mn/DOT with consultation as indicated within these rules by the Regional Development Commissions and the Metropolitan Council.

14 MCAR § 1.0016 Program development process. The program development process procedure shall be as follows:

A. Candidate projects shall be identified consistent with the phases of the Mn/DOT/PLAN Transportation Planning Process described in 14 MCAR §§ 1.0011-1.0014.

B. Candidate projects shall then be classified by region, mode, and if required, improvement type. Project categories shall include:

1. Aeronautics

2. Bikeways

3. Highways — new and reconstruction

4. Highways — facility upgrading and safety improvement

5. Highways — preservation

6. Rail — federal subsidy

7. Rail — state rehabilitation

8. Transit

C. Candidate projects shall then be evaluated utilizing weighted criteria and measures for each category developed by Mn/DOT personnel and the Regional Development Commissions and Metropolitan Council. The weighted criteria shall be used to rank projects. The currently applicable criteria shall be:

1. Aeronautics.

a. Improve airports with a large number of takeoffs and landings.

b. Improve airports with a large number of based aircraft.

c. Improve airports with a large number of enplanements.

d. Reduce the number of aircraft rerouted to other airports.

e. Improve design and operation of an airport.

f. Finance projects that have local financial support.

g. Finance projects that are in conformance with the State Airport Development Guide.

2. Bikeways.

a. Finance projects with the lowest unit construction costs.

b. Finance projects with the lowest maintenance costs.

c. Emphasize safety.

d. Support projects which serve the most major points of interest.

e. Support projects which remove physical barriers to bicycle movement.

3. Highways — new and reconstruction.

a. Reduce travel time.

b. Achieve uniform road quality on a given highway route.

c. Provide those improvements that will benefit the most users.

d. Upgrade roads to 9-ton that have weight restrictions placed on them every spring.

e. Improve the level of service.

f. Reduce accidents.

4. Highways — facility upgrading and safety improvement.

a. Provide those improvements that benefit the most users.

b. Reduce accidents.

c. Improve the level of service.

d. Upgrade roads to 9-ton that have weight restrictions placed on them every spring.

5. Highways — preservation.

a. Provide those improvements that will benefit the most users.

b. Lower annual maintenance costs.

c. Prevent further deterioration of a facility.

6. Rail — federal program.

a. Support projects with high shipper interest.

b. Reduce adverse community impact.

c. Increase the amount of traffic carried.

7. Rail — state program.

a. Reduce state's financial involvement.

b. Increase the amount of traffic carried.

c. Support projects with the greatest potential for repaying money invested by state and shippers.

d. Support projects which do not have alternate rail service.

e. Reduce adverse community impacts.

8. Transit.

a. Provide service to as many people as possible.

b. Provide service to as many commuters as possible.

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c. Provide service for people who cannot drive a private automobile.

d. Provide service for people who do not own an automobile.

e. Finance projects that have high transit ridership.

f. Provide the best transit service possible in areas which need service.

g. Finance projects that will have a low operating deficit.

D. The program shall be developed following application of identified considerations and constraints to the ranked list of projects by category. The Commissioner may exercise his authority to modify the ranked list of projects based upon current development activities in the state as well as available financial resources.

1. Considerations to be used in modifying the ranked list of projects included:

a. Local and regional priorities.

b. Project interdependencies.

c. Degree of project readiness.

d. Fair share allocation based upon demographic characteristics.

e. Statewide priorities. The currently applicable statewide transportation development priorities shall be:

(1) General. Unless otherwise directed by the legislature, maximize and fully utilize all federal transportation funds made available to the state.

(2) Aeronautics.

(a) To insure that all airports are maintained in a safe condition.

(b) To systematically complete a system of Interim Standard Microwave Landing Systems at key system airports by 1985.

(c) To insure proper consideration to the protection of the environment as impacted by the location and expansion of airport facilities.

(d) To insure that key recreational areas around the state have access to the air transportation system.

(3) Bikeways.

(a) Give priority to bikeway projects which eliminate safety hazards to existing bikeway trips.

(b) Give priority to bikeway projects which complete a gap or uncompleted section of a route or system.

(4) Highway development.

(a) A high priority in the highway development program is the completion of the interstate system or the withdrawal of interstate segments and development of substitute projects.

(b) All new highway development projects or major reconstructions in metropolitan areas shall include careful evaluation of exclusive lanes for high occupancy vehicles, as well as other preferential treatment alternates. Priority in highway development shall be given to projects which include special provision for these items.

(c) Emphasize modernization and preventive maintenance of important highway facilities already in place rather than focusing on new construction.

(d) Reevaluate proposed four lane facilities against the needs for safe, efficient, all-weather two lane roads in every region of the state. Focus on projects which reduce routine maintenance costs by including such things as joint resealing, narrow pavement widening, and overlays in capital improvement programs. (Subject to completion of Maintenance Needs Study).

(e) Continue to emphasize the reconstruction and replacement of important bridges.

(f) Emphasize reserving rights-of-way for future transportation purposes to meet clearly demonstrated needs in developing areas of the state.

(5) Railroads.

(a) Establish an essential rail system comprised of:

(i) Main lines based on current operations, pending a more detailed analysis of potential main line consolidation.

(ii) Lines necessary for national defense as designated by the U.S. Department of Defense.

(iii) Lines serving major energy users, e.g. existing power plants, future power plants, or major industry which has the potential to switch to coal.

(iv) Lines serving rail users which are unable to switch to other types of transportation facilities such

as viable mining operations or viable grain subterminals and multi-car loading facilities.

(v) Lines providing some type of geographic rail access to all areas of the state with significant commodities to ship by rail.

(b) Subsidy emphasis shall be for rail lines that have the potential to be self sustaining, have shipper support or are identified in (i) as essential to the state's rail system.

(c) Actively attempt to preserve the right-of-way of the essential rail system where there is presently no shipper interest to continue service.

(6) Transit.

(a) In administering state or federal funds, evaluate and give priority to transportation projects which are well coordinated with the existing system.

(b) Require that any transit system receiving state financial assistance show that provisions have been made for limited mobility persons to effectively utilize the systems service.

(c) Develop demonstration programs that will indicate the effectiveness and efficiency of a wide range of services.

2. The program development constraints which shall be currently applicable are:

a. Financial limitations which are imposed by means of the legislative biennial budget for Mn/DOT.

b. Personnel resources available to develop construction plans in addition to the availability of construction personnel.

c. Legally, Mn/DOT may be directed to commit staff and funds to special projects or Mn/DOT may not have authority to act at all in other areas.

E. Program review. The resultant preliminary program shall then be submitted to the regional development commissions and the Metropolitan Council and various governmental agencies and jurisdictions for official review and comment.

14 MCAR § 1.0017 Program update process. Program revisions shall be the result of the same process as shall be utilized to establish the program.

A. The criteria, criteria weights, considerations, which include development priorities, and constraints utilized in the programming process, shall be evaluated on an annual basis consistent with the provisions of the agreements with Mn/DOT and the Regional Development Commissions and Metropolitan Council.

B. The timetable for the program update process shall be:

1. 1st Quarter Fiscal Year.

a. Print draft of annual program for the following fiscal years.

b. Distribute draft for preliminary review.

c. Submit draft to regions and Metropolitan Planning Organizations for official review (A-95).

d. Distribute draft publically.

2. 2nd Quarter Fiscal Year. Progress Review.

3. 3rd Quarter Fiscal Year. Review criteria weights, considerations, priorities, and constraints.

4. 4th Quarter Fiscal Year.

a. Solicit projects for inclusion in program through public meetings.

b. Annual program update.

14 MCAR § 1.0018 Project deferments.

A. A project which once appears in a published program may be deferred for another project because of activities within the project itself which delay its progress.

B. A project with a scheduled implementation date shall be completed except under unusual circumstances in which case the Commissioner will provide documentation explaining why the project has been withdrawn, upon request.

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STATE CONTRACTS

Pursuant to the provisions of Laws of 1978, ch. 480, an agency must make reasonable effort to publicize the availability of any consultant services contract or professional and technical services contract which has an estimated cost of over $2,000.

Department of Administration procedures require that notice of any consultant services contract or professional and technical services contract which has an estimated cost of over $10,000 be printed in the *State Register*. These procedures also require that the following information be included in the notice: name of contact person, agency name and address, description of project and tasks, cost estimate, and final submission date of completed contract proposal.



Dred Scott, a Black servant of army surgeon John Emerson, lived at Fort Snelling in Minnesota from 1836 to 1838. While there he married Harriet Robinson, a former slave who had been freed by Lawrence Taliaferro, the fort's Indian agent. When Emerson was transferred to Missouri, he took the Scotts and their first child with him. After Emerson's death, Scott brought suit for his freedom in Missouri court on the basis of having lived in free territory for two years. A lower court agreed, but the state's supreme court reversed the decision. An appeal to the U.S. Supreme Court failed in 1857, further institutionalizing slavery in this country, but Scott was set free by a subsequent owner. (Minnesota Historical Society)

Department of Agriculture Shade Tree Program

Notice of Request for Proposals for Arbor Month Design Contract

The Department of Agriculture is seeking a consultant to provide graphic design services under contract as follows:

1. Development of an Arbor Month poster adaptable to several sizes;

2. Design of an Arbor Month button;

3. Design work to revise present program logo;

4. Line drawings and other artwork as needed for 16-20 page brochure; and

5. Layout and paste-up of 16-20 page brochure (copy provided).

The selected consultant will be paid up to $5,000.00 for services rendered. The actual contract payment will be based upon price estimate of the selected consultant and the actual services performed. Proposals should include an estimate for the entire "package" as well as for each individual item listed above. The contract will be awarded on or before October 11, 1978, and will continue through May 31, 1979.

Proposal submissions will be accepted until 4:00 p.m., October 6, 1978, by, and inquiries may be made to:

Clare Rossini
Shade Tree Program
Room 600
Bremer Building
Saint Paul, MN 55101
(612) 296-8580

Department of Health Personal Health Services Division

Notice of Request for Proposals for Family Planning Nurse Practitioner Training and Continuing Education Project

The Minnesota Department of Health is requesting proposals from interested agencies and persons to develop and

implement a Family Planning Nurse Practitioner Training and Continuing Education Project which will:

A. Provide a family planning nurse practitioner training course to increase the number of family planning nurse practitioners employed in Minnesota's subsidized family planning system.

B. Provide a series of lectures designed to expand the technical knowledge of practicing family planning nurse practitioners.

C. Provide practice sessions designed to improve clinical skills of practicing family planning nurse practitioners.

D. Maintain a registry of family planning nurse practitioners to allow for coordination of family planning nurse practitioner services in Minnesota.

E. Evaluate the impact of utilization of family planning nurse practitioners on family planning program effectiveness and efficiency.

F. Develop and implement a plan for promoting expanded utilization of family planning nurse practitioners by family planning agencies in Minnesota.

G. Develop and implement a plan for providing technical assistance to family planning nurse practitioners in Minnesota.

Interested persons may obtain a Request For Proposal, and further instructions by submitting a written request by October 2, 1978, to:

Judi Kapuscinski, Supervisor
Family Planning Unit
Minnesota Department of Health
717 Delaware Street S.E.
Minneapolis, MN 55440

Metropolitan Council

Notice of Request for Proposals for Provision of Financial Consulting Services

The Twin Cities Metropolitan Council, 300 Metro Square Building, St. Paul, MN solicits proposals for expert financial consultant assistance in the performance of financial feasibility determinations relative to metropolitan sports facilities, at an estimated cost of $25,000 to $37,500.

Proposals must be postmarked no later than 8:00 a.m., Monday, October 2, 1978, addressed to John Boland, Chairman, Metropolitan Council, 300 Metro Square Building, St. Paul, MN 55101. For information or copies of the Request for Proposal contact Mr. Donald Carroll at 291-6428 or Mr. Lowell Thompson at 291-6420.

Department of Natural Resources Minerals Division

Notice of Request for Proposals for Interpretation of Aerial Photographs to Determine Vegetation Type, Size/Height, and Density as well as Agricultural, Open and Wet Lands

Notice is hereby given that the Department of Natural Resources intends to engage the services of a consultant to prepare the above captioned report. Proposals must be submitted no later than October 16, 1978. The estimated amount of the contract is $6,000.

Direct inquiries to:

Department of Natural Resources
Division of Minerals
Box 45, Centennial Office Building
St. Paul, MN 55155

Attn: Arlo Knoll, Contract Manager
(612) 296-4807

OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, an agency, in preparing proposed rules, may seek information or opinion from sources outside the agency. Notices of intent to solicit outside opinion must be published in the *State Register* and all interested persons afforded the opportunity to submit data or views on the subject, either orally or in writing.

The *State Register* also publishes other official notices of state agencies, notices of meetings, and matters of public interest.

Department of Commerce Banking Division

Bulletin No. 1960: Maximum Lawful Rate of Interest for Mortgages for the Month of October, 1978

Notice is hereby given that the Banking Division, Department of Commerce, State of Minnesota, pursuant to Minn. Stat. § 47.20, subd. 4, the Conventional Home Loan Assistance and Protection Act, hereby determines that the maximum lawful rate of interest of home mortgages for the month of October, 1978, is ten (10.00) percent.

September 13, 1978

Robert A. Mampel
Commissioner of Banks



The seeds of the red maple provide food for squirrels and birds. Dark red, with a rugose coat, the seeds are only one-quarter of an inch in length and germinate as soon as they fall to the ground. (Drawing by Jane Gstalder)

Department of Commerce Securities Division

Notice of Intent to Solicit Outside Opinion Regarding Proposed Rules Governing Charitable Solicitations

Notice is hereby given that the Securities Division has begun consideration of proposed rules governing charitable solicitation in the State of Minnesota. In order to adequately determine the nature and utility of such rules, the Securities Division hereby requests information and comments from all interested individuals or groups concerning the subject matter of the proposed rules.

All interested or affected persons or groups are requested to participate. Statements of information and comment may be made orally or in writing. Written statements of information and comment may be addressed to:

Department of Commerce
Securities Division, Charitable Solicitation
500 Metro Square Building
St. Paul, Minnesota 55101

The proposed rules, if adopted, would among other things under Minn. Stat. ch. 309, require and define certain accounting practices as they pertain to charitable organizations registered with the Commerce Department.

September 18, 1978

Thomas E. Collins
Staff Attorney, Securities Division

Department of Health Executive Office

Notice of Public Hearing on Water Fluoridation

The Governor's Commission on Fluoridation will be holding public hearings on October 26 and 27 from 9:00-12:00 a.m. and 2:00-5:00 p.m. in Room 111 at the William Mitchell College of Law, 875 Summit Avenue, St. Paul, Minnesota 55105. The purpose of the hearings will be to receive testimony from interested parties concerning potential health hazards created by water fluoridation. Any individual or organization representative interested in testifying on the question should contact Professor Michael Steenson at the William Mitchell College of Law. Communications should specify the interest of the individual and the organization, if any, represented. Individuals wishing to make written submissions to the Commission should address them to Professor Steenson.

All requests to testify should be submitted no later than Friday, October 6, to permit time for scheduling.

STATE OF MINNESOTA
OFFICE OF THE STATE REGISTER

Suite 415, Hamm Building
408 St. Peter Street
St. Paul, Minnesota 55102
(612) 296-8239

ORDER FORM

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STATE OF MINNESOTA

DEPARTMENT OF COMMERCE

INSURANCE DIVISION

In the Matter of the Proposed Rules of the Minnesota Department of Commerce, Insurance Division, Relating to the Comprehensive Health Insurance Act, Minn. Stat. ch. 62E.

ORDER ADOPTING RULES

The above entitled matter came on for hearing before the Commissioner of Insurance of the State of Minnesota on the 1st day of November, 1978, at 9:30 a.m. in the Department of Commerce Hearing Room, 500 Metro Square Building, 7th and Robert Streets in the City of Saint Paul, County of Ramsey, State of Minnesota, after proper notice required by Minn. Stat. §15.0412 was served upon all persons, associations and other interested groups registered with the Secretary of State for that purpose.

After affording interested persons an opportunity to present written and oral data, statements and arguments, having heard all of the testimony, having considered all of the evidence adduced, and upon the records, files and proceedings herein, and applicable statutory standards or criteria, and having confirmed the need for the above captioned rules and the reasonableness thereof,

NOW, THEREFORE, IT IS ORDERED that these rules identified as 4 MCAR §1.3200 through and including 4 MCAR §1.3235 are adopted this 2nd day of March, 1979, pursuant to authority vested in me by Minn. Stat. §62E.09(i).

STATE OF MINNESOTA
INSURANCE DIVISION

J. P. Koleski March 2, 1979

J. P. KOLESKI
Acting Commissioner of Insurance

STATE OF MINNESOTA

DEPARTMENT OF COMMERCE

In the Matter of the Proposed Rules of the Minnesota Department of Commerce, Insurance Division, Relating to the Comprehensive Health Insurance Act, Minn. Stat. ch. 62E.

CERTIFICATE OF APPROVAL

I, Michael A. Pint, Chairman of the Commerce Commission of the State of Minnesota, pursuant to the authority granted by Minn. Stat. §45.021, hereby certify my approval of the above-entitled proposed rules of the State Insurance Division relating to the Comprehensive Health Insurance Act (Minn. Stat. ch. 62E) as ordered adopted by Acting Commissioner of Insurance J. P. Koleski on March 2, 1979.

STATE OF MINNESOTA
COMMERCE COMMISSION

Michael A. Pint

MICHAEL A. PINT

Dated: March 2, 1979.

ADMIN 1000 (Rev. 1/78)

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL - COMMERCE

Office Memorandum

TO : LEE SHEEHY
Special Assistant Attorney General
G-25 Administration Building

DATE: March 16, 1979

FROM : WILLIAM R. HOWARD
Special Assistant Attorney General

PHONE: 9412

SUBJECT: COMPREHENSIVE HEALTH INSURANCE ACT, CH. 62E

Pursuant to Minn. Stat. §15.0412, subd. 4 (Supp. 1977), I am attaching the official record in the above matter to the Attorney General for review under Attorney General Rules No. 302, 303, and 305.

WRH:sjg

Enc.

FILED
MAR 16 1979
ADMINISTRATIVE AGENCIES