

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File No. 1079

10/5 Dick Gomsrud will send corrected Order Adopting and Cert. of Compliance

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 10-1-84
DATE FOR REVIEW 10-10-84
DATE DUE 10-15-84

Adopted w/a hearing _____
Adopted w/o hearing ✓
Temporary rule _____

Approved 10-15-84 mjc Disapproved _____ Returned to Agency _____

Resubmitted _____ Due _____
Approved _____ Disapproved _____ Returned to Agency _____

Date filed w/Secretary of State 10-15-84 Revisor approved 10.3.84 disapproved _____

___✓___ Rule as Adopted

___✓___ Rule as Proposed

___?___ Order Adopting 8.25.84 Date ① cites as authority a statute that doesn't exist. ② Insufficient time

___✓___ Notice of Intent to Solicit Outside Opinion SR. 3.12.84. includes small biz statement, misciteation as above

___✓___ Order for rulemaking
___N/A___ date of Hearing

_____ Certificate of Board's Authorizing Resolution

___✓___ Notice of rulemaking same misciteation as above
___?___ Sufficiency no small biz statement

___✓___ Affidavit of Mailing Notice or rulemaking
___8.16.84___ At least 30 days prior to ~~hearing~~/adoption

___✓___ Mailing list Certificate

___✓___ Publication in State Register
___8.20.84___ At least 30/~~20~~ days prior to ~~hearing~~/adoption

___N/A___ Hearing Examiner's Report

_____ Chief Hearing Examiner's Report(s)
_____ Approving H.E.'s Report
_____ Approving agency action

_____ Agency's Findings of Fact

_____ LCRAR Report or agency Affidavit

_____ Certificate of Board's Resolution Adopting Rules

___✓___ Order Approving Incorporation by Reference

___✓___ Statement of Need and Reasonableness

___N/A___ Petition for Adoption of a Rule

___✓___ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

_____ Certificate of Compliance w/Rulemaking Procedures

_____ Affidavit of Mailing Notice of Submission to Attorney General

_____ Notice of Submission to the Attorney General

SF-00006-02

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO : Michael Hatch
Commissioner, Department of Commerce

DATE: October 15, 1984

FROM : Martha J. Casserly MJC
Special Assistant Attorney General

PHONE: 296-4692

SUBJECT: In the Matter of the Proposed Adoption of Rules Relating to Employee Health and Disability Joint Self-Insurance Plans.

Enclosed herewith are the rules you have submitted for approval. These rules have been approved by this office and filed with the Secretary of State. Please note that they have not been filed with the State Register. This must be done promptly by your agency.

Upon receipt and before transmittal to your agency, however, it is important that you recheck these rules as to:

1. Affixation of stamps of the Attorney General and Secretary of State;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages to the rules in the approved set.

If you have any questions in this regard, please contact me.

MJC:slz

Encs.

cc: Ms. Kathy Burek
Mr. Duane Harves

AG copy

Department of Commerce

Adopted Rules Governing Employee Health and Disability Joint Self-Insurance

Rules as Adopted

CHAPTER 2765

DEPARTMENT OF COMMERCE

EMPLOYEE HEALTH AND DISABILITY JOINT SELF-INSURANCE PLANS

2765.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 2765.0100 to 2765.1500, the terms defined in this part have the meanings given them.

Subp. 2. **Board.** "Board" means a plan's board of trustees.

Subp. 3. **Bylaws.** "Bylaws" means the statements adopted by a plan that prescribe its purpose, government, and administration.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Commerce.

Subp. 5. **Coverage.** "Coverage" means the right of a covered person to benefits provided directly or indirectly by a plan, by virtue of the coverage document.

Subp. 6. **Coverage document.** "Coverage document" means the document specifying the characteristics and duration of coverage provided through a plan.

Subp. 7. **Covered employee.** "Covered employee" means a plan member's employee who is covered through the plan, and a plan member's former employee receiving continued coverage under Minnesota Statutes, section 62A.17, subdivisions 1 to 5. "Covered employee" does not include dependents or other persons included under the coverage extended to a plan member's current or former employee.

Subp. 8. **Days.** "Days" means calendar days.

Subp. 9. **Financial administrator.** "Financial administrator" means an entity employing persons trained and experienced in money management and investments, and possessing

no less than five years experience as an organization with demonstrated competence in money management and investments.

Subp. 10. **Fund year.** "Fund year" means a plan's fiscal year, and must be the calendar year.

Subp. 11. **Incurred basis stop-loss insurance.** "Incurred basis stop-loss insurance" means the aggregate excess stop-loss insurance required by part 2765.1300, if on an incurred basis. The insurance is on an incurred basis if payments are charged against a fund year's deductible according to when liability for the payment was incurred.

Subp. 12. **Insurer.** "Insurer" means an insurance company licensed under Minnesota Statutes, section 60A.07, subdivision 4, and authorized by Minnesota Statutes, section 60A.06 to write sickness and disability insurance, or a service plan corporation licensed under Minnesota Statutes, section 62C.08.

Subp. 13. **Member.** "Member" means an employer that belongs to or participates in a plan. Reference to actions of a member includes actions on behalf of the member's covered employees and other covered persons.

Subp. 14. **Paid basis stop-loss insurance.** "Paid basis stop-loss insurance" means the aggregate excess stop-loss insurance required by part 2765.1300, if on a paid basis. The insurance is on a paid basis if payments are charged against a fund year's deductible according to when the payment was made.

Subp. 15. **Plan.** "Plan" means a joint self-insurance employee benefit plan approved under parts 2765.0100 to 2765.0250. Reference to actions of a plan includes actions by the plan's designated agents.

Subp. 16. **Premium.** "Premium" means the amount paid or to be paid for coverage by members. Premium does not include assessments or penalties.

Subp. 17. **Runoff plan.** "Runoff plan" means a plan that no longer has authority to self-insure, but that continues to exist for the purpose of paying claims, preparing reports, and administering transactions associated with the period when the plan provided coverage.

Subp. 18. **Self-insure.** "Self-insure" means to assume primary liability or responsibility for certain risks or benefits, rather than transferring liability or responsibility to some other entity.

Subp. 19. **Separate employer.** "Separate employer," for the purposes of meeting the minimum three-employer requirement, means an employer that is not the parent, subsidiary, or affiliate with a common parent of any other employer in the plan.

Subp. 20. **Service company.** "Service company" means an entity licensed under Minnesota Statutes, section 60A.23, subdivision 8 and rules adopted thereunder as a self-insurance plan administrator, or an entity named in Minnesota Statutes, section 60A.23, subdivision 8, paragraph (1), clause (a) or (b).

Subp. 21. **Short-term disability benefit.** "Short-term disability benefit" means income replacement payments of not more than one year's duration.

2765.0200 PURPOSE.

Parts 2765.0100 to 2765.1500 govern the formation, operation, and dissolution of multiple employer plans for joint self-insurance of employee health, dental, or short-term disability benefits. They are intended to ensure that the financial integrity of these plans is maintained, and that they are administered competently and equitably.

2765.0300 SCOPE.

The following are subject to the requirements of parts 2765.0100 to 2765.1500:

A. employers authorized to transact business in Minnesota that seek to jointly self-insure employee health, dental, or short-term disability benefits;

B. service companies that provide services to a plan; and

C. insurance companies licensed under Minnesota Statutes, section 60A.07, subdivision 4, or service plan corporations licensed under Minnesota Statutes, section 62C.08, that provide required stop-loss insurance to a plan.

2765.0400 BYLAWS.

Subpart 1. **Content.** Bylaws may contain any provisions that do not conflict with parts 2765.0100 to 2765.1500. Bylaws must, at a minimum, contain the following provisions:

A. the plan's name, purpose, and initial date of existence;

B. definitions of key terms;

C. a statement of the powers, duties, and responsibilities assigned to the board, the service company, and the financial administrator, and reserved to the membership;

D. the number, term of office, method of selection, and method of replacement of the members of the board;

E. the procedure for calling board meetings;

F. the method of periodic selection and review of the service company and financial administrator;

G. the procedure for amending the bylaws;

H. the procedure for resolving disputes among members, which must not include submitting disputes to the commissioner;

I. the criteria for membership in the plan, including standards of financial integrity and loss experience;

J. the procedure for admitting new members to the plan;

K. the criteria for expelling members from the plan, including nonpayment of premium;

L. the procedure for withdrawal and expulsion of members from the plan, including the minimum required period of membership;

M. a statement of the coverages the plan intends to provide;

N. the procedure for adding and dropping a member's participation in a particular coverage;

O. a schedule for premium payments by members and, if applicable, their employees;

P. the procedure for changing premium rates;

Q. the procedure for levying and collecting an

assessment;

R. a statement of who may have access to plan funds and for what purposes;

S. the procedure for distributing dividends, and the eligibility of past members and past covered employees for dividends; and

T. the procedure for distributing assets remaining upon the plan's dissolution.

Subp. 2. **Adoption and changes.** The bylaws must be adopted in writing by all initial members. Authority to change the bylaws must reside with the membership or the board, according to the terms of the bylaws. Authority to change the bylaws may not be delegated to a contractor or other outside party. The plan must file bylaw changes with the commissioner not less than 30 days after adoption.

2765.0500 BOARD.

Subpart 1. **Structure.** A plan must have a board of trustees consisting of officials or employees of the members. No member may have more than one representative on the board. No trustee may be an employee, agent, or representative of the plan's service company, financial administrator, insurer, or other person or entity under contract with the plan. Trustees shall be elected by vote of the membership. There shall be an odd number of trustees, with staggered terms to provide continuity. One trustee shall be designated the chairperson. The board shall meet no less than four times annually.

Subp. 2. **Duties.** The board is responsible for operation of the plan. The board may delegate some or all of its responsibilities to the chairperson or other trustees between board meetings. All responsibilities of the plan not expressly delegated by the board or parts 2765.0100 to 2765.1500 are the responsibility of the board. The board shall, at a minimum, have the following responsibilities:

A. fiduciary responsibility for the plan's operation and financial condition;

B. selection, supervision, and evaluation of the

service company, financial administrator, accountant, insurer, and any other contractors;

C. on the basis of the plan's overall financial condition, authorizing changes in premium, reserve, or investment practices; and declaring assessments or dividends as appropriate;

D. approving all reports concerning the plan's operations and status to the commissioner and the members;

E. monitoring delinquent premiums, loss experience, and the financial condition of individual members; and authorizing disciplinary action or expulsion as appropriate;

F. authorizing acceptance or rejection of applications for membership;

G. as permitted by the bylaws, making or recommending changes to the bylaws for the improvement of the plan's operation and financial integrity; and

H. monitoring the plan's compliance with all statutes and rules governing its operation.

2765.0600 APPLICATION.

Subpart 1. **Initial application.** Three or more separate employers may apply to the commissioner for authority to form a joint self-insurance plan, using forms available from the commissioner. Applications must be submitted not later than 60 days prior to the requested date for authority to self-insure. All reinsurance contracts must be submitted not later than 30 days prior to the requested date. Applications submitted without responses to certain questions, or with responses that are inadequate must be returned to the applicant for resubmission. Applications not returned to the applicant for resubmission within 14 days of receipt must be approved or disapproved within 60 days of receipt.

Subp. 2. **Renewal application.** Existing plans may apply for renewal of their self-insurance authority by so indicating on their annual status report preceding expiration of their current authority. Applications must be approved or disapproved within 60 days of receipt of the status report.

Subp. 3. **Exemptions.** Joint self-insurance plans that offer a program of coverage qualified under the Employees Retirements Income Security Act (ERISA), United States Code, title 29, sections 1001 et seq., are exempted from parts 2765.0100 to 2765.1500 upon filing with the commissioner notice of this qualification from the United States Department of Labor.

Subp. 4. **Merger.** Two or more existing plans may apply to merge if the new plan assumes all obligations of the former plans. Merger applications are subject to the same requirements as prospective new plans.

Subp. 5. **Approval and disapproval.** Upon approval of an application, the commissioner shall issue an order authorizing the proposed joint self-insurance plan. Initial authorization orders for new plans are effective until the third May 1st after the initial authorization date. Renewal authorization orders are for two-year periods commencing May 1st. Approval of applications for authority to self-insure must be granted if the proposed plan conforms with:

A. all requirements of parts 2765.0100 to 2765.1500;

B. all applicable requirements of Minnesota Statutes, chapters 62A and 62E, and related rules, as described in part 2765.1000, subpart 1;

C. Minnesota Statutes, sections 72A.19 to 72A.32; and

D. other applicable Minnesota statutes and rules.

2765.0700 ENDING SELF-INSURANCE, RUNOFF PERIOD, AND PLAN DISSOLUTION.

Subpart 1. **Ending self-insurance authority.** A plan may decide to end its self-insurance authority and cease to provide coverage, effective at the end of a fund year. The plan must notify the commissioner within 14 days of such a decision. A plan may not elect to end its self-insurance authority less than 45 days prior to the end of the fund year in question. Voluntary ending of self-insurance authority does not constitute plan dissolution under subpart 4.

Subp. 2. **Revocation of self-insurance authority.** The commissioner shall, by order, revoke the authority of a plan to

self-insure upon ten-days written notice if any of the following events occur or conditions develop, and if the commissioner judges them to be material:

A. failure of the plan to comply with parts 2765.0100 to 2765.1500; with all applicable requirements of Minnesota Statutes, chapters 62A, 62D, 62E, and related rules, as described in part 2765.1000, subpart 1; or with other applicable Minnesota statutes or rules;

B. failure of the plan to comply with any lawful order of the commissioner;

C. commission by the plan of an unfair or deceptive practice as defined in Minnesota Statutes, sections 72A.17 to 72A.32, or in related rules; or

D. a deterioration of the plan's financial integrity to the extent that its present or future ability to meet obligations promptly and in full is or will be significantly impaired.

Subp. 3. **Runoff period.** A plan shall continue to exist as a runoff plan after its authority to self-insure has ended, for the purpose of paying claims, preparing reports, and administering transactions associated with the period when the plan provided coverage. A runoff plan must continue to comply with all appropriate provisions of parts 2765.0100 to 2765.1500, and with all other applicable Minnesota statutes and rules. Authority to exist as a runoff plan is open-ended, and does not require renewal of authority under part 2765.0600, subpart 2.

Subp. 4. **Dissolution.** A plan, including a runoff plan, that desires to cease existence shall apply to the commissioner for authorization to dissolve. Applications must be approved or disapproved within 60 days of receipt. Dissolution without authorization is prohibited and void, and does not absolve a plan or runoff plan from fulfilling its continuing obligations, and does not absolve its members from assessment under part 2765.1400, subpart 6. The plan's assets at the time of dissolution must be distributed to the members and covered employees as provided in the bylaws. Authorization to dissolve

must be granted if either of the following conditions are met:

A. the plan demonstrates that it has no outstanding liabilities, including incurred but not reported liabilities; or

B. the plan has obtained an irrevocable commitment from a licensed insurer that provides for payment of all outstanding liabilities, and for providing all related services, including payment of claims, preparation of reports, and administration of transactions associated with the period when the plan provided coverage.

2765.0800 ADMINISTRATION.

Subpart 1. **Service company.** A plan must contract with a service company for services necessary to the plan's day-to-day operations, except services and responsibilities reserved to the members, the board, individual trustees, the financial administrator, or other contractors. The service company must have expertise in and be licensed for administering health benefits. Subject to the oversight of the board, the service company shall, directly or through subcontractors, provide all services directly related to the administration of coverage. These services include but are not limited to:

A. accounting and recordkeeping;

B. billing and collection of premiums and assessments;

C. claims investigation, settlement, and reserving;

D. claims payment, including claims wholly or partially subject to stop-loss insurance or member deductibles;

E. general administration;

F. loss control, safety programs, or both; and

G. underwriting.

Subp. 2. **Financial administrator.** A plan must contract with a financial administrator for investment of the plan's assets and other financial or accounting services. No staff members of the financial administrator may be an owner, officer, employee, or agent of the service company, or of a subcontractor of the service company.

Subp. 3. **Recordkeeping.** A plan must maintain within the state of Minnesota all records necessary to verify the accuracy

and completeness of all reports submitted to the commissioner under part 2765.1500. The commissioner may examine the plan's records in order to ascertain the plan's compliance with parts 2765.0100 to 2765.1500, and with other applicable statutes and rules. All records concerning claims, reserves, financial transactions, and other matters necessary to the plan's operations are the plan's property.

stat auth?

2765.0900 MEMBERSHIP.

Subpart 1. **Availability.** Plan membership is available only to employers domiciled and authorized to transact business in Minnesota. A plan may establish other nondiscriminatory criteria for membership. Nothing in these rules requires a plan to offer membership to an employer that does not meet the plan's underwriting standards.

Subp. 2. **Joining.** New members must be admitted according to the standards and procedures specified in the bylaws. Membership is not effective before the applicant has signed a membership agreement affirming its commitment to comply with the bylaws and parts 2765.0100 to 2765.1500. The membership agreement must disclose that under the rules governing this plan, the Minnesota commissioner of commerce may order that an assessment be levied against member employers, if necessary to maintain the plan's sound financial condition.

Subp. 3. **Leaving.** The membership agreement must state the procedures for leaving the plan. A member must notify the plan of its desire to withdraw not less than 30 days before the date upon which it desires to withdraw. If the board determines that the withdrawal would cause the plan to be in violation of the minimum number of employers and covered employees requirement of Minnesota Statutes, section 62H.01, or any other requirement of parts 2765.0100 to 2765.1500 the plan shall notify the commissioner as required under subpart 5. Withdrawal from a plan is prohibited and void unless:

A. the member will have belonged to the plan continuously:

(1) until the end of the current fund year; or

(2) until the end of the succeeding fund year for new members that join in the last three months of the fund year; or

(3) for a longer period if required by the bylaws; and

B. all outstanding premiums and assessments owed by the member have been paid.

Subp. 4. **Expulsion.** At least annually the plan shall review the status and experience of each member by comparison with the criteria for expulsion in the bylaws. Expulsion is subject to the procedures and requirements for voluntary withdrawal of a member, except that:

A. a member may be expelled with outstanding premiums or assessments owing; and

B. a member may be expelled notwithstanding that the minimum term of membership has not been satisfied.

Subp. 5. **Minimum covered employees and employers.** A plan shall monitor the number of employees it covers. If the number of covered employees is less than 300, the plan shall notify the commissioner at monthly intervals of the number of covered employees, until the number exceeds 300 for two consecutive months. If the number of covered employees becomes less than 250, or the number of members becomes less than three, the plan shall notify the commissioner:

A. of its intent to end its self-insurance authority; or

B. of its proposal for restoring compliance with Minnesota Statutes, section 62H.01.

If the proposal is unlikely, in the commissioner's judgment, to restore compliance within 90 days, or if after 90 days the plan continues to have less than 250 covered employees or less than three members, the commissioner shall revoke the plan's self-insurance authority.

Subp. 6. **Runoff plan membership.** After revocation of a plan's self-insurance authority, or after a plan notifies the commissioner in writing of its intent to end self-insurance

authority voluntarily, no member may join, leave, or be expelled from the plan.

2765.1000 COVERAGE.

Subpart 1. **Coverage administration and related requirements.** Plans are subject to the requirements of Minnesota statutes and rules applicable to insurance companies providing insurance in Minnesota similar to the plan's coverage. These include requirements concerning coverage content, coverage administration, rates, underwriting, and related matters, including but not limited to:

A. the requirements of Minnesota Statutes, section 60A.082, and related rules, as applicable to group medical expense insurance and group disability income insurance;

B. the requirements of Minnesota Statutes, chapter 62A, and related rules, as applicable to group accident and health insurance as defined in Minnesota Statutes, section 62A.10, including but not limited to:

(1) filing and requesting approval for coverage documents and rates;

(2) coverage document language requirements;

(3) mandated benefits;

(4) employee notice requirements;

(5) requirements to offer continuation of coverage to employees and other covered persons; and

(6) requirements to offer conversion coverage through licensed insurers or health maintenance organizations to employees and other covered persons;

C. the requirements of Minnesota Statutes, sections 62A.23 and 62A.24, and related rules, as applicable to group disability income insurance;

D. the requirements of Minnesota Statutes, sections 62A.31 to 62A.42, and related rules, as applicable to insurance covering persons covered by medicare; and

E. the requirements of Minnesota Statutes, chapter 62E, and related rules, as applicable to plans of health coverage as defined in Minnesota Statutes, section 62E.02,

subdivision 9.

Subp. 2. **Coverage to individuals.** Joint self-insurance plans shall not offer coverage to individuals other than members' employees and their dependents, except as required following termination of employment under Minnesota Statutes, section 62A.17, subdivisions 1 to 5. Plans must comply with the conversion coverage requirements of Minnesota Statutes, sections 62A.17, subdivision 6, and 62E.16, by arrangements with licensed insurers or health maintenance organizations.

Subp. 3. **Health maintenance organization coverage.** A plan may arrange for covered persons to have an option of health maintenance organization coverage, including employees of employers required to provide such an option by Minnesota Statutes, section 62E.17. Such an arrangement must be through a licensed health maintenance organization.

Subp. 4. **Uniform underwriting.** All coverages offered by a plan must be available according to the same underwriting standards to all employees of all members.

Subp. 5. **Term of coverage.** A plan shall not commit itself to providing coverage for any period which extends beyond the term of any stop-loss insurance policies required under part 2765.1300.

Subp. 6. **Continuing responsibility.** Notwithstanding cancellation or termination of coverage to a particular member, ceasing to offer a particular coverage, or ending or revocation of authority to self-insure, a plan retains indefinitely all responsibilities to covered employees and other covered persons associated with the period while coverage was in force. This responsibility ceases only after a plan dissolves under part 2765.0700, subpart 4.

2765.1100 PREMIUMS AND DIVIDENDS.

Subpart 1. **Premium payments.** The fund year must be the basis for calculating members' premiums. A plan may permit installment payments if payment is always due before premium is to be earned. Any delinquencies in payments by employees must be paid on their behalf by the employer, with the employer

having the right to seek reimbursement from the employee. A plan shall promptly take appropriate action to collect any members' premiums or assessments that are past due. Collection costs are the obligation of the delinquent member. Payments determined to be uncollectible must be presented to the stop-loss insurer for reimbursement, as required by part 2765.1300, subpart 4.

Subp. 2. **Dividends.** A plan may declare and pay a dividend or distribution from its surplus only if:

A. the dividend would not cause the plan's surplus to be negative;

B. the plan does not have a stop-loss aggregate advancement liability; and

C. the dividend is apportioned on the basis of the relative amounts of premium paid by members and covered employees, and provides for proportional payments to members and covered employees.

2765.1200 RESERVES.

Subpart 1. **Loss and premium reserves.** A plan must establish reserves for all incurred losses, both reported and unreported, and for unearned premiums. To the extent that the amount of a loss is uncertain, reserves must be set conservatively. As the degree of uncertainty concerning a loss is changed by new events or information, the amount of the reserve must be changed appropriately. Accounting for reserves must be as required by the financial statement forms and instructions, under part 2765.1500, subpart 1.

Subp. 2. **Full funding reserves.** To comply with the full funding requirement of Minnesota Statutes, section 62H.02, a plan must establish full funding reserves corresponding to its aggregate excess stop-loss insurance for each fund year.

A. The amount of the reserves must be calculated as required by the financial statement forms and instructions, under part 2765.1500, subpart 1. The forms and instructions must provide that the base amount of the full funding reserves is equal to the plan's maximum possible liability under the

aggregate excess stop-loss insurance, with credits for:

(1) individual excess stop-loss insurance reimbursements; and

(2) losses paid and reserves expected to be chargeable against the aggregate excess stop-loss insurance deductible.

B. Separate full funding reserves must be maintained for each fund year, beginning at the fund year's inception. Plans with paid basis stop-loss insurance must maintain each year's full funding reserve until 90 days after the fund year's end. Plans with incurred basis stop-loss insurance must maintain each year's full funding reserve until one year after the fund year's end.

C. Plans with paid basis stop-loss insurance must also maintain a separate runoff full funding reserve. The runoff reserve's purpose is to fully fund the plan's liability in the event of stop-loss insurance non-renewal. The runoff full funding reserve must be maintained until plan dissolution.

Subp. 3. **Surplus or aggregate advancement.** A plan must protect itself from cash flow difficulties by either of the following two methods.

A. Establishing and maintaining a surplus equal to the greater of:

(1) three times the average paid monthly premium during the most recent fund year;

(2) three times estimated monthly premium, for plans that do not yet have one fund year's experience; or

(3) $100,000.

B. Obtaining language in the plan's aggregate excess stop-loss insurance policy requiring the insurer to advance funds to the plan under the conditions prescribed by this item. Any funds so advanced must be included in the fund-year settle-up calculation under the stop-loss insurance terms, if not previously repaid. No limit may be set on the amount of funds that the plan may require to be advanced. The policy language must include these sentences: "If, in good faith, the

plan judges that it is suffering, or will soon suffer cash flow difficulties, to the extent that its ability to meet its obligations promptly and in full is or will be significantly impaired, the plan may borrow from the insurer funds sufficient in the plan's good faith judgment to correct the difficulties. Such funds shall be considered an advance against the insurer's potential aggregate excess insurance liability for the current fund year. If, as of the final reporting for that fund year, the insurer's liability is determined to be less than the amount of the aggregate advancement, the difference shall then be considered a debt of the plan to the insurer, and reasonable interest may be charged commencing at that time. Until the final reporting, no interest may be charged. The plan shall, in good faith, repay the advance or debt as rapidly as its financial resources permit, without incurring further cash flow difficulties." The policy must not alter or qualify these terms to harm the plan's rights materially.

2765.1300 STOP-LOSS INSURANCE.

Subpart 1. **Purchase and alteration.** The plan must inform the commissioner at least 90 days prior to expiration of any required stop-loss insurance policy whether it intends to renew the policy, and whether the insurer is willing to renew the policy. Alteration of a required stop-loss insurance policy mid-term with the effect of reducing coverage, and cancellation by the plan mid-term, are prohibited. Required stop-loss insurance policies must be noncancellable for a minimum of two years, for any cause including nonpayment of premium. If more than one stop-loss insurance policy is obtained in fulfillment of this part's requirements, their expiration dates must be the same.

Subp. 2. **Individual excess.** A plan must have and maintain individual excess stop-loss insurance, that provides for the insurer to assume all liability in excess of $25,000 per person per year under all coverages the plan offers. The reporting period under this coverage must be no less than one year after the fund year's conclusion. A plan may apply to the

commissioner for increasing the individual excess stop-loss insurance limit, up to $50,000. The commissioner must approve this application if the increased limit would not be detrimental to the solvency and stability of the plan, considering the plan's experience, size, surplus, and other factors affecting financial integrity.

Subp. 3. **Aggregate excess.** A plan must have and maintain aggregate excess stop-loss insurance that provides for the insurer to assume all liability in excess of a specified amount of losses for each fund year. The aggregate excess coverage may be in the form of incurred basis stop-loss insurance or paid basis stop-loss insurance. Plans using paid basis stop-loss insurance must have and maintain extended or runoff aggregate excess stop-loss insurance on an incurred basis. The extended or runoff coverage must provide for the insurer to assume all liability in excess of a specified amount of losses incurred while the paid basis stop-loss insurance was in force, but paid after its termination or nonrenewal. The reporting period under paid basis insurance must be no less than three months after the fund year's conclusion. The reporting period under incurred basis insurance, including extended or runoff insurance, must be no less than one year after the fund year's conclusion.

Subp. 4. **Delinquencies and insolvencies.** A plan must have and maintain the following language in its required aggregate excess stop-loss insurance policy: "The insurer shall, at the plan's or the commissioner's request, pay premium to the plan on behalf of a member that fails to pay due to insolvency, unauthorized withdrawal from the plan, or any other reason. The insurer may attempt to collect reimbursement from the member on whose behalf the insurer is called upon to pay premium." The policy must not alter or qualify these terms to harm the plan's rights materially.

Subp. 5. **Surety coverage.** A plan must have and maintain the following language in its required aggregate excess stop-loss insurance policy: "The insurer shall, at the commissioner's request, assume direct responsibility for the

plan's coverage and all other responsibilities under parts 2765.0100 to 2765.1500 and related statutes, if the plan becomes insolvent, ceases operations without authorization, or otherwise fails to fulfill its responsibilities under parts 2765.0100 to 2765.1500 and related statutes. The insurer may attempt to collect reimbursement from the plan or a member on whose behalf the insurer is called upon to pay premium, pay claims, or incur other extraordinary expenses. However, the insurer must fulfill its responsibilities under this section while any collection attempts are pending. The insurer's responsibilities extend to all matters arising during or attributable to the policy period, and do not terminate with the end of the policy period." The policy must not alter or qualify these terms to harm the plan's rights materially.

Subp. 6. **Return of liability.** No liability or other responsibilities transferred to an insurer under this part may, directly or indirectly, be returned to a plan, a member, or a member's parent, subsidiary, or affiliate. This does not prohibit the insurer from seeking reimbursement from the plan or a member, as permitted under subparts 4 and 5.

2765.1400 FINANCIAL INTEGRITY.

Subpart 1. **Fidelity bond.** All contractors and individuals who handle plan funds or who will have authority to gain access to plan funds, including trustees, must be covered by a fidelity bond. The bond must cover losses from dishonesty, robbery, forgery or alteration, misplacement, and mysterious and unexplainable disappearance. The amount of coverage for each occurrence must be $300,000 or more. The plan must purchase a fidelity bond covering the required contractors and individuals, or submit separate proof of coverage for all required contractors and individuals not covered under the plan's bond.

Subp. 2. **Integrity of assets.** A plan's assets:

A. must not be commingled with the assets of any member;

B. must not be loaned to anyone for any purpose, or used as security for a loan, except as permitted under subpart 5

for investments;

C. must be employed solely for the purposes stated in the bylaws, and in compliance with parts 2765.0100 to 2765.1500 and related statutes; and

D. must not be considered the property or right of any member, covered employee, or other covered person, except:

(1) for benefits under the coverage documents;

(2) for dividends declared in accordance with part 2765.1100, subpart 2; and

(3) for a portion of the assets remaining after the plan's dissolution, in accordance with part 2765.0700, subpart 4.

Subp. 3. **Sources and uses of funds.** A plan may expend funds for payment of losses and expenses, and for other costs customarily borne by insurers under conventional insurance policies in Minnesota. Except as provided in part 2765.1200, subpart 3, item B, a plan must not borrow money or issue debt instruments. A plan may bring legal suits to collect delinquent debts. A plan must not obtain funds through subrogation of the rights of covered employees or other covered persons. A plan may receive funds only from:

A. its members as premiums, assessments, or penalties;

B. its insurers or indemnitors pursuant to insurance or indemnification agreements;

C. dividends, interest, or the proceeds of sale of investments;

D. refunds of excess payments;

E. coordination of benefits with automobile coverage, workers' compensation coverage, and other employee health benefit coverage; or

F. collection of money owed to the plan.

Subp. 4. **Separate accounts.** A plan may establish separate accounts for the payment of claims or certain types of expenses. These accounts must be used only by the service company, its authorized subcontractors, or the financial administrator, as appropriate to the account's purpose. The

amount in these special accounts must not exceed an amount reasonably sufficient to pay the claims or expenses for which it is established. All monetary and investment assets not in these accounts must be under the control of the financial administrator.

Subp. 5. **Investments.** A plan's investments are subject to the requirements of Minnesota Statutes, section 475.66, as regards both permitted types of investments, maturities, and depositories. In addition, a plan must not invest in securities or debt of a member, or a member's parent, subsidiary, or affiliate; or any person or entity under contract with the plan.

Subp. 6. **Monitoring financial condition.** The board must regularly monitor the plan's revenues, expenses, and loss development, and evaluate its current and expected financial condition. The board must attempt in good faith to maintain or restore the plan's sound financial condition, using any means at its disposal. These means include but are not limited to adjusting premium rates, underwriting standards, dividend rates, expulsion standards, and other powers granted in parts 2765.0100 to 2765.1500 and the bylaws. If the commissioner judges that the board's actions are inadequate to maintain or restore the plan's sound financial condition, the commissioner shall, as appropriate: order an increase in the premium rates; revoke the plan's self-insurance authority; or order that an assessment be levied against the members.

Members must not require covered employees to pay a portion of an assessment, nor must covered employees be required to pay any amount for premium increases on coverage in force. The amount of assessments must not be more than the amount of members' most recent annual premium, including the portion paid by covered employees.

2765.1500 REPORTING.

Subpart 1. **Financial statements.** A plan must prepare annual financial statements containing a balance sheet; a full funding reserves calculation worksheet; a statement of revenues, expenses, and surplus; a statement of changes in financial

position; and a schedule of investments. The statements must be prepared on forms and according to instructions prescribed by the commissioner. The financial statements must be filed with the commissioner no later than 30 days after the fund year's conclusion. The financial statements must be audited by an independent certified public accountant, and an audit report must be filed with the commissioner no later than 180 days after the fund year's conclusion. A plan's first annual financial statement, and every second annual financial statement thereafter must be accompanied by a statement from a qualified actuary concerning the balance sheet items that are based on actuarial assumptions and methods. The form of the actuary's statement and the scope of the actuarial review must be according to instructions prescribed by the commissioner.

Subp. 2. **Quarterly reports.** A plan must file quarterly reports with the commissioner no later than 30 days after the end of the first, second, and third quarters of each fund year. Quarterly reports must contain statements of the plan's:

A. current total cash on hand and on deposit, and total investments;

B. current total reserve for unearned and advance premiums, total reserve for outstanding losses reported and unreported, total operating full funding reserve, and total runoff full funding reserve;

C. dividends declared during the quarter;

D. gross premiums written during the quarter;

E. losses paid during the quarter;

F. proximity to the aggregate excess stop-loss insurance attachment point for the current fund year and, if applicable, the past fund year;

G. current total members and covered employees; and

H. any other matters the commissioner requests that the board address.

Subp. 3. **Extraordinary audits.** Upon sufficient cause, the commissioner shall require a plan to investigate the accuracy of one or more entries on its financial statements or quarterly

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reports, and to report its findings. If necessary for the investigation's purposes, the commissioner shall require a plan to contract with a qualified actuary, claims specialist, auditor, or other specialists as appropriate to the type of entry being investigated. If warranted by investigation's findings, the commissioner shall require changes in the plan's reserving, accounting, or recordkeeping practices. These extraordinary audits are in addition to the commissioner's rights to examine self-insurance plans under Minnesota Statutes, section 60A.03, subdivisions 3, 5, and 6, and section 60A.031. Sufficient cause includes:

A. losses that appear significantly different than losses experienced by other self-insurance plans or insurance companies for similar coverage;

B. unusual changes in the amount of entries from period to period that are not sufficiently explained by the financial statements, quarterly reports, or footnotes; or

C. other indications that a plan's financial statements or quarterly reports may not accurately reflect the plan's status and transactions.

Subp. 4. **Annual status report.** No later than 30 days after the fund year's conclusion, a plan must file with the commissioner a statement describing any changes that have occurred in the information filed with its initial application for authority to self-insure, or with the plan's most recent status report. The status report must be filed in a form and according to instructions prescribed by the commissioner.

Subp. 5. **Penalty.** The financial statements and status report required under subparts 1 and 4 are considered together to be a plan's annual statement. This filing and other filings required by parts 2765.0100 to 2765.1500 and related statutes are subject to Minnesota Statutes, section 72A.061, as applicable to licensed insurance companies for comparable filings.

Subp. 6. **Revenue fee.** No later than 60 days after each fund year's conclusion, a plan must file a report with the

commissioner of revenue disclosing the total amount of claims paid during the fund year, with no deduction for claims wholly or partially reimbursed through stop-loss insurance. The report must be filed on a form available from the commissioner of revenue. At the time of filing the report, the plan shall pay the fee required by Minnesota Statutes, section 62H.07, to the commissioner of revenue in the amount of two percent of the total amount of claims paid during the fund year, with no deduction for claims wholly or partially reimbursed through stop-loss insurance.

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
OCT 15 1984
Joan Anderson Growe
Secretary of State
9:45 AM

APPROVED AS TO FORM AND LEGALITY
October 15 1984
HUBERT H. HUMPHREY, III
ATTORNEY GENERAL
BY Martha J Cassely
SPECIAL ASSISTANT ATTORNEY GENERAL

Rules as Proposed (all new material)

CHAPTER 2765

DEPARTMENT OF COMMERCE

EMPLOYEE HEALTH AND DISABILITY JOINT SELF-INSURANCE PLANS

2765.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 2765.0100 to 2765.1500, the terms defined in this part have the meanings given them.

Subp. 2. **Board.** "Board" means a plan's board of trustees.

Subp. 3. **Bylaws.** "Bylaws" means the statements adopted by a plan that prescribe its purpose, government, and administration.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Commerce.

Subp. 5. **Coverage.** "Coverage" means the right of a covered person to benefits provided directly or indirectly by a plan, by virtue of the coverage document.

Subp. 6. **Coverage document.** "Coverage document" means the document specifying the characteristics and duration of coverage provided through a plan.

Subp. 7. **Covered employee.** "Covered employee" means a plan member's employee who is covered through the plan, and a plan member's former employee receiving continued coverage under Minnesota Statutes, section 62A.17, subdivisions 1 to 5. "Covered employee" does not include dependents or other persons included under the coverage extended to a plan member's current or former employee.

Subp. 8. **Days.** "Days" means calendar days.

Subp. 9. **Financial administrator.** "Financial administrator" means an entity employing persons trained and experienced in money management and investments, and possessing no less than five years experience as an organization with demonstrated competence in money management and investments.

Subp. 10. **Fund year.** "Fund year" means a plan's fiscal year, and must be the calendar year.

Subp. 11. **Incurred basis stop-loss insurance.** "Incurred

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basis stop-loss insurance" means the aggregate excess stop-loss insurance required by part 2765.1300, if on an incurred basis. The insurance is on an incurred basis if payments are charged against a fund year's deductible according to when liability for the payment was incurred.

Subp. 12. **Insurer.** "Insurer" means an insurance company licensed under Minnesota Statutes, section 60A.07, subdivision 4, and authorized by Minnesota Statutes, section 60A.06 to write sickness and disability insurance, or a service plan corporation licensed under Minnesota Statutes, section 62C.08.

Subp. 13. **Member.** "Member" means an employer that belongs to or participates in a plan. Reference to actions of a member includes actions on behalf of the member's covered employees and other covered persons.

Subp. 14. **Paid basis stop-loss insurance.** "Paid basis stop-loss insurance" means the aggregate excess stop-loss insurance required by part 2765.1300, if on a paid basis. The insurance is on a paid basis if payments are charged against a fund year's deductible according to when the payment was made.

Subp. 15. **Plan.** "Plan" means a joint self-insurance employee benefit plan approved under parts 2765.0100 to 2765.0250. Reference to actions of a plan includes actions by the plan's designated agents.

Subp. 16. **Premium.** "Premium" means the amount paid or to be paid for coverage by members. Premium does not include assessments or penalties.

Subp. 17. **Runoff plan.** "Runoff plan" means a plan that no longer has authority to self-insure, but that continues to exist for the purpose of paying claims, preparing reports, and administering transactions associated with the period when the plan provided coverage.

Subp. 18. **Self-insure.** "Self-insure" means to assume primary liability or responsibility for certain risks or benefits, rather than transferring liability or responsibility to some other entity.

Subp. 19. **Separate employer.** "Separate employer," for the

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purposes of meeting the minimum three-employer requirement, means an employer that is not the parent, subsidiary, or affiliate with a common parent of any other employer in the plan.

Subp. 20. **Service company.** "Service company" means an entity licensed under Minnesota Statutes, section 60A.23, subdivision 8 and rules adopted thereunder as a self-insurance plan administrator, or an entity named in Minnesota Statutes, section 60A.23, subdivision 8, paragraph (1), clause (a) or (b).

Subp. 21. **Short-term disability benefit.** "Short-term disability benefit" means income replacement payments of not more than one year's duration.

2765.0200 PURPOSE.

Parts 2765.0100 to 2765.1500 govern the formation, operation, and dissolution of multiple employer plans for joint self-insurance of employee health, dental, or short-term disability benefits. They are intended to ensure that the financial integrity of these plans is maintained, and that they are administered competently and equitably.

2765.0300 SCOPE.

The following are subject to the requirements of parts 2765.0100 to 2765.1500:

A. employers authorized to transact business in Minnesota that seek to jointly self-insure employee health, dental, or short-term disability benefits;

B. service companies that provide services to a plan; and

C. insurance companies licensed under Minnesota Statutes, section 60A.07, subdivision 4, or service plan corporations licensed under Minnesota Statutes, section 62C.08, that provide required stop-loss insurance to a plan.

2765.0400 BYLAWS.

Subpart 1. **Content.** Bylaws may contain any provisions that do not conflict with parts 2765.0100 to 2765.1500. Bylaws must, at a minimum, contain the following provisions:

A. the plan's name, purpose, and initial date of

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existence;

B. definitions of key terms;

C. a statement of the powers, duties, and responsibilities assigned to the board, the service company, and the financial administrator, and reserved to the membership;

D. the number, term of office, method of selection, and method of replacement of the members of the board;

E. the procedure for calling board meetings;

F. the method of periodic selection and review of the service company and financial administrator;

G. the procedure for amending the bylaws;

H. the procedure for resolving disputes among members, which must not include submitting disputes to the commissioner;

I. the criteria for membership in the plan, including standards of financial integrity and loss experience;

J. the procedure for admitting new members to the plan;

K. the criteria for expelling members from the plan, including nonpayment of premium;

L. the procedure for withdrawal and expulsion of members from the plan, including the minimum required period of membership;

M. a statement of the coverages the plan intends to provide;

N. the procedure for adding and dropping a member's participation in a particular coverage;

O. a schedule for premium payments by members and, if applicable, their employees;

P. the procedure for changing premium rates;

Q. the procedure for levying and collecting an assessment;

R. a statement of who may have access to plan funds and for what purposes;

S. the procedure for distributing dividends, and the eligibility of past members and past covered employees for

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dividends; and

T. the procedure for distributing assets remaining upon the plan's dissolution.

Subp. 2. **Adoption and changes.** The bylaws must be adopted in writing by all initial members. Authority to change the bylaws must reside with the membership or the board, according to the terms of the bylaws. Authority to change the bylaws may not be delegated to a contractor or other outside party. The plan must file bylaw changes with the commissioner not less than 30 days after adoption.

2765.0500 BOARD.

Subpart 1. **Structure.** A plan must have a board of trustees consisting of officials or employees of the members. No member may have more than one representative on the board. No trustee may be an employee, agent, or representative of the plan's service company, financial administrator, insurer, or other person or entity under contract with the plan. Trustees shall be elected by vote of the membership. There shall be an odd number of trustees, with staggered terms to provide continuity. One trustee shall be designated the chairperson. The board shall meet no less than four times annually.

Subp. 2. **Duties.** The board is responsible for operation of the plan. The board may delegate some or all of its responsibilities to the chairperson or other trustees between board meetings. All responsibilities of the plan not expressly delegated by the board or parts 2765.0100 to 2765.1500 are the responsibility of the board. The board shall, at a minimum, have the following responsibilities:

A. fiduciary responsibility for the plan's operation and financial condition;

B. selection, supervision, and evaluation of the service company, financial administrator, accountant, insurer, and any other contractors;

C. on the basis of the plan's overall financial condition, authorizing changes in premium, reserve, or investment practices; and declaring assessments or dividends as

appropriate;

D. approving all reports concerning the plan's operations and status to the commissioner and the members;

E. monitoring delinquent premiums, loss experience, and the financial condition of individual members; and authorizing disciplinary action or expulsion as appropriate;

F. authorizing acceptance or rejection of applications for membership;

G. as permitted by the bylaws, making or recommending changes to the bylaws for the improvement of the plan's operation and financial integrity; and

H. monitoring the plan's compliance with all statutes and rules governing its operation.

2765.0600 APPLICATION.

Subpart 1. **Initial application.** Three or more separate employers may apply to the commissioner for authority to form a joint self-insurance plan, using forms available from the commissioner. Applications must be submitted not later than 60 days prior to the requested date for authority to self-insure. All reinsurance contracts must be submitted not later than 30 days prior to the requested date. Applications submitted without responses to certain questions, or with responses that are inadequate must be returned to the applicant for resubmission. Applications not returned to the applicant for resubmission within 14 days of receipt must be approved or disapproved within 60 days of receipt.

Subp. 2. **Renewal application.** Existing plans may apply for renewal of their self-insurance authority by so indicating on their annual status report preceding expiration of their current authority. Applications must be approved or disapproved within 60 days of receipt of the status report.

Subp. 3. **Exemptions.** Joint self-insurance plans that offer a program of coverage qualified under the Employees Retirements Income Security Act (ERISA), United States Code, title 29, sections 1001 et seq., are exempted from parts 2765.0100 to 2765.1500 upon filing with the commissioner notice

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of this qualification from the United States Department of Labor.

Subp. 4. **Merger.** Two or more existing plans may apply to merge if the new plan assumes all obligations of the former plans. Merger applications are subject to the same requirements as prospective new plans.

Subp. 5. **Approval and disapproval.** Upon approval of an application, the commissioner shall issue an order authorizing the proposed joint self-insurance plan. Initial authorization orders for new plans are effective until the third May 1st after the initial authorization date. Renewal authorization orders are for two-year periods commencing May 1st. Approval of applications for authority to self-insure must be granted if the proposed plan conforms with:

A. all requirements of parts 2765.0100 to 2765.1500;

B. all applicable requirements of Minnesota Statutes, chapters 62A and 62E, and related rules, as described in part 2765.1000, subpart 1;

C. Minnesota Statutes, sections 72A.19 to 72A.32; and

D. other applicable Minnesota statutes and rules.

2765.0700 ENDING SELF-INSURANCE, RUNOFF PERIOD, AND PLAN DISSOLUTION.

Subpart 1. **Ending self-insurance authority.** A plan may decide to end its self-insurance authority and cease to provide coverage, effective at the end of a fund year. The plan must notify the commissioner within 14 days of such a decision. A plan may not elect to end its self-insurance authority less than 45 days prior to the end of the fund year in question. Voluntary ending of self-insurance authority does not constitute plan dissolution under subpart 4.

Subp. 2. **Revocation of self-insurance authority.** The commissioner shall, by order, revoke the authority of a plan to self-insure upon ten-days written notice if any of the following events occur or conditions develop, and if the commissioner judges them to be material:

A. failure of the plan to comply with parts 2765.0100 to 2765.1500; with all applicable requirements of Minnesota

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Statutes, chapters 62A, 62D, 62E, and related rules, as described in part 2765.1000, subpart 1; or with other applicable Minnesota statutes or rules;

B. failure of the plan to comply with any lawful order of the commissioner;

C. commission by the plan of an unfair or deceptive practice as defined in Minnesota Statutes, sections 72A.17 to 72A.32, or in related rules; or

D. a deterioration of the plan's financial integrity to the extent that its present or future ability to meet obligations promptly and in full is or will be significantly impaired.

Subp. 3. **Runoff period.** A plan shall continue to exist as a runoff plan after its authority to self-insure has ended, for the purpose of paying claims, preparing reports, and administering transactions associated with the period when the plan provided coverage. A runoff plan must continue to comply with all appropriate provisions of parts 2765.0100 to 2765.1500, and with all other applicable Minnesota statutes and rules. Authority to exist as a runoff plan is open-ended, and does not require renewal of authority under part 2765.0600, subpart 2.

Subp. 4. **Dissolution.** A plan, including a runoff plan, that desires to cease existence shall apply to the commissioner for authorization to dissolve. Applications must be approved or disapproved within 60 days of receipt. Dissolution without authorization is prohibited and void, and does not absolve a plan or runoff plan from fulfilling its continuing obligations, and does not absolve its members from assessment under part 2765.1400, subpart 6. The plan's assets at the time of dissolution must be distributed to the members and covered employees as provided in the bylaws. Authorization to dissolve must be granted if either of the following conditions are met:

A. the plan demonstrates that it has no outstanding liabilities, including incurred but not reported liabilities; or

B. the plan has obtained an irrevocable commitment from a licensed insurer that provides for payment of all

outstanding liabilities, and for providing all related services, including payment of claims, preparation of reports, and administration of transactions associated with the period when the plan provided coverage.

2765.0800 ADMINISTRATION.

Subpart 1. **Service company.** A plan must contract with a service company for services necessary to the plan's day-to-day operations, except services and responsibilities reserved to the members, the board, individual trustees, the financial administrator, or other contractors. The service company must have expertise in and be licensed for administering health benefits. Subject to the oversight of the board, the service company shall, directly or through subcontractors, provide all services directly related to the administration of coverage. These services include but are not limited to:

A. accounting and recordkeeping;

B. billing and collection of premiums and assessments;

C. claims investigation, settlement, and reserving;

D. claims payment, including claims wholly or partially subject to stop-loss insurance or member deductibles;

E. general administration;

F. loss control, safety programs, or both; and

G. underwriting.

Subp. 2. **Financial administrator.** A plan must contract with a financial administrator for investment of the plan's assets and other financial or accounting services. No staff members of the financial administrator may be an owner, officer, employee, or agent of the service company, or of a subcontractor of the service company.

Subp. 3. **Recordkeeping.** A plan must maintain within the state of Minnesota all records necessary to verify the accuracy and completeness of all reports submitted to the commissioner under part 2765.1500. The commissioner may examine the plan's records in order to ascertain the plan's compliance with parts 2765.0100 to 2765.1500, and with other applicable statutes and rules. All records concerning claims, reserves, financial

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transactions, and other matters necessary to the plan's operations are the plan's property.

2765.0900 MEMBERSHIP.

Subpart 1. **Availability.** Plan membership is available only to employers domiciled and authorized to transact business in Minnesota. A plan may establish other nondiscriminatory criteria for membership. Nothing in these rules requires a plan to offer membership to an employer that does not meet the plan's underwriting standards.

Subp. 2. **Joining.** New members must be admitted according to the standards and procedures specified in the bylaws. Membership is not effective before the applicant has signed a membership agreement affirming its commitment to comply with the bylaws and parts 2765.0100 to 2765.1500. The membership agreement must disclose that under the rules governing this plan, the Minnesota commissioner of commerce may order that an assessment be levied against member employers, if necessary to maintain the plan's sound financial condition.

Subp. 3. **Leaving.** The membership agreement must state the procedures for leaving the plan. A member must notify the plan of its desire to withdraw not less than 30 days before the date upon which it desires to withdraw. If the board determines that the withdrawal would cause the plan to be in violation of the minimum number of employers and covered employees requirement of Minnesota Statutes, section 62H.01, or any other requirement of parts 2765.0100 to 2765.1500 the plan shall notify the commissioner as required under subpart 5. Withdrawal from a plan is prohibited and void unless:

A. the member will have belonged to the plan continuously:

(1) until the end of the current fund year; or

(2) until the end of the succeeding fund year for new members that join in the last three months of the fund year; or

(3) for a longer period if required by the bylaws; and

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B. all outstanding premiums and assessments owed by the member have been paid.

Subp. 4. **Expulsion.** At least annually the plan shall review the status and experience of each member by comparison with the criteria for expulsion in the bylaws. Expulsion is subject to the procedures and requirements for voluntary withdrawal of a member, except that:

A. a member may be expelled with outstanding premiums or assessments owing; and

B. a member may be expelled notwithstanding that the minimum term of membership has not been satisfied.

Subp. 5. **Minimum covered employees and employers.** A plan shall monitor the number of employees it covers. If the number of covered employees is less than 300, the plan shall notify the commissioner at monthly intervals of the number of covered employees, until the number exceeds 300 for two consecutive months. If the number of covered employees becomes less than 250, or the number of members becomes less than three, the plan shall notify the commissioner:

A. of its intent to end its self-insurance authority; or

B. of its proposal for restoring compliance with Minnesota Statutes, section 62H.01.

If the proposal is unlikely, in the commissioner's judgment, to restore compliance within 90 days, or if after 90 days the plan continues to have less than 250 covered employees or less than three members, the commissioner shall revoke the plan's self-insurance authority.

Subp. 6. **Runoff plan membership.** After revocation of a plan's self-insurance authority, or after a plan notifies the commissioner in writing of its intent to end self-insurance authority voluntarily, no member may join, leave, or be expelled from the plan.

2765.1000 COVERAGE.

Subpart 1. **Coverage administration and related requirements.** Plans are subject to the requirements of

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Minnesota statutes and rules applicable to insurance companies providing insurance in Minnesota similar to the plan's coverage. These include requirements concerning coverage content, coverage administration, rates, underwriting, and related matters, including but not limited to:

A. the requirements of Minnesota Statutes, section 60A.082, and related rules, as applicable to group medical expense insurance and group disability income insurance;

B. the requirements of Minnesota Statutes, chapter 62A, and related rules, as applicable to group accident and health insurance as defined in Minnesota Statutes, section 62A.10, including but not limited to:

(1) filing and requesting approval for coverage documents and rates;

(2) coverage document language requirements;

(3) mandated benefits;

(4) employee notice requirements;

(5) requirements to offer continuation of coverage to employees and other covered persons; and

(6) requirements to offer conversion coverage through licensed insurers or health maintenance organizations to employees and other covered persons;

C. the requirements of Minnesota Statutes, sections 62A.23 and 62A.24, and related rules, as applicable to group disability income insurance;

D. the requirements of Minnesota Statutes, sections 62A.31 to 62A.42, and related rules, as applicable to insurance covering persons covered by medicare; and

E. the requirements of Minnesota Statutes, chapter 62E, and related rules, as applicable to plans of health coverage as defined in Minnesota Statutes, section 62E.02, subdivision 9.

Subp. 2. **Coverage to individuals.** Joint self-insurance plans shall not offer coverage to individuals other than members' employees and their dependents, except as required following termination of employment under Minnesota Statutes,

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section 62A.17, subdivisions 1 to 5. Plans must comply with the conversion coverage requirements of Minnesota Statutes, sections 62A.17, subdivision 6, and 62E.16, by arrangements with licensed insurers or health maintenance organizations.

Subp. 3. **Health maintenance organization coverage.** A plan may arrange for covered persons to have an option of health maintenance organization coverage, including employees of employers required to provide such an option by Minnesota Statutes, section 62E.17. Such an arrangement must be through a licensed health maintenance organization.

Subp. 4. **Uniform underwriting.** All coverages offered by a plan must be available according to the same underwriting standards to all employees of all members.

Subp. 5. **Term of coverage.** A plan shall not commit itself to providing coverage for any period which extends beyond the term of any stop-loss insurance policies required under part 2765.1300.

Subp. 6. **Continuing responsibility.** Notwithstanding cancellation or termination of coverage to a particular member, ceasing to offer a particular coverage, or ending or revocation of authority to self-insure, a plan retains indefinitely all responsibilities to covered employees and other covered persons associated with the period while coverage was in force. This responsibility ceases only after a plan dissolves under part 2765.0700, subpart 4.

2765.1100 PREMIUMS AND DIVIDENDS.

Subpart 1. **Premium payments.** The fund year must be the basis for calculating members' premiums. A plan may permit installment payments if payment is always due before premium is to be earned. Any delinquencies in payments by employees must be paid on their behalf by the employer, with the employer having the right to seek reimbursement from the employee. A plan shall promptly take appropriate action to collect any members' premiums or assessments that are past due. Collection costs are the obligation of the delinquent member. Payments determined to be uncollectible must be presented to the

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stop-loss insurer for reimbursement, as required by part 2765.1300, subpart 4.

Subp. 2. **Dividends.** A plan may declare and pay a dividend or distribution from its surplus only if:

A. the dividend would not cause the plan's surplus to be negative;

B. the plan does not have a stop-loss aggregate advancement liability; and

C. the dividend is apportioned on the basis of the relative amounts of premium paid by members and covered employees, and provides for proportional payments to members and covered employees.

2765.1200 RESERVES.

Subpart 1. **Loss and premium reserves.** A plan must establish reserves for all incurred losses, both reported and unreported, and for unearned premiums. To the extent that the amount of a loss is uncertain, reserves must be set conservatively. As the degree of uncertainty concerning a loss is changed by new events or information, the amount of the reserve must be changed appropriately. Accounting for reserves must be as required by the financial statement forms and instructions, under part 2765.1500, subpart 1.

Subp. 2. **Full funding reserves.** To comply with the full funding requirement of Minnesota Statutes, section 62H.02, a plan must establish full funding reserves corresponding to its aggregate excess stop-loss insurance for each fund year.

A. The amount of the reserves must be calculated as required by the financial statement forms and instructions, under part 2765.1500, subpart 1. The forms and instructions must provide that the base amount of the full funding reserves is equal to the plan's maximum possible liability under the aggregate excess stop-loss insurance, with credits for:

(1) individual excess stop-loss insurance reimbursements; and

(2) losses paid and reserves expected to be chargeable against the aggregate excess stop-loss insurance

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deductible.

B. Separate full funding reserves must be maintained for each fund year, beginning at the fund year's inception. Plans with paid basis stop-loss insurance must maintain each year's full funding reserve until 90 days after the fund year's end. Plans with incurred basis stop-loss insurance must maintain each year's full funding reserve until one year after the fund year's end.

C. Plans with paid basis stop-loss insurance must also maintain a separate runoff full funding reserve. The runoff reserve's purpose is to fully fund the plan's liability in the event of stop-loss insurance non-renewal. The runoff full funding reserve must be maintained until plan dissolution.

Subp. 3. **Surplus or aggregate advancement.** A plan must protect itself from cash flow difficulties by either of the following two methods.

A. Establishing and maintaining a surplus equal to the greater of:

(1) three times the average paid monthly premium during the most recent fund year;

(2) three times estimated monthly premium, for plans that do not yet have one fund year's experience; or

(3) $100,000.

B. Obtaining language in the plan's aggregate excess stop-loss insurance policy requiring the insurer to advance funds to the plan under the conditions prescribed by this item. Any funds so advanced must be included in the fund-year settle-up calculation under the stop-loss insurance terms, if not previously repaid. No limit may be set on the amount of funds that the plan may require to be advanced. The policy language must include these sentences: "If, in good faith, the plan judges that it is suffering, or will soon suffer cash flow difficulties, to the extent that its ability to meet its obligations promptly and in full is or will be significantly impaired, the plan may borrow from the insurer funds sufficient in the plan's good faith judgment to correct the difficulties.

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Such funds shall be considered an advance against the insurer's potential aggregate excess insurance liability for the current fund year. If, as of the final reporting for that fund year, the insurer's liability is determined to be less than the amount of the aggregate advancement, the difference shall then be considered a debt of the plan to the insurer, and reasonable interest may be charged commencing at that time. Until the final reporting, no interest may be charged. The plan shall, in good faith, repay the advance or debt as rapidly as its financial resources permit, without incurring further cash flow difficulties." The policy must not alter or qualify these terms to harm the plan's rights materially.

2765.1300 STOP-LOSS INSURANCE.

Subpart 1. **Purchase and alteration.** The plan must inform the commissioner at least 90 days prior to expiration of any required stop-loss insurance policy whether it intends to renew the policy, and whether the insurer is willing to renew the policy. Alteration of a required stop-loss insurance policy mid-term with the effect of reducing coverage, and cancellation by the plan mid-term, are prohibited. Required stop-loss insurance policies must be noncancellable for a minimum of two years, for any cause including nonpayment of premium. If more than one stop-loss insurance policy is obtained in fulfillment of this part's requirements, their expiration dates must be the same.

Subp. 2. **Individual excess.** A plan must have and maintain individual excess stop-loss insurance, that provides for the insurer to assume all liability in excess of $25,000 per person per year under all coverages the plan offers. The reporting period under this coverage must be no less than one year after the fund year's conclusion. A plan may apply to the commissioner for increasing the individual excess stop-loss insurance limit, up to $50,000. The commissioner must approve this application if the increased limit would not be detrimental to the solvency and stability of the plan, considering the plan's experience, size, surplus, and other factors affecting

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financial integrity.

Subp. 3. **Aggregate excess.** A plan must have and maintain aggregate excess stop-loss insurance that provides for the insurer to assume all liability in excess of a specified amount of losses for each fund year. The aggregate excess coverage may be in the form of incurred basis stop-loss insurance or paid basis stop-loss insurance. Plans using paid basis stop-loss insurance must have and maintain extended or runoff aggregate excess stop-loss insurance on an incurred basis. The extended or runoff coverage must provide for the insurer to assume all liability in excess of a specified amount of losses incurred while the paid basis stop-loss insurance was in force, but paid after its termination or nonrenewal. The reporting period under paid basis insurance must be no less than three months after the fund year's conclusion. The reporting period under incurred basis insurance, including extended or runoff insurance, must be no less than one year after the fund year's conclusion.

Subp. 4. **Delinquencies and insolvencies.** A plan must have and maintain the following language in its required aggregate excess stop-loss insurance policy: "The insurer shall, at the plan's or the commissioner's request, pay premium to the plan on behalf of a member that fails to pay due to insolvency, unauthorized withdrawal from the plan, or any other reason. The insurer may attempt to collect reimbursement from the member on whose behalf the insurer is called upon to pay premium." The policy must not alter or qualify these terms to harm the plan's rights materially.

Subp. 5. **Surety coverage.** A plan must have and maintain the following language in its required aggregate excess stop-loss insurance policy: "The insurer shall, at the commissioner's request, assume direct responsibility for the plan's coverage and all other responsibilities under parts 2765.0100 to 2765.1500 and related statutes, if the plan becomes insolvent, ceases operations without authorization, or otherwise fails to fulfill its responsibilities under parts 2765.0100 to 2765.1500 and related statutes. The insurer may attempt to

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collect reimbursement from the plan or a member on whose behalf the insurer is called upon to pay premium, pay claims, or incur other extraordinary expenses. However, the insurer must fulfill its responsibilities under this section while any collection attempts are pending. The insurer's responsibilities extend to all matters arising during or attributable to the policy period, and do not terminate with the end of the policy period." The policy must not alter or qualify these terms to harm the plan's rights materially.

Subp. 6. **Return of liability.** No liability or other responsibilities transferred to an insurer under this part may, directly or indirectly, be returned to a plan, a member, or a member's parent, subsidiary, or affiliate. This does not prohibit the insurer from seeking reimbursement from the plan or a member, as permitted under subparts 4 and 5.

2765.1400 FINANCIAL INTEGRITY.

Subpart 1. **Fidelity bond.** All contractors and individuals who handle plan funds or who will have authority to gain access to plan funds, including trustees, must be covered by a fidelity bond. The bond must cover losses from dishonesty, robbery, forgery or alteration, misplacement, and mysterious and unexplainable disappearance. The amount of coverage for each occurrence must be $300,000 or more. The plan must purchase a fidelity bond covering the required contractors and individuals, or submit separate proof of coverage for all required contractors and individuals not covered under the plan's bond.

Subp. 2. **Integrity of assets.** A plan's assets:

A. must not be commingled with the assets of any member;

B. must not be loaned to anyone for any purpose, or used as security for a loan, except as permitted under subpart 5 for investments;

C. must be employed solely for the purposes stated in the bylaws, and in compliance with parts 2765.0100 to 2765.1500 and related statutes; and

D. must not be considered the property or right of

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any member, covered employee, or other covered person, except:

(1) for benefits under the coverage documents;

(2) for dividends declared in accordance with part 2765.1100, subpart 2; and

(3) for a portion of the assets remaining after the plan's dissolution, in accordance with part 2765.0700, subpart 4.

Subp. 3. **Sources and uses of funds.** A plan may expend funds for payment of losses and expenses, and for other costs customarily borne by insurers under conventional insurance policies in Minnesota. Except as provided in part 2765.1200, subpart 3, item B, a plan must not borrow money or issue debt instruments. A plan may bring legal suits to collect delinquent debts. A plan must not obtain funds through subrogation of the rights of covered employees or other covered persons. A plan may receive funds only from:

A. its members as premiums, assessments, or penalties;

B. its insurers or indemnitors pursuant to insurance or indemnification agreements;

C. dividends, interest, or the proceeds of sale of investments;

D. refunds of excess payments;

E. coordination of benefits with automobile coverage, workers' compensation coverage, and other employee health benefit coverage; or

F. collection of money owed to the plan.

Subp. 4. **Separate accounts.** A plan may establish separate accounts for the payment of claims or certain types of expenses. These accounts must be used only by the service company, its authorized subcontractors, or the financial administrator, as appropriate to the account's purpose. The amount in these special accounts must not exceed an amount reasonably sufficient to pay the claims or expenses for which it is established. All monetary and investment assets not in these accounts must be under the control of the financial administrator.

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Subp. 5. **Investments.** A plan's investments are subject to the requirements of Minnesota Statutes, section 475.66, as regards both permitted types of investments, maturities, and depositories. In addition, a plan must not invest in securities or debt of a member, or a member's parent, subsidiary, or affiliate; or any person or entity under contract with the plan.

Subp. 6. **Monitoring financial condition.** The board must regularly monitor the plan's revenues, expenses, and loss development, and evaluate its current and expected financial condition. The board must attempt in good faith to maintain or restore the plan's sound financial condition, using any means at its disposal. These means include but are not limited to adjusting premium rates, underwriting standards, dividend rates, expulsion standards, and other powers granted in parts 2765.0100 to 2765.1500 and the bylaws. If the commissioner judges that the board's actions are inadequate to maintain or restore the plan's sound financial condition, the commissioner shall, as appropriate: order an increase in the premium rates; revoke the plan's self-insurance authority; or order that an assessment be levied against the members.

Members must not require covered employees to pay a portion of an assessment, nor must covered employees be required to pay any amount for premium increases on coverage in force. The amount of assessments must not be more than the amount of members' most recent annual premium, including the portion paid by covered employees.

2765.1500 REPORTING.

Subpart 1. **Financial statements.** A plan must prepare annual financial statements containing a balance sheet; a full funding reserves calculation worksheet; a statement of revenues, expenses, and surplus; a statement of changes in financial position; and a schedule of investments. The statements must be prepared on forms and according to instructions prescribed by the commissioner. The financial statements must be filed with the commissioner no later than 30 days after the fund year's conclusion. The financial statements must be audited by an

independent certified public accountant, and an audit report must be filed with the commissioner no later than 180 days after the fund year's conclusion. A plan's first annual financial statement, and every second annual financial statement thereafter must be accompanied by a statement from a qualified actuary concerning the balance sheet items that are based on actuarial assumptions and methods. The form of the actuary's statement and the scope of the actuarial review must be according to instructions prescribed by the commissioner.

Subp. 2. **Quarterly reports.** A plan must file quarterly reports with the commissioner no later than 30 days after the end of the first, second, and third quarters of each fund year. Quarterly reports must contain statements of the plan's:

A. current total cash on hand and on deposit, and total investments;

B. current total reserve for unearned and advance premiums, total reserve for outstanding losses reported and unreported, total operating full funding reserve, and total runoff full funding reserve;

C. dividends declared during the quarter;

D. gross premiums written during the quarter;

E. losses paid during the quarter;

F. proximity to the aggregate excess stop-loss insurance attachment point for the current fund year and, if applicable, the past fund year;

G. current total members and covered employees; and

H. any other matters the commissioner requests that the board address.

Subp. 3. **Extraordinary audits.** Upon sufficient cause, the commissioner shall require a plan to investigate the accuracy of one or more entries on its financial statements or quarterly reports, and to report its findings. If necessary for the investigation's purposes, the commissioner shall require a plan to contract with a qualified actuary, claims specialist, auditor, or other specialists as appropriate to the type of entry being investigated. If warranted by investigation's

findings, the commissioner shall require changes in the plan's reserving, accounting, or recordkeeping practices. These extraordinary audits are in addition to the commissioner's rights to examine self-insurance plans under Minnesota Statutes, section 60A.03, subdivisions 3, 5, and 6, and section 60A.031. Sufficient cause includes:

A. losses that appear significantly different than losses experienced by other self-insurance plans or insurance companies for similar coverage;

B. unusual changes in the amount of entries from period to period that are not sufficiently explained by the financial statements, quarterly reports, or footnotes; or

C. other indications that a plan's financial statements or quarterly reports may not accurately reflect the plan's status and transactions.

Subp. 4. **Annual status report.** No later than 30 days after the fund year's conclusion, a plan must file with the commissioner a statement describing any changes that have occurred in the information filed with its initial application for authority to self-insure, or with the plan's most recent status report. The status report must be filed in a form and according to instructions prescribed by the commissioner.

Subp. 5. **Penalty.** The financial statements and status report required under subparts 1 and 4 are considered together to be a plan's annual statement. This filing and other filings required by parts 2765.0100 to 2765.1500 and related statutes are subject to Minnesota Statutes, section 72A.061, as applicable to licensed insurance companies for comparable filings.

Subp. 6. **Revenue fee.** No later than 60 days after each fund year's conclusion, a plan must file a report with the commissioner of revenue disclosing the total amount of claims paid during the fund year, with no deduction for claims wholly or partially reimbursed through stop-loss insurance. The report must be filed on a form available from the commissioner of revenue. At the time of filing the report, the plan shall pay

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the fee required by Minnesota Statutes, section 62H.07, to the commissioner of revenue in the amount of two percent of the total amount of claims paid during the fund year, with no deduction for claims wholly or partially reimbursed through stop-loss insurance.

APPROVED BY THE REVISOR OF STATUTES' OFFICE BY:

OFFICE OF THE REVISOR OF STATUTES

Proposed Rule

RD528

Agency: Department of Commerce

Division:

Agency Contact: Dick Gomsrud

Minnesota Rules: Parts 2765.0100 to 2765.1500

Title: Proposed Rules Governing Employee Health and Disability Joint Self-Insurance

Type of Rules: Permanent

Incorporations by Reference: None

Steven C. Cross
Revisor of Statutes

Paul M. Marinac
Assistant Deputy Revisor
Phone: 296-0948
Date: July 30, 1984

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE

In the Matter of the Proposed Adoption of Rules Relating to Employee Health and Disability Self-Insurance Plans

ORDER ADOPTING RULES

Notice of the Commissioner's intent to adopt the above-entitled rules without a public hearing was published in the State Register on August 20, 1984 and was sent by the United States mail to all persons on the list maintained by the Department of Commerce pursuant to Minn. Stat. Section 14.14, subd. 1a, on August 16, 1984.

After affording interested and affected persons an opportunity to submit comments for 30 days after Notice, receiving fewer than twenty-five (25) written requests for a public hearing within the 30-day comment period, reviewing and considering the comments, and determining the need for and reasonableness of the above-captioned rules.

NOW, THEREFORE, IT IS ORDERED that these rules identified as Employee Health and Disability Self-Insurance Plans are adopted this 25th day of September , 1984 pursuant to authority vested in me by Minn. Stat. Section 62A.06 .

MICHAEL A. HATCH
Commissioner of Commerce

2 B replaced by New Order Adopting

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE

In the Matter of the Proposed Adoption of Rules Relating to Employee Health and Disability Joint Self-Insurance Plans

ORDER ADOPTING RULES

Notice of the Commissioner's intent to adopt the above-entitled rules without a public hearing was published in the State Register on August 20, 1984 and was sent by the United States mail to all persons on the list maintained by the Department of Commerce pursuant to Minn. Stat. Section 14.14, subd. 1a, on August 16, 1984.

After affording interested and affected persons an opportunity to submit comments for 30 days after Notice, receiving fewer than twenty-five (25) written requests for a public hearing within the 30-day comment period, reviewing and considering the comments, and determining the need for and reasonableness of the above-captioned rules,

NOW, THEREFORE, IT IS ORDERED that these rules identified as Employee Health and Disability Joint Self-Insurance Plans are adopted this 25th day of August, 1984 pursuant to authority vested in me by Minn. Stat. Section 60H.06.

Michael A. Hatch
Commissioner of Commerce

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

Outside Opinion Sought Regarding Proposed Rules Relating to Joint Self-Insurance Employee Health Plans Including the Impact of the Rules on Small Businesses

Notice is hereby given that the Department of Commerce is seeking information or opinions from persons outside the agency in preparing to promulgate new rules governing joint self-insurance employee health plans. Promulgation of these rules is authorized by Minnesota Statutes, section 60H.06.

Outside opinion is also being solicited as to how these rules will affect small businesses as defined by Minnesota Laws 1983, ch. 188, codified as Minnesota Statutes § 14.115, subd. 1.

The Department of Commerce requests information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit statements of information or comment orally or in writing to: John Klein, Department of Commerce, 500 Metro Square Building, St. Paul, MN 55101, (612) 297-3238.

All statements of information and comment shall be accepted until April 11, 1984. Any written material received by the Department of Commerce shall become part of the record in the event that the rules are promulgated.

Michael A. Hatch
Commissioner of Commerce

Department of Energy and Economic Development Community Development Division

Comments Sought on the Proposed Final Statement for the Small Cities Community Development Block Grant Program

Notice is hereby given that the Minnesota Department of Energy and Economic Development, Community Development Division, is seeking comments or opinions from sources outside the agency in preparing to submit the Final Statement for the Small Cities Community Development Block Grant Program. The Final Statement will be submitted to the U.S. Department of Housing and Urban Development by March 31, 1984.

The Final Statement will consist of the Administrative Rules Governing the Community Development Block Grant Program, which are found at 10 MCAR § 1.500-1.565 and were published as adopted in the *State Register* on November 28, 1983 (8 S.R. 1263-1268); a description of the use of funds in the 1983 grant program; and an assessment of the relationship of the use of funds to the community development objectives in 10 MCAR § 1.500-1.565 and to the requirements of section 104(b)(3) of the U.S. Housing and Community Development Act of 1974, as amended (P.L. 97-35).

The Minnesota Department of Energy and Economic Development, Community Development Division, requests comments or opinions concerning the assessments of the 1983 grant program. Interested or affected persons, groups, or units of general local government may submit statements or comment orally or in writing. Written statements should be addressed to:

Michael J. McMahon, Director
Fiscal Operations, Community Development
Minnesota Department of Energy and Economic Development
940 American Center Building
150 East Kellogg Boulevard
St. Paul, MN 55101

Oral statements will be received during regular business hours over the telephone at (612) 296-2102 and in person at the above address.

All statements and comments shall be accepted until 4:30 p.m., March 26, 1984. Statements and comments will be included as part of the Final Statement submitted to the U.S. Department of Housing and Urban Development.

State of Minnesota
Department of Commerce

Notice of Intent to Solicit Outside Opinion Regarding Proposed Rules Relating to Joint Self-Insurance Employee Health Plans including the Impact of the Rules on Small Businesses

Notice is hereby given that the Department of Commerce is seeking information or opinions from persons outside the agency in preparing to promulgate new rules governing joint self-insurance employee health plans. Promulgation of these rules is authorized by Minnesota Statutes, section 60H.06.

Outside opinion is also being solicited as to how these rules will affect small businesses as defined by Minnesota Laws 1983, ch. 188, codified as Minnesota Statutes § 14.115, subd. 1.

The Department of Commerce requests information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit statements of information or comment orally or in writing to: John Klein, Department of Commerce, 500 Metro Square Building, St. Paul, MN 55101, (612) 297-3238.

All statements of information and comment shall be accepted until April 11, 1984. Any written material received by the Department of Commerce shall become part of the record in the event that the rules are promulgated.

Michael A. Hatch
Commissioner of Commerce

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE

In the Matter of the Proposed Adoption of Rules Relating to Employee Health and Disability Joint Self-Insurance

ORDER FOR NOTICE OF INTENT TO ADOPT RULES WITHOUT PUBLIC HEARING

IT IS ORDERED this 20th day of August, 1984 that Notice of Intent to Adopt Rules Without Public Hearing in the above-entitled matter be given to all persons who have registered their names with the Department of Commerce for that purpose and be published in the State Register.

Michael A. Hatch
Commissioner of Commerce

In the Matter of the Proposed Adoption of
Rules Relating to

AFFIDAVIT OF
MAILING

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Robin Hanson, being first duly sworn, deposes and says:

That on the 16th day of August, 1984, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of [Hearing/Intent to Adopt Rules Without Public Hearing] by depositing in the State of Minnesota Central Mail System for United States mailing at said City of St. Paul, a copy properly enveloped, with postage prepaid, on all persons and associations who have requested that their names be placed on file with the Department of Commerce for the purpose of receiving notice of the proposed adoption of rules.

A copy of the proposed rules is attached.

Subscribed and sworn to before me this
16th day of August, 1984.

Nancy J. Link

NANCY J. LINK
NOTARY PUBLIC - MINNESOTA
HENNEPIN COUNTY
The Commission Expires Nov. 22, 1984

State of Minnesota
Department of Commerce

In the Matter of the Proposed Adoption of
Rules Relating to Employee Health and Disability
Joint Self-Insurance Plans

Notice of Intent to Adopt Rules Without a Public Hearing

Notice is hereby given that the Department of Commerce proposes to adopt the above-entitled rules without a public hearing. The Commissioner of Commerce has determined that the proposed adoption of these rules will be noncontroversial in nature and has elected to follow the procedures set forth in Minnesota Statutes, section 14.21.

Persons interested in these rules shall have 30 days to submit comments in support of or in opposition to the rules. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed. The proposed rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change.

No public hearing will be held unless twenty-five (25) or more persons make a written request for a hearing within the 30-day comment period. In the event a public hearing is required, the agency will proceed according to the provisions of Minnesota Statutes, section 14.14, subd. 1.

Persons who wish to submit comments or a written request for a public hearing should submit them to John Klein, Department of Commerce, 500 Metro Square Building, St. Paul, MN 55101. Any person requesting a public hearing should state her/his name and address, identify the portion of the proposed rule addressed, the reason for the request and any change proposed and send this information to the above address.

Authority for the adoption of these rules is contained in Minnesota Statutes, section 60H.06. Additionally, a Statement of Need and Reasonableness describing the need for and reasonableness of each provision and identifying the data and information relied upon to support the proposed rules has been prepared and is available upon request.

Upon adoption of the final rules without a public hearing, the proposed rules, this Notice, the Statement of Need and Reasonableness, all written comments received, and the final Rules as Adopted will be delivered to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the final rules as proposed for adoption, should submit a written statement of such request to Robin Hanson, Department of Commerce, 500 Metro Square Bldg., St. Paul, MN 55101.

A copy of the proposed rules is attached to this Notice.

Copies of this Notice and the proposed rules are available and may be obtained by contacting Robin Hanson at the above address.

Michael A. Hatch
Commissioner of Commerce

STATE OF MINNESOTA

COUNTY OF RAMSEY

CERTIFICATE

In the Matter of the Proposed Adoption of
Rules Relating to Employee Health and Disability
Joint Self-Insurance Plans

I hereby certify that the list of persons, associations, and other interested groups who have requested, pursuant to Minnesota Statutes, section 14.14, subd. 1a, that their names be placed on file with and maintained by the Department of Commerce for the purpose of receiving notice of the proposed adoption of rules is accurate and complete as of 12:00 P.M., this 16th day of August, 1984.

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identifies the data and information relied upon to support the proposed amendments has been prepared and is available upon request from Mr. Heil.

Upon adoption of the final amended rules without a public hearing, the proposed rules, this notice, the Statement of Need and Reasonableness, all written comments received, and the final rules as adopted will be delivered to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the final rules as adopted, should submit a written statement of such request to Mr. Heil.

The Commissioner is authorized by Minnesota Statutes, Section 18A.43, Subd. 1 to promulgate rules for proper enforcement of Minnesota Statutes, Sections 18A.21 to 18A.45. This includes regulating the use of pesticides and the designation of restricted use pesticides.

The proposed amendments to the pesticide rules would bring Minnesota's restrictions for Lindane use into conformity with federal regulations. The proposed change would allow Lindane to be sold for uses allowed by federal labeling requirements without requiring retailers to purchase a restricted use pesticide dealers license.

The proposed amendments will impact and benefit small business as defined in Minnesota Statutes, Section 14.115, because repealing Minnesota's restrictions on Lindane will allow retailers to sell the product in accordance with federal regulations and lessen state licensing and record keeping burdens.

Please be advised that Minnesota Statutes, Chapter 10A requires each lobbyist to register with the State Ethical Practices Board within five (5) days after he or she commences lobbying. A lobbyist is defined in Minnesota Statutes, Section 10A.01, subdivision 11 (Supp. 1979) 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 $250.00, 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 $250.00, 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, 40 State Office Building, St. Paul, MN 55155, (612) 296-5615.

One free copy of this notice and the proposed rules are available and may be obtained by contacting Mr. Heil.

August 6, 1984

Jim Nichols,
Commissioner of Agriculture

Rules as Proposed

1505.1070 RESTRICTED USE PESTICIDES.

Restricted use pesticides shall be those so classified by the administrator of the EPA. Additionally, all pesticides uses classified as restricted use by any other federal or state agency statutorily authorized to do said classification, as well as the pesticides listed in ~~parts~~ part 1505.1080 ~~and 1505.1090~~, shall, for the purposes of the administration of parts 1505.0830 to 1505.1290, be classified as restricted use pesticides.

REPEALER. Minnesota Rules, part 1505.1090 is repealed.

Department of Commerce

Proposed Rules Governing Employee Health and Disability Joint Self-Insurance

Notice of Intent to Adopt Rules without a Public Hearing

Notice is hereby given that the Department of Commerce proposes to adopt the above-entitled rules without a public hearing. The Commissioner of Commerce has determined that the proposed adoption of these rules will be noncontroversial in nature and has elected to follow the procedures set forth in Minnesota Statutes, section 14.21.

Persons interested in these rules shall have 30 days to submit comments in support of or in opposition to the rules. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

The proposed rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change.

No public hearing will be held unless twenty-five (25) or more persons make a written request for a hearing within the 30-day comment period. In the event a public hearing is required, the agency will proceed according to the provisions of Minnesota Statutes, section 14.14, subd. 1.

Persons who wish to submit comments or a written request for a public hearing should submit them to John Klein, Department of Commerce, 500 Metro Square Building, St. Paul, MN 55101. Any person requesting a public hearing should state her/his name and address, identify the portion of the proposed rule addressed, the reason for the request and any change proposed and send this information to the above address.

Authority for the adoption of these rules is contained in Minnesota Statutes, section 60H.06. Additionally, a Statement of Need and Reasonableness describing the need for and reasonableness of each provision and identifying the data and information relied upon to support the proposed rules has been prepared and is available upon request.

Upon adoption of the final rules without a public hearing, the proposed rules, this notice, the Statement of Need and Reasonableness, all written comments received, and the final rules as adopted will be delivered to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the final rules as proposed for adoption, should submit a written statement of such request to Robin Hanson, Department of Commerce, 500 Metro Square Bldg., St. Paul, MN 55101.

A copy of the proposed rules is attached to this notice.

Copies of this notice and the proposed rules are available and may be obtained by contacting Robin Hanson at the above address.

Michael A. Hatch
Commissioner of Commerce

Rules as Proposed (all new material)

CHAPTER 2765
DEPARTMENT OF COMMERCE
EMPLOYEE HEALTH AND DISABILITY JOINT SELF-INSURANCE PLANS

2765.0100 DEFINITIONS.

Subpart 1. Scope. For the purposes of parts 2765.0100 to 2765.1500, the terms defined in this part have the meanings given them.

Subp. 2. Board. "Board" means a plan's board of trustees.

Subp. 3. Bylaws. "Bylaws" means the statements adopted by a plan that prescribe its purpose, government, and administration.

Subp. 4. Commissioner. "Commissioner" means the commissioner of the Department of Commerce.

Subp. 5. Coverage. "Coverage" means the right of a covered person to benefits provided directly or indirectly by a plan, by virtue of the coverage document.

Subp. 6. Coverage document. "Coverage document" means the document specifying the characteristics and duration of coverage provided through a plan.

Subp. 7. Covered employee. "Covered employee" means a plan member's employee who is covered through the plan, and a plan member's former employee receiving continued coverage under Minnesota Statutes, section 62A.17, subdivisions 1 to 5. "Covered employee" does not include dependents or other persons included under the coverage extended to a plan member's current or former employee.

Subp. 8. Days. "Days" means calendar days.

Subp. 9. Financial administrator. "Financial administrator" means an entity employing persons trained and experienced in money management and investments, and possessing no less than five years experience as an organization with demonstrated competence in money management and investments.

KEY: 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." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Subp. 10. Fund year. "Fund year" means a plan's fiscal year, and must be the calendar year.

Subp. 11. Incurred basis stop-loss insurance. "Incurred basis stop-loss insurance" means the aggregate excess stop-loss insurance required by part 2765.1300, if on an incurred basis. The insurance is on an incurred basis if payments are charged against a fund year's deductible according to when liability for the payment was incurred.

Subp. 12. Insurer. "Insurer" means an insurance company licensed under Minnesota Statutes, section 60A.07, subdivision 4, and authorized by Minnesota Statutes, section 60A.06 to write sickness and disability insurance, or a service plan corporation licensed under Minnesota Statutes, section 62C.08.

Subp. 13. Member. "Member" means an employer that belongs to or participates in a plan. Reference to actions of a member includes actions on behalf of the member's covered employees and other covered persons.

Subp. 14. Paid basis stop-loss insurance. "Paid basis stop-loss insurance" means the aggregate excess stop-loss insurance required by part 2765.1300, if on a paid basis. The insurance is on a paid basis if payments are charged against a fund year's deductible according to when the payment was made.

Subp. 15. Plan. "Plan" means a joint self-insurance employee benefit plan approved under parts 2765.0100 to 2765.0250. Reference to actions of a plan includes actions by the plan's designated agents.

Subp. 16. Premium. "Premium" means the amount paid or to be paid for coverage by members. Premium does not include assessments or penalties.

Subp. 17. Runoff plan. "Runoff plan" means a plan that no longer has authority to self-insure, but that continues to exist for the purpose of paying claims, preparing reports, and administering transactions associated with the period when the plan provided coverage.

Subp. 18. Self-insure. "Self-insure" means to assume primary liability or responsibility for certain risks or benefits, rather than transferring liability or responsibility to some other entity.

Subp. 19. Separate employer. "Separate employer," for the purposes of meeting the minimum three-employer requirement, means an employer that is not the parent, subsidiary, or affiliate with a common parent of any other employer in the plan.

Subp. 20. Service company. "Service company" means an entity licensed under Minnesota Statutes, section 60A.23, subdivision 8 and rules adopted thereunder as a self-insurance plan administrator, or an entity named in Minnesota Statutes, section 60A.23, subdivision 8, paragraph (1), clause (a) or (b).

Subp. 21. Short-term disability benefit. "Short-term disability benefit" means income replacement payments of not more than one year's duration.

2765.0200 PURPOSE.

Parts 2765.0100 to 2765.1500 govern the formation, operation, and dissolution of multiple employer plans for joint self-insurance of employee health, dental, or short-term disability benefits. They are intended to ensure that the financial integrity of these plans is maintained, and that they are administered competently and equitably.

2765.0300 SCOPE.

The following are subject to the requirements of parts 2765.0100 to 2765.1500:

A. employers authorized to transact business in Minnesota that seek to jointly self-insure employee health, dental, or short-term disability benefits;

B. service companies that provide services to a plan; and

C. insurance companies licensed under Minnesota Statutes, section 60A.07, subdivision 4, or service plan corporations licensed under Minnesota Statutes, section 62C.08, that provide required stop-loss insurance to a plan.

2765.0400 BYLAWS.

Subpart 1. Content. Bylaws may contain any provisions that do not conflict with parts 2765.0100 to 2765.1500. Bylaws must, at a minimum, contain the following provisions:

A. the plan's name, purpose, and initial date of existence;

B. definitions of key terms;

C. a statement of the powers, duties, and responsibilities assigned to the board, the service company, and the financial administrator, and reserved to the membership;

D. the number, term of office, method of selection, and method of replacement of the members of the board;

E. the procedure for calling board meetings;

F. the method of periodic selection and review of the service company and financial administrator;

G. the procedure for amending the bylaws;

H. the procedure for resolving disputes among members, which must not include submitting disputes to th commissioner;

I. the criteria for membership in the plan, including standards of financial integrity and loss experience;

J. the procedure for admitting new members to the plan;

K. the criteria for expelling members from the plan, including nonpayment of premium;

L. the procedure for withdrawal and expulsion of members from the plan, including the minimum required period membership;

M. a statement of the coverages the plan intends to provide;

N. the procedure for adding and dropping a member's participation in a particular coverage;

O. a schedule for premium payments by members and, if applicable, their employees;

P. the procedure for changing premium rates;

Q. the procedure for levying and collecting an assessment;

R. a statement of who may have access to plan funds and for what purposes;

S. the procedure for distributing dividends, and the eligibility of past members and past covered employees f dividends; and

T. the procedure for distributing assets remaining upon the plan's dissolution.

Subp. 2. Adoption and changes. The bylaws must be adopted in writing by all initial members. Authority to change th bylaws must reside with the membership or the board, according to the terms of the bylaws. Authority to change the bylav may not be delegated to a contractor or other outside party. The plan must file bylaw changes with the commissioner not le than 30 days after adoption.

2765.0500 BOARD.

Subpart 1. Structure. A plan must have a board of trustees consisting of officials or employees of the members. No memb may have more than one representative on the board. No trustee may be an employee, agent, or representative of the plan service company, financial administrator, insurer, or other person or entity under contract with the plan. Trustees shall l elected by vote of the membership. There shall be an odd number of trustees, with staggered terms to provide continuity. O trustee shall be designated the chairperson. The board shall meet no less than four times annually.

Subp. 2. Duties. The board is responsible for operation of the plan. The board may delegate some or all of its responsibiliti to the chairperson or other trustees between board meetings. All responsibilities of the plan not expressly delegated by th board or parts 2765.0100 to 2765.1500 are the responsibility of the board. The board shall, at a minimum, have the followi responsibilities:

A. fiduciary responsibility for the plan's operation and financial condition;

B. selection, supervision, and evaluation of the service company, financial administrator, accountant, insurer, and a other contractors;

C. on the basis of the plan's overall financial condition, authorizing changes in premium, reserve, or investme practices; and declaring assessments or dividends as appropriate;

D. approving all reports concerning the plan's operations and status to the commissioner and the members;

E. monitoring delinquent premiums, loss experience, and the financial condition of individual members; and authorizi disciplinary action or expulsion as appropriate;

F. authorizing acceptance or rejection of applications for membership;

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G. as permitted by the bylaws, making or recommending changes to the bylaws for the improvement of the plan's operation and financial integrity; and

H. monitoring the plan's compliance with all statutes and rules governing its operation.

2765.0600 APPLICATION.

Subpart 1. Initial application. Three or more separate employers may apply to the commissioner for authority to form a joint self-insurance plan, using forms available from the commissioner. Applications must be submitted not later than 60 days prior to the requested date for authority to self-insure. All reinsurance contracts must be submitted not later than 30 days prior to the requested date. Applications submitted without responses to certain questions, or with responses that are inadequate must be returned to the applicant for resubmission. Applications not returned to the applicant for resubmission within 14 days of receipt must be approved or disapproved within 60 days of receipt.

Subp. 2. Renewal application. Existing plans may apply for renewal of their self-insurance authority by so indicating on their annual status report preceding expiration of their current authority. Applications must be approved or disapproved within 60 days of receipt of the status report.

Subp. 3. Exemptions. Joint self-insurance plans that offer a program of coverage qualified under the Employees Retirements Income Security Act (ERISA), United States Code, title 29, sections 1001 et seq., are exempted from parts 2765.0100 to 2765.1500 upon filing with the commissioner notice of this qualification from the United States Department of Labor.

Subp. 4. Merger. Two or more existing plans may apply to merge if the new plan assumes all obligations of the former plans. Merger applications are subject to the same requirements as prospective new plans.

Subp. 5. Approval and disapproval. Upon approval of an application, the commissioner shall issue an order authorizing the proposed joint self-insurance plan. Initial authorization orders for new plans are effective until the third May 1st after the initial authorization date. Renewal authorization orders are for two-year periods commencing May 1st. Approval of applications for authority to self-insure must be granted if the proposed plan conforms with:

A. all requirements of parts 2765.0100 to 2765.1500;

B. all applicable requirements of Minnesota Statutes, chapters 62A and 62E, and related rules, as described in part 2765.1000, subpart 1;

C. Minnesota Statutes, sections 72A.19 to 72A.32; and

D. other applicable Minnesota statutes and rules.

2765.0700 ENDING SELF-INSURANCE, RUNOFF PERIOD, AND PLAN DISSOLUTION.

Subpart. 1. Ending self-insurance authority. A plan may decide to end its self-insurance authority and cease to provide coverage, effective at the end of a fund year. The plan must notify the commissioner within 14 days of such a decision. A plan may not elect to end its self-insurance authority less than 45 days prior to the end of the fund year in question. Voluntary ending of self-insurance authority does not constitute plan dissolution under subpart 4.

Subp. 2. Revocation of self-insurance authority. The commissioner shall, by order, revoke the authority of a plan to self-insure upon ten-days written notice if any of the following events occur or conditions develop, and if the commissioner judges them to be material:

A. failure of the plan to comply with parts 2765.0100 to 2765.1500; with all applicable requirements of Minnesota Statutes, chapters 62A, 62D, 62E, and related rules, as described in part 2765.1000, subpart 1; or with other applicable Minnesota statutes or rules;

B. failure of the plan to comply with any lawful order of the commissioner;

C. commission by the plan of an unfair or deceptive practice as defined in Minnesota Statutes, sections 72A.17 to 72A.32, or in related rules; or

D. a deterioration of the plan's financial integrity to the extent that its present or future ability to meet obligations promptly and in full is or will be significantly impaired.

Subp. 3. Runoff period. A plan shall continue to exist as a runoff plan after its authority to self-insure has ended for the purpose of paying claims, preparing reports, and administering transactions associated with the period when the plan provided coverage. A runoff plan must continue to comply with all appropriate provisions of parts 2765.0100 to 2765.1500, and with all other applicable Minnesota statutes and rules. Authority to exist as a runoff plan is open-ended, and does not require renewal of authority under part 2765.0600, subpart 2.

Subp. 4. Dissolution. A plan, including a runoff plan, that desires to cease existence shall apply to the commissioner for authorization to dissolve. Applications must be approved or disapproved within 60 days of receipt. Dissolution without

authorization is prohibited and void, and does not absolve a plan or runoff plan from fulfilling its continuing obligations, and does not absolve its members from assessment under part 2765.1400, subpart 6. The plan's assets at the time of dissolution must be distributed to the members and covered employees as provided in the bylaws. Authorization to dissolve must be granted if either of the following conditions are met:

A. the plan demonstrates that it has no outstanding liabilities, including incurred but not reported liabilities; or

B. the plan has obtained an irrevocable commitment from a licensed insurer that provides for payment of all outstanding liabilities, and for providing all related services, including payment of claims, preparation of reports, and administration of transactions associated with the period when the plan provided coverage.

2765.0800 ADMINISTRATION.

Subpart 1. Service company. A plan must contract with a service company for services necessary to the plan's day-to-day operations, except services and responsibilities reserved to the members, the board, individual trustees, the financial administrator, or other contractors. The service company must have expertise in and be licensed for administering health benefits. Subject to the oversight of the board, the service company shall, directly or through subcontractors, provide all services directly related to the administration of coverage. These services include but are not limited to:

A. accounting and recordkeeping;

B. billing and collection of premiums and assessments;

C. claims investigation, settlement, and reserving;

D. claims payment, including claims wholly or partially subject to stop-loss insurance or member deductibles;

E. general administration;

F. loss control, safety programs, or both; and

G. underwriting.

Subp. 2. Financial administrator. A plan must contract with a financial administrator for investment of the plan's assets and other financial or accounting services. No staff members of the financial administrator may be an owner, officer, employee, or agent of the service company, or of a subcontractor of the service company.

Subp. 3. Recordkeeping. A plan must maintain within the state of Minnesota all records necessary to verify the accuracy and completeness of all reports submitted to the commissioner under part 2765.1500. The commissioner may examine the plan's records in order to ascertain the plan's compliance with parts 2765.0100 to 2765.1500, and with other applicable statutes and rules. All records concerning claims, reserves, financial transactions, and other matters necessary to the plan's operations are the plan's property.

2765.0900 MEMBERSHIP.

Subpart 1. Availability. Plan membership is available only to employers domiciled and authorized to transact business in Minnesota. A plan may establish other nondiscriminatory criteria for membership. Nothing in these rules requires a plan to offer membership to an employer that does not meet the plan's underwriting standards.

Subp. 2. Joining. New members must be admitted according to the standards and procedures specified in the bylaws. Membership is not effective before the applicant has signed a membership agreement affirming its commitment to comply with the bylaws and parts 2765.0100 to 2765.1500. The membership agreement must disclose that under the rules governing this plan, the Minnesota commissioner of commerce may order that an assessment be levied against member employers, if necessary to maintain the plan's sound fiinancial condition.

Subp. 3. Leaving. The membership agreement must state the procedures for leaving the plan. A member must notify the plan of its desire to withdraw not less than 30 days before the date upon which it desires to withdraw. If the board determines that the withdrawal would cause the plan to be in violation of the minimum number of employers and covered employees requirement of Minnesota Statutes, section 62H.01, or any other requirement of parts 2765.0100 to 2765.1500 the plan shall notify the commissioner as required under subpart 5. Withdrawal from a plan is prohibited and void unless:

A. the member will have belonged to the plan continuously:

(1) until the end of the current fund year; or

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(2) until the end of the succeeding fund year for new members that join in the last three months of the fund year; or

(3) for a longer period if required by the bylaws; and

B. all outstanding premiums and assessments owed by the member have been paid.

Subp. 4. Expulsion. At least annually the plan shall review the status and experience of each member by comparison with the criteria for expulsion in the bylaws. Expulsion is subject to the procedures and requirements for voluntary withdrawal of a member, except that:

A. a member may be expelled with outstanding premiums or assessments owing; and

B. a member may be expelled notwithstanding that the minimum term of membership has not been satisfied.

Subp. 5. Minimum covered employees and employers. A plan shall monitor the number of employees it covers. If the number of covered employees is less than 300, the plan shall notify the commissioner at monthly intervals of the number of covered employees, until the number exceeds 300 for two consecutive months. If the number of covered employees becomes less than 250, or the number of members becomes less than three, the plan shall notify the commissioner:

A. of its intent to end its self-insurance authority; or

B. of its proposal for restoring compliance with Minnesota Statutes, section 62H.01.

If the proposal is unlikely, in the commissioner's judgment, to restore compliance within 90 days, or if after 90 days the plan continues to have less than 250 covered employees or less than three members, the commissioner shall revoke the plan's self-insurance authority.

Subp. 6. Runoff plan membership. After revocation of a plan's self-insurance authority, or after a plan notifies the commissioner in writing of its intent to end self-insurance authority voluntarily, no member may join, leave, or be expelled from the plan.

2765.1000 COVERAGE.

Subpart 1. Coverage administration and related requirements. Plans are subject to the requirements of Minnesota statutes and rules applicable to insurance companies providing insurance in Minnesota similar to the plan's coverage. These include requirements concerning coverage content, coverage administration, rates, underwriting, and related matters, including but not limited to:

A. the requirements of Minnesota Statutes, section 60A.082, and related rules, as applicable to group medical expense insurance and group disability income insurance;

B. the requirements of Minnesota Statutes, chapter 62A, and related rules, as applicable to group accident and health insurance as defined in Minnesota Statutes, section 62A.10, including but not limited to:

(1) filing and requesting approval for coverage documents and rates;

(2) coverage document language requirements;

(3) mandated benefits;

(4) employee notice requirements;

(5) requirements to offer continuation of coverage to employees and other covered persons; and

(6) requirements to offer conversion coverage through licensed insurers or health maintenance organizations to employees and other covered persons;

C. the requirements of Minnesota Statutes, sections 62A.23 and 62A.24, and related rules, as applicable to group disability income insurance;

D. the requirements of Minnesota Statutes, sections 62A.31 to 62A.42, and related rules, as applicable to insurance covering persons covered by medicare; and

E. the requirements of Minnesota Statutes, chapter 62E, and related rules, as applicable to plans of health coverage as defined in Minnesota Statutes, section 62E.02, subdivision 9.

Subp. 2. Coverage to individuals. Joint self-insurance plans shall not offer coverage to individuals other than members' employees and their dependents, except as required following termination of employment under Minnesota Statues, section 62A.17, subdivisions 1 to 5. Plans must comply with the conversion coverage requirements of Minnesota Statutes, sections 62A.17, subdivision 6, and 62E.16, by arrangements with licensed insurers or health maintenance organizations.

Subp. 3. Health maintenance organization coverage. A plan may arrange for covered persons to have an option of health

maintenance organization coverage, including employees of employers required to provide such an option by Minnesota Statutes, section 62E.17. Such an arrangement must be through a licensed health maintenance organization.

Subp. 4. Uniform underwriting. All coverages offered by a plan must be available according to the same underwriting standards to all employees of all members.

Subp. 5. Term of coverage. A plan shall not commit itself to providing coverage for any period which extends beyond the term of any stop-loss insurance policies required under part 2765.1300.

Subp. 6. Continuing responsibility. Notwithstanding cancellation or termination of coverage to a particular member, ceasing to offer a particular coverage, or ending or revocation of authority to self-insure, a plan retains indefinitely all responsibilities to covered employees and other covered persons associated with the period while coverage was in force. This responsibility ceases only after a plan dissolves under part 2765.0700, subpart 4.

2765.1100 PREMIUMS AND DIVIDENDS.

Subpart 1. Premium payments. The fund year must be the basis for calculating members' premiums. A plan may permit installment payments if payment is always due before premium is to be earned. Any delinquencies in payments by employees must be paid on their behalf by the employer, with the employer having the right to seek reimbursement from the employee. A plan shall promptly take appropriate action to collect any members' premiums or assessments that are past due. Collection costs are the obligation of the delinquent member. Payments determined to be uncollectible must be presented to the stop-loss insurer for reimbursement, as required by part 2765.1300, subpart 4.

Subp. 2. Dividends. A plan may declare and pay a dividend or distribution from its surplus only if:

A. the dividend would not cause the plan's surplus to be negative;

B. the plan does not have a stop-loss aggregate advancement liability; and

C. the dividend is apportioned on the basis of the relative amounts of premium paid by members and covered employees, and provides for proportional payments to members and covered employees.

2765.1200 RESERVES.

Subpart 1. Loss and premium reserves. A plan must establish reserves for all incurred losses, both reported and unreported, and for unearned premiums. To the extent that the amount of a loss is uncertain, reserves must be set conservatively. As the degree of uncertainty concerning a loss is changed by new events or information, the amount of the reserve must be changed appropriately. Accounting for reserves must be as required by the financial statement forms and instructions, under part 2765.1500, subpart 1.

Subp. 2. Full funding reserves. To comply with the full funding requirement of Minnesota Statutes, section 62H.02, a plan must establish full funding reserves corresponding to its aggregate excess stop-loss insurance for each fund year.

A. The amount of the reserves must be calculated as required by the financial statement forms and instructions, under part 2765.1500, subpart 1. The forms and instructions must provide that the base amount of the full funding reserves is equal to the plan's maximum possible liability under the aggregate excess stop-loss insurance, with credits for:

(1) individual excess stop-loss insurance reimbursements; and

(2) losses paid and reserves expected to be chargeable against the aggregate excess stop-loss insurance deductible.

B. Separate full funding reserves must be maintained for each fund year, beginning at the fund year's inception. Plans with paid basis stop-loss insurance must maintain each year's full funding reserve until 90 days after the fund year's end. Plans with incurred basis stop-loss insurance must maintain each year's full funding reserve until one year after the fund year's end.

C. Plans with paid basis stop-loss insurance must also maintain a separate runoff full funding reserve. The runoff reserve's purpose is to fully fund the plan's liability in the event of stop-loss insurance non-renewal. The runoff full funding reserve must be maintained until plan dissolution.

Subp. 3. Surplus or aggregate advancement. A plan must protect itself from cash flow difficulties by either of the following two methods.

A. Establishing and maintaining a surplus equal to the greater of:

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(1) three times the average paid monthly premium during the most recent fund year;

(2) three times estimated monthly premium, for plans that do not yet have one fund year's experience; or

(3) $100,000.

B. Obtaining language in the plan's aggregate excess stop-loss insurance policy requiring the insurer to advance funds to the plan under the conditions prescribed by this item. Any funds so advanced must be included in the fund-year settle-up calculation under the stop-loss insurance terms, if not previously repaid. No limit may be set on the amount of funds that the plan may require to be advanced. The policy language must include these sentences: "If, in good faith, the plan judges that it is suffering, or will soon suffer cash flow difficulties, to the extent that its ability to meet its obligations promptly and in full is or will be significantly impaired, the plan may borrow from the insurer funds sufficient in the plan's good faith judgment to correct the difficulties. Such funds shall be considered an advance against the insurer's potential aggregate excess insurance liability for the current fund year. If, as of the final reporting for that fund year, the insurer's liability is determined to be less than the amount of the aggregate advancement, the difference shall then be considered a debt of the plan to the insurer, and reasonable interest may be charged commencing at that time. Until the final reporting, no interest may be charged. The plan shall, in good faith, repay the advance or debt as rapidly as its financial resources permit, without incurring further cash flow difficulties." The policy must not alter or qualify these terms to harm the plan's rights materially.

2765.1300 STOP-LOSS INSURANCE.

Subpart 1. Purchase and alteration. The plan must inform the commissioner at least 90 days prior to expiration of any required stop-loss insurance policy whether it intends to renew the policy, and whether the insurer is willing to renew the policy. Alteration of a required stop-loss insurance policy mid-term with the effect of reducing coverage, and cancellation by the plan mid-term, are prohibited. Required stop-loss insurance policies must be noncancellable for a minimum of two years, for any cause including nonpayment of premium. If more than one stop-loss insurance policy is obtained in fulfillment of this part's requirements, their expiration dates must be the same.

Subp. 2. Individual excess. A plan must have and maintain individual excess stop-loss insurance, that provides for the insurer to assume all liability in excess of $25,000 per person per year under all coverages the plan offers. The reporting period under this coverage must be no less than one year after the fund year's conclusion. A plan may apply to the commissioner for increasing the individual excess stop-loss insurance limit, up to $50,000. The commissioner must approve this application if the increased limit would not be detrimental to the solvency and stability of the plan, considering the plan's experience, size, surplus, and other factors affecting financial integrity.

Subp. 3. Aggregate excess. A plan must have and maintain aggregate excess stop-loss insurance that provides for the insurer to assume all liability in excess of a specified amount of losses for each fund year. The aggregate excess coverage may be in the form of incurred basis stop-loss insurance or paid basis stop-loss insurance. Plans using paid basis stop-loss insurance must have and maintain extended or runoff aggregate excess stop-loss insurance on an incurred basis. The extended or runoff coverage must provide for the insurer to assume all liability in excess of a specified amount of losses incurred while the paid basis stop-loss insurance was in force, but paid after its termination or nonrenewal. The reporting period under paid basis insurance must be no less than three months after the fund year's conclusion. The reporting period under incurred basis insurance, including extended or runoff insurance, must be no less than one year after the fund year's conclusion.

Subp. 4. Delinquencies and insolvencies. A plan must have and maintain the following language in its required aggregate excess stop-loss insurance policy: "The insurer shall, at the plan's or the commissioner's request, pay premium to the plan on behalf of a member that fails to pay due to insolvency, unauthorized withdrawal from the plan, or any other reason. The insurer may attempt to collect reimbursement from the member on whose behalf the insurer is called upon to pay premium." The policy must not alter or qualify these terms to harm the plan's rights materially.

Subp. 5. Surety coverage. A plan must have and maintain the following language in its required aggregate excess stop-loss insurance policy: "The insurer shall, at the commissioner's request, assume direct responsibility for the plan's coverage and all other responsibilities under parts 2765.0100 to 2765.1500 and related statutes, if the plan becomes insolvent, ceases operations without authorization, or otherwise fails to fulfill its responsibilities under parts 2765.0100 to 2765.1500 and related statutes. The insurer may attempt to collect reimbursement from the plan or a member on whose behalf the insurer is called upon to pay premium, pay claims, or incur other extraordinary expenses. However, the insurer must fulfill its responsibilities under this section while any collection attempts are pending. The insurer's responsibilities extend to all matters arising during or attributable to the policy period, and do not terminate with the end of the policy period." The policy must not alter or qualify these terms to harm the plan's rights materially.

Subp. 6. Return of liability. No liability or other responsibilities transferred to an insurer under this part may, directly or indirectly, be returned to a plan, a member, or a member's parent, subsidiary, or affiliate. This does not prohibit the insurer from seeking reimbursement from the plan or a member, as permitted under subparts 4 and 5.

2765.1400 FINANCIAL INTEGRITY.

Subpart 1. Fidelity bond. All contractors and individuals who handle plan funds or who will have authority to gain access to plan funds, including trustees, must be covered by a fidelity bond. The bond must cover losses from dishonesty, robbery, forgery or alteration, misplacement, and mysterious and unexplainable disappearance. The amount of coverage for each occurrence must be $300,000 or more. The plan must purchase a fidelity bond covering the required contractors and individuals, or submit separate proof of coverage for all required contractors and individuals not covered under the plan's bond.

Subp. 2. Integrity of assets. A plan's assets:

A. must not be commingled with the assets of any member;

B. must not be loaned to anyone for any purpose, or used as security for a loan, except as permitted under subpart 5 for investments;

C. must be employed solely for the purposes stated in the bylaws, and in compliance with parts 2765.0100 to 2765.1500 and related statutes; and

D. must not be considered the property or right of any member, covered employee, or other covered person, except:

(1) for benefits under the coverage documents;

(2) for dividends declared in accordance with part 2765.1100, subpart 2; and

(3) for a portion of the assets remaining after the plan's dissolution, in accordance with part 2765.0700, subpart 4.

Subp. 3. Sources and uses of funds. A plan may expend funds for payment of losses and expenses, and for other costs customarily borne by insurers under conventional insurance policies in Minnesota. Except as provided in part 2765.1200, subpart 3, item B, a plan must not borrow money or issue debt instruments. A plan may bring legal suits to collect delinquent debts. A plan must not obtain funds through subrogation of the rights of covered employees or other covered persons. A plan may receive funds only from:

A. its members as premiums, assessments, or penalties;

B. its insurers or indemnitors pursuant to insurance or indemnification agreements;

C. dividends, interest, or the proceeds of sale of investments;

D. refunds of excess payments;

E. coordination of benefits with automobile coverage, workers' compensation coverage, and other employee health benefit coverage; or

F. collection of money owed to the plan.

Subp. 4. Separate accounts. A plan may establish separate accounts for the payment of claims or certain types of expenses. These accounts must be used only by the service company, its authorized subcontractors, or the financial administrator, as appropriate to the account's purpose. The amount in these special accounts must not exceed an amount reasonably sufficient to pay the claims or expenses for which it is established. All monetary and investment assets not in these accounts must be under the control of the financial administrator.

Subp. 5. Investments. A plan's investments are subject to the requirements of Minnesota Statutes, section 475.66, as regards both permitted types of investments, maturities, and depositories. In addition, a plan must not invest in securities or debt of a member, or a member's parent, subsidiary, or affiliate; or any person or entity under contract with the plan.

Subp. 6. Monitoring financial condition. The board must regularly monitor the plan's revenues, expenses, and loss development, and evaluate its current and expected financial condition. The board must attempt in good faith to maintain or restore the plan's sound financial condition, using any means at its disposal. These means include but are not limited to adjusting premium rates, underwriting standards, dividend rates, expulsion standards, and other powers granted in parts 2765.0100 to 2765.1500 and the bylaws. If the commissioner judges that the board's actions are inadequate to maintain or restore the plan's sound financial condition, the commissioner shall, as appropriate: order an increase in the premium rates; revoke the plan's self-insurance authority; or order that an assessment be levied against the members.

Members must not require covered employees to pay a portion of an assessment, nor must covered employees be required

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to pay any amount for premium increases on coverage in force. The amount of assessments must not be more than the amount of members' most recent annual premium, including the portion paid by covered employees.

2765.1500 REPORTING.

Subpart 1. Financial statements. A plan must prepare annual financial statements containing a balance sheet; a full funding reserves calculation worksheet; a statement of revenues, expenses, and suprlus; a statement of changes in financial position; and a schedule of investments. The statements must be prepared on forms and according to instructions prescribed by the commissioner. The financial statements must be filed with the commissioner no later than 30 days after the fund year's conclusion. The financial statements must be audited by an independent certified public accountant, and an audit report must be filed with the commissioner no later than 180 days after the fund year's conclusion. A plan's first annual financial statement, and every second annual financial statement thereafter must be accompanied by a statement from a qualified actuary concerning the balance sheet items that are based on actuarial assumptions and methods. The form of the actuary's statement and the scope of the actuarial review must be according to instructions prescribed by the commissioner.

Subp. 2. Quarterly reports. A plan must file quarterly reports with the commissioner no later than 30 days after the end of the first, second, and third quarters of each fund year. Quarterly reports must contain statements of the plan's:

A. current total cash on hand and on deposit, and total investments;

B. current total reserve for unearned and advance premiums, total reserve for outstanding losses reported and unreported, total operating full funding reserve, and total runoff full funding reserve;

C. dividends declared during the quarter;

D. gross premiums written during the quarter;

E. losses paid during the quarter;

F. proximity to the aggregate excess stop-loss insurance attachment point for the current fund year and, if applicable, the past fund year;

G. current total members and covered employees; and

H. any other matters the commissioner requests that the board address.

Subp. 3. Extraordinary audits. Upon sufficient cause, the commissioner shall require a plan to investigate the accuracy of one or more entries on its financial statements or quarterly reports, and to report its findings. If necessary for the investigation's purposes, the commissioner shall require a plan to contract with a qualified actuary, claims specialist, auditor, or other specialists as appropriate to the type of entry being investigated. If warranted by investigation's findings, the commissioner shall require changes in the plan's reserving, accounting, or recordkeeping practices. These extraordinary audits are in addition to the commissioner's rights to examine self-insurance plans under Minnesota Statutes, section 60A.03, subdivisions 3, 5, and 6, and section 60A.031. Sufficient cause includes:

A. losses that appear significantly different than losses experienced by other self-insurance plans or insurance companies for similar coverage;

B. unusual changes in the amount of entries from period to period that are not sufficiently explained by the financial statements, quarterly reports, or footnotes; or

C. other indications that a plan's financial statements or quarterly reports may not accurately reflect the plan's status and transactions.

Subp. 4. Annual status report. No later than 30 days after the fund year's conclusion, a plan must file with the commissioner a statement describing any changes that have occurred in the information filed with its initial application for authority to self-insure, or with the plan's most recent status report. The status report must be filed in a form and according to instructions prescribed by the commissioner.

Subp. 5. Penalty. The financial statements and status report required under subparts 1 and 4 are considered together to be a plan's annual statement. This filing and other filings required by parts 2765.0100 to 2765.1500 and related statutes are subject to Minnesota Statutes, section 72A.061, as applicable to licensed insurance companies for comparable filings.

Subp. 6. Revenue fee. No later than 60 days after each fund year's conclusion, a plan must file a report with the commissioner of revenue disclosing the total amount of claims paid during the fund year, with no deduction for claims wholly or partially reimbursed through stop-loss insurance. The report must be filed on a form available from the commissioner of revenue. At the time of filing the report, the plan shall pay the fee required by Minnesota Statutes, section 62H.07, to the commissioner of revenue in the amount of two percent of the total amount of claims paid during the fund year, with no deduction for claims wholly or partially reimbursed through stop-loss insurance.

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE

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

STATEMENT OF NEED AND REASONABLENESS OF PROPOSED RULES

STATEMENT OF AUTHORITY

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

FACTS ESTABLISHING NEED AND REASONABLENESS

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

Part 2765.0100 Definitions.

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

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

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

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

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

Part 2765.0200 Purpose.

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

Part 2765.0300 Scope.

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

Part 2765.0400 ByLaws.

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

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

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

Part 2765.0500 Board.

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

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

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

Part 2765.0600 Application.

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

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

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

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

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

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

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

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

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

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

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

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

Part 2765.0800 Administration.

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

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

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

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

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

Part 2765.0900 Membership.

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

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

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

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

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

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

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

Part 2765.1000 Coverage.

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

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

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

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

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

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

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

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

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

Part 2765.1100 Premiums and dividends.

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

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

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

Part 2765.1200 Reserves.

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

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

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

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

Part 2765.1300 Stop-loss insurance.

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

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

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

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

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

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

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

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

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

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

Part 2765.1400 Financial integrity.

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

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

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

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

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

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

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

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

Part 2765.1500 Reporting.

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

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

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

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

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

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

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

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

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

IMPACT ON SMALL BUSINESSES

Qualitative impact.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quantitative impact.

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

CONCLUSION

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