FIFTY-FIRST DAY

St. Paul, Minnesota, Tuesday, May 7, 2013

The Senate met at 3:00 p.m. and was called to order by the President.

CALL OF THE SENATE

Senator Bakk imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

Prayer was offered by the Chaplain, Rev. Kevin McDonough.

The members of the Senate gave the pledge of allegiance to the flag of the United States of America.

The roll was called, and the following Senators answered to their names:

Anderson	Eaton	Johnson	Ortman	Sheran
Bakk	Eken	Kent	Osmek	Sieben
Benson	Fischbach	Kiffmeyer	Pappas	Skoe
Brown	Franzen	Koenen	Pederson, J.	Sparks
Carlson	Gazelka	Latz	Petersen, B.	Stumpf
Chamberlain	Goodwin	Limmer	Pratt	Thompson
Champion	Hall	Lourey	Reinert	Tomassoni
Clausen	Hann	Marty	Rest	Torres Ray
Cohen	Hawj	Metzen	Rosen	Weber
Dahle	Hayden	Miller	Saxhaug	Westrom
Dahms	Hoffman	Nelson	Scalze	Wiger
Dibble	Ingebrigtsen	Newman	Schmit	Wiklund
Dziedzic	Jensen	Nienow	Senjem	

The President declared a quorum present.

The reading of the Journal was dispensed with and the Journal, as printed and corrected, was approved.

MESSAGES FROM THE HOUSE

Madam President:

I have the honor to announce the passage by the House of the following Senate File, herewith returned: S.F. No. 748.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 7, 2013

Madam President:

I have the honor to announce the passage by the House of the following House Files, herewith transmitted: H.F. Nos. 161, 215, 461, 1451 and 826.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted May 6, 2013

Madam President:

I have the honor to announce the passage by the House of the following House File, herewith transmitted: H.F. No. 542.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted May 7, 2013

FIRST READING OF HOUSE BILLS

The following bills were read the first time.

H.F. No. 161: A bill for an act relating to probate; authorizing inventory and emergency order protecting specified personal property of homicide victim to preserve rights of decedent's heirs and beneficiaries; adding notice of rights and procedures to crime victims' chapter; amending Minnesota Statutes 2012, sections 524.2-803; 524.3-614; 524.3-615; 611A.02, subdivision 2.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 196, now on General Orders.

H.F. No. 215: A bill for an act relating to health; permitting licensed health care professionals to order use of physical agent modalities, electrical stimulation, and ultrasound devices; amending Minnesota Statutes 2012, section 148.6440, subdivision 1.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 330, now on General Orders.

H.F. No. 461: A bill for an act relating to natural resources; requiring general permit for mechanical control of certain cattails.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 248, now on General Orders.

H.F. No. 1451: A bill for an act relating to transportation; bridges; providing for disposition of remnant steel of I-35W bridge; proposing coding for new law in Minnesota Statutes, chapter 3.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 1305, now on General Orders.

H.F. No. 826: A bill for an act relating to education; providing for safe and supportive schools; authorizing rulemaking; amending Minnesota Statutes 2012, sections 120B.36, subdivision 1; 121A.55; 121A.69, subdivision 3; 122A.60, subdivisions 1a, 3; 124D.10, subdivision 8; 124D.895, subdivision 1; 124D.8955; 125B.15; 127A.42, subdivision 2; proposing coding for new law in

Minnesota Statutes, chapters 121A; 127A; repealing Minnesota Statutes 2012, sections 121A.03; 121A.0695.

Referred to the Committee on Finance.

H.F. No. 542: A bill for an act relating to state government; establishing expectations for classified employees as nonpartisan resources to all decision makers; providing additional whistleblower protection to state employees; amending Minnesota Statutes 2012, section 181.932, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 43A.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 443, now on General Orders.

REPORTS OF COMMITTEES

Senator Bakk moved that the Committee Reports at the Desk be now adopted. The motion prevailed.

Senator Cohen from the Committee on Finance, to which was re-referred

S.F. No. 661: A bill for an act relating to campaign finance; providing for additional disclosure; making various changes to campaign finance and public disclosure law; expanding jurisdiction of Campaign Finance and Public Disclosure Board; expanding definition of public official; amending Minnesota Statutes 2012, sections 10A.01, subdivisions 10, 11, 27, 28, 35, by adding subdivisions; 10A.02, subdivisions 9, 10, 11, 12, 15; 10A.025, subdivisions 2, 3, 4; 10A.04, subdivision 5; 10A.105, subdivision 1; 10A.12, subdivisions 1, 1a, 2; 10A.121; 10A.14, subdivision 1, by adding a subdivision; 10A.15, subdivisions 1, 2, 3; 10A.16; 10A.20, subdivisions 1, 2, 3, 4, 5, 6, 7, 12, by adding a subdivision; 10A.241; 10A.242, subdivision 1; 10A.25, subdivisions 2, 2a, 3, 3a; 10A.257, subdivision 1; 10A.27, subdivisions 1, 9, 10, 11, 13, 14, 15; 10A.273, subdivisions 1, 4; 10A.30; 10A.31, subdivisions 1, 4, 7; 10A.315; 10A.321, subdivision 1; 10A.322, subdivision 4; 10A.323; 10A.324, subdivision 1; 211B.32, subdivision 1; 211B.37; proposing coding for new law in Minnesota Statutes, chapter 10A; repealing Minnesota Statutes 2012, sections 10A.24; 10A.242; 10A.25, subdivision 6.

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

Delete everything after the enacting clause and insert:

"**ARTICLE 1**

POLICY CHANGES

Section 1. Minnesota Statutes 2012, section 10A.01, is amended by adding a subdivision to read:

Subd. 7c. **Ballot question political committee.** "Ballot question political committee" means a political committee that makes only expenditures to promote or defeat a ballot question and disbursements permitted under section 10A.121, subdivision 1.

Sec. 2. Minnesota Statutes 2012, section 10A.01, is amended by adding a subdivision to read:

Subd. 7d. **Ballot question political fund.** "Ballot question political fund" means a political fund that makes only expenditures to promote or defeat a ballot question and disbursements permitted under section 10A.121, subdivision 1.

Sec. 3. Minnesota Statutes 2012, section 10A.01, subdivision 10, is amended to read:

Subd. 10. **Candidate.** "Candidate" means an individual who seeks nomination or election as a state constitutional officer, legislator, or judge. An individual is deemed to seek nomination or election if the individual has taken the action necessary under the law of this state to qualify for nomination or election, has received contributions or made expenditures in excess of $100, or has given implicit or explicit consent for any other person to receive contributions or make expenditures in excess of $100, for the purpose of bringing about the individual's nomination or election. A candidate remains a candidate until the candidate's principal campaign committee is dissolved as provided in section ~~10A.24~~ 10A.243.

Sec. 4. Minnesota Statutes 2012, section 10A.01, subdivision 11, is amended to read:

Subd. 11. **Contribution.** (a) "Contribution" means money, a negotiable instrument, or a donation in kind that is given to a political committee, political fund, principal campaign committee, or party unit. An allocation by an association of general treasury money to be used for activities that must be or are reported through the association's political fund is considered to be a contribution for the purposes of disclosure required by this chapter.

(b) "Contribution" includes a loan or advance of credit to a political committee, political fund, principal campaign committee, or party unit, if the loan or advance of credit is: (1) forgiven; or (2) repaid by an individual or an association other than the political committee, political fund, principal campaign committee, or party unit to which the loan or advance of credit was made. If an advance of credit or a loan is forgiven or repaid as provided in this paragraph, it is a contribution in the year in which the loan or advance of credit was made.

(c) "Contribution" does not include services provided without compensation by an individual volunteering personal time on behalf of a candidate, ballot question, political committee, political fund, principal campaign committee, or party unit; the publishing or broadcasting of news items or editorial comments by the news media; or an individual's unreimbursed personal use of an automobile owned by the individual while volunteering personal time.

Sec. 5. Minnesota Statutes 2012, section 10A.01, subdivision 16, is amended to read:

Subd. 16. **Election cycle.** "Election cycle" means the period from January 1 following a general election for an office to December 31 following the next general election for that office, except that "election cycle" for a special election means the period from the date the special election writ is issued to 60 days after the special election is held. For a regular election, the period from January 1 of the year prior to an election year through December 31 of the election year is the "election segment" of the election cycle. Each other two-year segment of an election cycle is a "non-election segment" of the election cycle. An election cycle that consists of two calendar years has only an election segment. The election segment of a special election cycle includes the entire special election cycle.

Sec. 6. Minnesota Statutes 2012, section 10A.01, is amended by adding a subdivision to read:

Subd. 16a. **Expressly advocating.** "Expressly advocating" means:

(1) that a communication clearly identifies a candidate and uses words or phrases of express advocacy; or

(2) that a communication, when taken as a whole and with limited reference to external events, such as the proximity to the election, is susceptible of no interpretation by a reasonable person other than as advocating the election or defeat of one or more clearly identified candidates.

Sec. 7. Minnesota Statutes 2012, section 10A.01, is amended by adding a subdivision to read:

Subd. 17c. **General treasury money.** "General treasury money" means money that an association other than a principal campaign committee, party unit, or political committee accumulates through membership dues and fees, donations to the association for its general purposes, and income from the operation of a business. General treasury money does not include money collected to influence the nomination or election of candidates or to promote or defeat a ballot question.

Sec. 8. Minnesota Statutes 2012, section 10A.01, is amended by adding a subdivision to read:

Subd. 26a. **Person.** "Person" means an individual, an association, a political subdivision, or a public higher education system.

Sec. 9. Minnesota Statutes 2012, section 10A.01, subdivision 27, is amended to read:

Subd. 27. **Political committee.** "Political committee" means an association whose major purpose is to influence the nomination or election of ~~a candidate~~ one or more candidates or to promote or defeat a ballot question, other than a principal campaign committee or a political party unit.

Sec. 10. Minnesota Statutes 2012, section 10A.01, subdivision 28, is amended to read:

Subd. 28. **Political fund.** "Political fund" means an accumulation of dues or voluntary contributions by an association other than a political committee, principal campaign committee, or party unit, if the accumulation is collected or expended to influence the nomination or election of ~~a candidate~~ one or more candidates or to promote or defeat a ballot question. The term "political fund" as used in this chapter may also refer to the association acting through its political fund.

Sec. 11. Minnesota Statutes 2012, section 10A.02, subdivision 9, is amended to read:

Subd. 9. **Documents; information.** The executive director must inspect all material filed with the board as promptly as necessary to comply with this chapter ~~and~~, with other provisions of law requiring the filing of a document with the board, and with other provisions of law under the board's jurisdiction pursuant to subdivision 11. The executive director must immediately notify ~~the~~ an individual ~~required to file a document with the board~~ if a written complaint is filed with the board alleging, or it otherwise appears, that a document filed with the board is inaccurate or does not comply with this chapter, or that the individual has failed to file a document required by this chapter or has failed to comply with this chapter or other provisions under the board's jurisdiction pursuant to subdivision 11. ~~The executive director may provide an individual required to file a document under this chapter with factual information concerning the limitations on corporate campaign contributions imposed by section 211B.15.~~

Sec. 12. Minnesota Statutes 2012, section 10A.02, subdivision 10, is amended to read:

Subd. 10. **Audits and investigations.** The board may make audits and investigations, impose statutory civil penalties, and issue orders for compliance with respect to ~~statements and reports that are filed or that should have been filed under~~ the requirements of this chapter and provisions under the board's jurisdiction pursuant to subdivision 11. In all matters relating to its official duties, the

board has the power to issue subpoenas and cause them to be served. If a person does not comply with a subpoena, the board may apply to the District Court of Ramsey County for issuance of an order compelling obedience to the subpoena. A person failing to obey the order is punishable by the court as for contempt.

Sec. 13. Minnesota Statutes 2012, section 10A.02, subdivision 11, is amended to read:

Subd. 11. **Violations; enforcement.** (a) The board may investigate any alleged violation of this chapter. The board may also investigate an alleged violation of section 211B.04, 211B.12, or 211B.15 by or related to a candidate, treasurer, principal campaign committee, political committee, political fund, or party unit, as those terms are defined in this chapter. The board must investigate any violation that is alleged in a written complaint filed with the board and must within 30 days after the filing of the complaint make ~~a public finding of whether there is probable cause to believe a violation has occurred~~ findings and conclusions as to whether a violation has occurred and must issue an order, except that if the complaint alleges a violation of section 10A.25 or 10A.27, the board must either enter a conciliation agreement or make ~~a~~ public ~~finding of whether there is probable cause,~~ findings and conclusions as to whether a violation has occurred and must issue an order within 60 days after the filing of the complaint. The deadline for action on a written complaint may be extended by majority vote of the board.

(b) The board may bring legal actions or negotiate settlements in its own name to recover money raised from contributions subject to the conditions in this paragraph.

(1) No action may be commenced unless the board has made a formal determination, after an investigation, that the money was raised for political purposes as defined in section 211B.01, subdivision 6, and that the money was used for purposes not permitted under this chapter or under section 211B.12.

(2) Prior to commencing an action, the board must give the association whose money was misused written notice by certified mail of its intent to take action under this subdivision and must give the association a reasonable opportunity, for a period of not less than 90 days, to recover the money without board intervention. This period must be extended for at least an additional 90 days for good cause if the association is actively pursuing recovery of the money. The board may not commence a legal action under this subdivision if the association has commenced a legal action for the recovery of the same money.

(3) Any funds recovered under this subdivision must be deposited in a campaign finance recovery account in the special revenue fund and are appropriated as follows:

(i) an amount equal to the board's actual costs and disbursements in the action, including court reporter fees for depositions taken in the course of an investigation, is appropriated to the board for its operations;

(ii) an amount equal to the reasonable value of legal services provided by the Office of the Attorney General in the recovery matter, calculated on the same basis as is used for charging legal fees to state agencies, is appropriated to the Office of the Attorney General for its operations; and

(iii) any remaining balance is appropriated to the board for distribution to the association to which the money was originally contributed.

(4) Notwithstanding clause (3), item (iii), if the candidate of a principal campaign committee is the person who used the association's money for illegal purposes, or if the association or political fund whose money was misused is no longer registered with the board, any money remaining after the payments specified in clause (3), items (i) and (ii), must be transferred to the general account of the state elections campaign account.

(5) Any action by the board under this paragraph must be commenced not later than four years after the improper use of money is shown on a report filed with the board or the board has actual knowledge of improper use. No action may be commenced under this paragraph for improper uses disclosed on reports for calendar years prior to 2011.

(6) If the board prevails in an action brought under this subdivision and the court makes a finding that the misuse of funds was willful, the court may enter judgment in favor of the board and against the person misusing the funds in the amount of the misused funds.

~~(b)~~ (c) Within a reasonable time after beginning an investigation of an individual or association, the board must notify the individual or association of the fact of the investigation. The board must not make a finding of whether there is probable cause to believe a violation has occurred without notifying the individual or association of the nature of the allegations and affording an opportunity to answer those allegations.

~~(c)~~ (d) A hearing or action of the board concerning a complaint or investigation other than a finding concerning probable cause or a conciliation agreement is confidential. Until the board makes a public finding concerning probable cause or enters a conciliation agreement:

(1) a member, employee, or agent of the board must not disclose to an individual information obtained by that member, employee, or agent concerning a complaint or investigation except as required to carry out the investigation or take action in the matter as authorized by this chapter; and

(2) an individual who discloses information contrary to this subdivision is subject to a civil penalty imposed by the board of up to $1,000.

(e) A matter that is under the board's jurisdiction pursuant to this section and that may result in a criminal offense must be finally disposed of by the board before the alleged violation may be prosecuted by a city or county attorney.

Sec. 14. Minnesota Statutes 2012, section 10A.02, subdivision 12, is amended to read:

Subd. 12. **Advisory opinions.** (a) The board may issue and publish advisory opinions on the requirements of this chapter and of those sections listed in subdivision 11 based upon real or hypothetical situations. An application for an advisory opinion may be made only by ~~an individual or association~~ a person who is subject to chapter 10A and who wishes to use the opinion to guide the ~~individual's or the association's~~ person's own conduct. The board must issue written opinions on all such questions submitted to it within 30 days after receipt of written application, unless a majority of the board agrees to extend the time limit.

(b) A written advisory opinion issued by the board is binding on the board in a subsequent board proceeding concerning the person making or covered by the request and is a defense in a judicial proceeding that involves the subject matter of the opinion and is brought against the person making or covered by the request unless:

(1) the board has amended or revoked the opinion before the initiation of the board or judicial proceeding, has notified the person making or covered by the request of its action, and has allowed at least 30 days for the person to do anything that might be necessary to comply with the amended or revoked opinion;

(2) the request has omitted or misstated material facts; or

(3) the person making or covered by the request has not acted in good faith in reliance on the opinion.

(c) A request for an opinion and the opinion itself are nonpublic data. The board, however, may publish an opinion or a summary of an opinion, but may not include in the publication the name of the requester, the name of a person covered by a request from an agency or political subdivision, or any other information that might identify the requester, unless the person consents to the inclusion.

Sec. 15. Minnesota Statutes 2012, section 10A.02, subdivision 15, is amended to read:

Subd. 15. **Disposition of fees.** The board must deposit all fees and civil penalties collected under this chapter into the general fund in the state treasury.

Sec. 16. Minnesota Statutes 2012, section 10A.025, subdivision 2, is amended to read:

Subd. 2. **Penalty for false statements.** (a) A report or statement required to be filed under this chapter must be signed and certified as true by the individual required to file the report. The signature may be an electronic signature consisting of a password assigned by the board.

(b) An individual ~~who signs and certifies~~ shall not sign and certify to be true a report or statement knowing it contains false information or ~~who knowingly~~ knowing it omits required information ~~is guilty of a gross misdemeanor and subject to a civil penalty imposed by the board of up to $3,000~~.

(c) An individual shall not knowingly provide false or incomplete information to a treasurer with the intent that the treasurer will rely on that information in signing and certifying to be true a report or statement.

(d) A person who violates paragraph (b) or (c) is subject to a civil penalty imposed by the board of up to $3,000. A violation of paragraph (b) or (c) is a gross misdemeanor.

(e) The board may impose an additional civil penalty of up to $3,000 on the principal campaign committee or candidate, party unit, political committee, or association that has a political fund that is affiliated with an individual who violated paragraph (b) or (c).

Sec. 17. Minnesota Statutes 2012, section 10A.025, subdivision 3, is amended to read:

Subd. 3. **Record keeping; penalty.** (a) A person required to file a report or statement or who has accepted record-keeping responsibility for the filer must maintain records on the matters required to be reported, including vouchers, canceled checks, bills, invoices, worksheets, and receipts, that will provide in sufficient detail the necessary information from which the filed reports and statements may be verified, explained, clarified, and checked for accuracy and completeness. The person must keep the records available for audit, inspection, or examination by the board or its authorized representatives for four years from the date of filing of the reports or statements or

of changes or corrections to them. ~~A person who knowingly violates this subdivision is guilty of a misdemeanor.~~

(b) The board may impose a civil penalty of up to $3,000 on a person who knowingly violates this subdivision. The board may impose a separate civil penalty of up to $3,000 on the principal campaign committee or candidate, party unit, political committee, or association that has a political fund that is affiliated with an individual who violated this subdivision.

(c) A knowing violation of this subdivision is a misdemeanor.

Sec. 18. Minnesota Statutes 2012, section 10A.105, subdivision 1, is amended to read:

Subdivision 1. **Single committee.** A candidate must not accept contributions from a source, other than self, in aggregate in excess of ~~$100~~ $750 or accept a public subsidy unless the candidate designates and causes to be formed a single principal campaign committee for each office sought. A candidate may not authorize, designate, or cause to be formed any other political committee bearing the candidate's name or title or otherwise operating under the direct or indirect control of the candidate. However, a candidate may be involved in the direct or indirect control of a party unit.

Sec. 19. Minnesota Statutes 2012, section 10A.12, subdivision 1, is amended to read:

Subdivision 1. **When required for contributions and approved expenditures.** An association other than a political committee or party unit may not contribute more than ~~$100~~ $750 in aggregate in any ~~one~~ calendar year to candidates, political committees, or party units or make ~~any~~ approved ~~or independent expenditure or expenditure to promote or defeat a ballot question~~ expenditures of more than $750 in aggregate in any calendar year unless the contribution or expenditure is made ~~from~~ through a political fund.

Sec. 20. Minnesota Statutes 2012, section 10A.12, subdivision 1a, is amended to read:

Subd. 1a. **When required for independent expenditures or ballot questions.** An association other than a political committee that makes only independent expenditures ~~and disbursements permitted under section 10A.121, subdivision 1,~~ or expenditures to promote or defeat a ballot question must do so ~~by forming and registering~~ through an independent expenditure or ballot question political fund if the ~~expenditure is in excess of $100~~ independent expenditures aggregate more than $1,500 in a calendar year or if the expenditures to promote or defeat a ballot question aggregate more than $5,000 in a calendar year, or by contributing to an existing independent expenditure or ballot question political committee or ~~political~~ fund.

Sec. 21. Minnesota Statutes 2012, section 10A.12, subdivision 2, is amended to read:

Subd. 2. **Commingling prohibited.** The contents of ~~a~~ an association's political fund may not be commingled with other funds or with the personal funds of an officer or member of the association or the fund. It is not commingling for an association that uses only its own general treasury money to make expenditures and disbursements permitted under section 10A.121, subdivision 1, directly from the depository used for its general treasury money. An association that accepts more than $1,500 in contributions to influence the nomination or election of candidates or more than $5,000 in contributions to promote or defeat a ballot question must establish a separate depository for those contributions.

Sec. 22. Minnesota Statutes 2012, section 10A.121, is amended to read:

10A.121 INDEPENDENT EXPENDITURE AND BALLOT QUESTION POLITICAL COMMITTEES AND ~~INDEPENDENT EXPENDITURE POLITICAL~~ FUNDS.

Subdivision 1. **Permitted disbursements.** An independent expenditure political committee or ~~an independent expenditure political~~ fund, or a ballot question political committee or fund, ~~in addition to making independent expenditures,~~ may:

(1) pay costs associated with its fund-raising and general operations;

(2) pay for communications that do not constitute contributions or approved expenditures; ~~and~~

(3) make contributions to ~~other~~ independent expenditure or ballot question political committees or ~~independent expenditure political~~ funds;

(4) make independent expenditures;

(5) make disbursements for electioneering communications;

(6) make expenditures to promote or defeat ballot questions;

(7) return a contribution to its source;

(8) for a political fund, record bookkeeping entries transferring the association's general treasury money allocated for political purposes back to the general treasury of the association; and

(9) for a political fund, return general treasury money transferred to a separate depository to the general depository of the association.

Subd. 2. **Penalty.** (a) An independent expenditure political committee or independent expenditure political fund is subject to a civil penalty of up to four times the amount of the contribution or approved expenditure if it does the following:

(1) makes a contribution to a candidate, party unit, political committee, or political fund other than an independent expenditure political committee or an independent expenditure political fund; or

(2) makes an approved expenditure.

(b) No other penalty provided in law may be imposed for conduct that is subject to a civil penalty under this section.

Sec. 23. Minnesota Statutes 2012, section 10A.14, subdivision 1, is amended to read:

Subdivision 1. **First registration.** The treasurer of a political committee, political fund, principal campaign committee, or party unit must register with the board by filing a registration statement ~~of organization~~ no later than 14 days after the committee, fund, or party unit has made a contribution, received contributions, or made expenditures in excess of ~~$100~~ $750, or by the end of the next business day after it has received a loan or contribution that must be reported under section 10A.20, subdivision 5, whichever is earlier. This subdivision does not apply to ballot question or independent expenditure political committees or funds, which are subject to subdivision 1a.

Sec. 24. Minnesota Statutes 2012, section 10A.14, is amended by adding a subdivision to read:

Subd. 1a. **Independent expenditure or ballot question political committees and funds; first registration; reporting.** The treasurer of an independent expenditure or ballot question political committee or fund must register with the board by filing a registration statement:

(1) no later than 14 calendar days after the committee or the association registering the political fund has:

(i) received aggregate contributions for independent expenditures of more than $1,500 in a calendar year;

(ii) received aggregate contributions for expenditures to promote or defeat a ballot question of more than $5,000 in a calendar year;

(iii) made aggregate independent expenditures of more than $1,500 in a calendar year; or

(iv) made aggregate expenditures to promote or defeat a ballot question of more than $5,000 in a calendar year; or

(2) by the end of the next business day after it has received a loan or contribution that must be reported under section 10A.20, subdivision 5, and it has met one of the requirements of clause (1).

Sec. 25. Minnesota Statutes 2012, section 10A.15, subdivision 1, is amended to read:

Subdivision 1. **Anonymous contributions.** A political committee, political fund, principal campaign committee, or party unit may not retain an anonymous contribution in excess of $20, but must forward it to the board for deposit in the general account of the state elections campaign ~~fund~~ account.

Sec. 26. Minnesota Statutes 2012, section 10A.15, subdivision 3, is amended to read:

Subd. 3. **Deposit.** All contributions received by or on behalf of a candidate, principal campaign committee, political committee, political fund, or party unit must be deposited in an account designated "Campaign Fund of ..... (name of candidate, committee, fund, or party unit)." All contributions must be deposited promptly upon receipt and, except for contributions received during the last three days of a reporting period as described in section 10A.20, must be deposited during the reporting period in which they were received. A contribution received during the last three days of a reporting period must be deposited within 72 hours after receipt and must be reported as received during the reporting period whether or not deposited within that period. A candidate, principal campaign committee, political committee, political fund, or party unit may refuse to accept a contribution. A deposited contribution may be returned to the contributor within ~~60~~ 90 days after deposit. A contribution deposited and not returned within ~~60~~ 90 days after that deposit must be reported as accepted.

Sec. 27. Minnesota Statutes 2012, section 10A.20, subdivision 1, is amended to read:

Subdivision 1. **First filing; duration.** The treasurer of a political committee, political fund, principal campaign committee, or party unit must begin to file the reports required by this section ~~in~~ for the first year it receives contributions or makes expenditures ~~in excess of $100~~ that require it to register under section 10A.14 and must continue to file until the committee, fund, or party unit is terminated. The reports must be filed electronically in a standards-based open format specified by the board. For good cause shown, the board must grant exemptions to the requirement that reports be filed electronically.

Sec. 28. Minnesota Statutes 2012, section 10A.20, subdivision 2, is amended to read:

Subd. 2. **Time for filing.** (a) The reports must be filed with the board on or before January 31 of each year and additional reports must be filed as required and in accordance with paragraphs (b) to (d).

(b) In each year in which the name of ~~the~~ a candidate for legislative or district court judicial office is on the ballot, the report of the principal campaign committee must be filed 15 days before a primary and ten days before a general election, seven days before a special primary and a special election, and ten days after a special election cycle.

(c) In each general election year, a political committee ~~or~~, a political fund ~~must file reports 28 and 15 days before a primary and 42 and ten days before a general election. Beginning in 2012, reports required under this paragraph must also be filed 56 days before a primary.~~, a state party committee, a party unit established by all or a part of the party organization within a house of the legislature, and the principal campaign committee of a candidate for constitutional or appellate court judicial office must file reports on the following schedule:

(1) a first-quarter report covering the calendar year through March 31, which is due April 14;

(2) in a year in which a primary election is held in August, a report covering the calendar year through May 31, which is due June 14;

(3) in a year in which a primary election is held before August, a pre-general-election report covering the calendar year through July 15, which is due July 29;

(4) a pre-primary-election report due 15 days before a primary election;

(5) a pre-general-election report due 42 days before the general election;

(6) a pre-general-election report due ten days before a general election; and

(7) for a special election, a constitutional office candidate whose name is on the ballot must file reports seven days before a special primary and a special election, and ten days after a special election cycle.

(d) In each general election year, a party unit not included in paragraph (c) must file reports 15 days before a primary election and ten days before a general election.

(e) Notwithstanding paragraphs (a) to (d), the principal campaign committee of a candidate whose name will not be on the general election ballot is not required to file the report due ten days before a general election or seven days before a special election.

Sec. 29. Minnesota Statutes 2012, section 10A.20, subdivision 3, is amended to read:

Subd. 3. **Contents of report.** (a) The report required by this section must include each of the items listed in paragraphs (b) to (o) that are applicable to the filer. The board shall prescribe forms based on filer type indicating which of those items must be included on the filer's report.

~~(a)~~ (b) The report must disclose the amount of liquid assets on hand at the beginning of the reporting period.

~~(b)~~ (c) The report must disclose the name, address, and employer, or occupation if self-employed, of each individual or association that has made one or more contributions to the reporting entity,

including the purchase of tickets for a fund-raising effort, that in aggregate within the year exceed ~~$100~~ $200 for legislative or statewide candidates or more than $500 for ballot questions, together with the amount and date of each contribution, and the aggregate amount of contributions within the year from each source so disclosed. A donation in kind must be disclosed at its fair market value. An approved expenditure must be listed as a donation in kind. A donation in kind is considered consumed in the reporting period in which it is received. The names of contributors must be listed in alphabetical order. Contributions from the same contributor must be listed under the same name. When a contribution received from a contributor in a reporting period is added to previously reported unitemized contributions from the same contributor and the aggregate exceeds the disclosure threshold of this paragraph, the name, address, and employer, or occupation if self-employed, of the contributor must then be listed on the report.

~~(c)~~ (d) The report must disclose the sum of contributions to the reporting entity during the reporting period.

~~(d)~~ (e) The report must disclose each loan made or received by the reporting entity within the year in aggregate in excess of ~~$100~~ $200, continuously reported until repaid or forgiven, together with the name, address, occupation, and principal place of business, if any, of the lender and any endorser and the date and amount of the loan. If a loan made to the principal campaign committee of a candidate is forgiven or is repaid by an entity other than that principal campaign committee, it must be reported as a contribution for the year in which the loan was made.

~~(e)~~ (f) The report must disclose each receipt over ~~$100~~ $200 during the reporting period not otherwise listed under paragraphs ~~(b)~~ (c) to ~~(d)~~ (e).

~~(f)~~ (g) The report must disclose the sum of all receipts of the reporting entity during the reporting period.

~~(g)~~ (h) The report must disclose the name and address of each individual or association to whom aggregate expenditures, ~~including~~ approved expenditures, independent expenditures, ballot question expenditures, and disbursements for electioneering communications have been made by or on behalf of the reporting entity within the year in excess of ~~$100~~ $200, together with the amount, date, and purpose of each expenditure and the name and address of, and office sought by, each candidate on whose behalf the expenditure was made or, in the case of electioneering communications, each candidate identified positively in the communication, identification of the ballot question that the expenditure was intended to promote or defeat and an indication of whether the expenditure was to promote or to defeat the ballot question, and in the case of independent expenditures made in opposition to a candidate or electioneering communications in which a candidate is identified negatively, the candidate's name, address, and office sought. A reporting entity making an expenditure on behalf of more than one candidate for state or legislative office must allocate the expenditure among the candidates on a reasonable cost basis and report the allocation for each candidate.

~~(h)~~ (i) The report must disclose the sum of all expenditures made by or on behalf of the reporting entity during the reporting period.

~~(i)~~ (j) The report must disclose the amount and nature of an advance of credit incurred by the reporting entity, continuously reported until paid or forgiven. If an advance of credit incurred by the principal campaign committee of a candidate is forgiven by the creditor or paid by an entity other

than that principal campaign committee, it must be reported as a donation in kind for the year in which the advance of credit was made.

~~(j)~~ (k) The report must disclose the name and address of each political committee, political fund, principal campaign committee, or party unit to which contributions have been made that aggregate in excess of ~~$100~~ $200 within the year and the amount and date of each contribution.

~~(k)~~ (l) The report must disclose the sum of all contributions made by the reporting entity during the reporting period.

~~(l)~~ (m) The report must disclose the name and address of each individual or association to whom noncampaign disbursements have been made that aggregate in excess of ~~$100~~ $200 within the year by or on behalf of the reporting entity and the amount, date, and purpose of each noncampaign disbursement.

~~(m)~~ (n) The report must disclose the sum of all noncampaign disbursements made within the year by or on behalf of the reporting entity.

~~(n)~~ (o) The report must disclose the name and address of a nonprofit corporation that provides administrative assistance to a political committee or political fund as authorized by section 211B.15, subdivision 17, the type of administrative assistance provided, and the aggregate fair market value of each type of assistance provided to the political committee or political fund during the reporting period.

Sec. 30. Minnesota Statutes 2012, section 10A.20, subdivision 5, is amended to read:

Subd. 5. **~~Preelection~~ Pre-election reports.** (a) Any loan, contribution, or contributions:

(1) to a political committee or political fund from any one source totaling more than $1,000 ~~or more, or in a statewide election for~~;

(2) to the principal campaign committee of a candidate for an appellate court judicial office~~, any loan, contribution, or contributions from any one source~~ totaling more than $2,000 ~~or more, or in any judicial~~;

(3) to the principal campaign committee of a candidate for district court judge totaling more than $400 ~~or more, and any loan, contribution, or contributions~~; or

(4) to the principal campaign committee of a candidate for constitutional office or for the legislature ~~from any one source~~ totaling ~~80~~ more than 50 percent ~~or more~~ of the election cycle contribution limit for the office, received between the last day covered in the last report before an election and the election must be reported to the board ~~in one of the following ways:~~ in the manner provided in paragraph (b).

(b) A loan, contribution, or contributions required to be reported to the board under paragraph (a) must be reported to the board either:

(1) in person by the end of the next business day after its receipt; or

(2) by electronic means sent within 24 hours after its receipt.

(c) These loans and contributions must also be reported in the next required report.

(d) This notice requirement does not apply ~~with respect to~~ in a primary ~~in which the statewide or legislative~~ election to a candidate who is unopposed in the primary, in a primary election to a ballot question political committee or fund, or in a general election to a candidate whose name is not on the general election ballot. The board must post the report on its Web site by the end of the next business day after it is received.

(e) This subdivision does not apply to a ballot question or independent expenditure political committee or fund that has not met the registration threshold of section 10A.14, subdivision 1a. However, if a contribution that would be subject to this section triggers the registration requirement in section 10A.14, subdivision 1a, then both registration under that section and reporting under this section are required.

Sec. 31. Minnesota Statutes 2012, section 10A.20, subdivision 6, is amended to read:

Subd. 6. **Report when no committee.** (a) A candidate who does not designate and cause to be formed a principal campaign committee and ~~an individual~~ who makes ~~independent expenditures or~~ campaign expenditures ~~expressly advocating the approval or defeat of a ballot question~~ in aggregate in excess of ~~$100~~ $750 in a year must file with the board a report containing the information required by subdivision 3. Reports required by this subdivision must be filed ~~on~~ by the dates on which reports by principal campaign committees~~, funds, and party units are~~ must be filed.

(b) An individual who makes independent expenditures that aggregate more than $1,500 in a calendar year or expenditures to promote or defeat a ballot question that aggregate more than $5,000 in a calendar year must file with the board a report containing the information required by subdivision 3. A report required by this subdivision must be filed by the date on which the next report by political committees and political funds must be filed.

Sec. 32. Minnesota Statutes 2012, section 10A.20, subdivision 7, is amended to read:

Subd. 7. **Statement of inactivity.** If a ~~reporting entity~~ principal campaign committee, party unit, or political committee, has no receipts or expenditures during a reporting period, the treasurer must file with the board at the time required by this section a statement to that effect.

Sec. 33. Minnesota Statutes 2012, section 10A.20, is amended by adding a subdivision to read:

Subd. 7a. **Activity of political fund.** An association is not required to file any statement or report for a reporting period when the association accepted no contributions into the association's political fund and made no expenditures from its political fund since the last date included in its most recent filed report. If the association maintains a separate checking account for its political fund, the receipt of interest on the proceeds of that account and the payment of fees to maintain that account do not constitute activity that requires the filing of a report for an otherwise inactive political fund.

Sec. 34. **[10A.201] ELECTIONEERING COMMUNICATIONS.**

Subdivision 1. **Electioneering communication.** (a) "Electioneering communication" means a communication distributed by television, radio, satellite, or cable broadcasting system; by means of printed material, signs, or billboards; or through the use of telephone communications that:

(1) refers to a clearly identified candidate;

(2) is made within:

(i) 30 days before a primary election or special primary election for the office sought by the candidate; or

(ii) 60 days before a general election or special election for the office sought by the candidate;

(3) is targeted to the relevant electorate; and

(4) is made without the express or implied consent, authorization, or cooperation of, and not in concert with or at the request or suggestion of, a candidate or a candidate's principal campaign committee or agent.

(b) Electioneering communication does not include:

(1) the publishing or broadcasting of news items or editorial comments by the news media;

(2) a communication that constitutes an approved expenditure or an independent expenditure;

(3) a communication by an association distributed only to the association's own members, donors, or subscribers in a newsletter or similar publication in a form that is routinely sent to the association's members;

(4) a voter guide, which is a pamphlet or similar printed materials, intended to help voters compare candidates' positions on a set of issues, as long as each of the following is true:

(i) the guide does not focus on a single issue or a narrow range of issues, but includes questions and subjects sufficient to encompass major issues of interest to the entire electorate;

(ii) the questions and any other description of the issues are clear and unbiased in both their structure and content;

(iii) the questions posed and provided to the candidates are identical to those included in the guide;

(iv) each candidate included in the guide is given a reasonable amount of time and the same opportunity as other candidates to respond to the questions;

(v) if the candidate is given limited choices for an answer to a question, for example: "support," "oppose," "yes," or"no," the candidate is also given an opportunity, subject to reasonable limits, to explain the candidate's position in the candidate's own words; the fact that a candidate provided an explanation is clearly indicated in the guide; and the guide clearly indicates that the explanations will be made available for public inspection, subject to reasonable conditions;

(vi) answers included in the guide are those provided by the candidates in response to questions, the candidate's answers are unedited, and the answers appear in close proximity to the question to which they respond;

(vii) if the guide includes candidates' positions based on information other than responses provided directly by the candidate, the positions are based on recorded votes, reliable media reports, or public statements of the candidates and are presented in an unedited and unbiased manner; and

(viii) the guide includes all major party candidates for each office listed in the guide;

(5) any other communication specified in board rules or advisory opinions as being excluded from the definition of electioneering communications; or

(6) a communication that:

(i) refers to a clearly identified candidate who is an incumbent member of the legislature or a constitutional officer;

(ii) refers to a clearly identified issue that is or was before the legislature in the form of an introduced bill; and

(iii) is made when the legislature is in session or within ten days after the last day of a regular session of the legislature.

(c) A communication that meets the requirements of paragraph (a) but is made with the authorization or express or implied consent of, or in cooperation or in concert with, or at the request or suggestion of a candidate, a candidate's principal campaign committee, or a candidate's agent is an approved expenditure.

(d) Distributing a voter guide questionnaire, survey, or similar document to candidates and communications with candidates limited to obtaining their responses, without more, do not constitute communications that would result in the voter guide being an approved expenditure on behalf of the candidate.

Subd. 2. **Targeted to relevant electorate.** (a) For purposes of this section, a communication that refers to a clearly identified candidate is targeted to the relevant electorate if the communication is distributed to or can be received by more than 1,500 persons in the district the candidate seeks to represent, in the case of a candidate for the house of representatives, senate, or a district court judicial office or by more than 6,000 persons in the state, in the case of a candidate for constitutional office or appellate court judicial office.

(b) A communication consisting of printed materials, other than signs, billboards, or advertisements published in the print media, is targeted to the relevant electorate if it meets the requirements of paragraph (a) and is distributed to voters by means of United States mail or through direct delivery to a resident's home or business.

Subd. 3. **Disclosure of electioneering communications.** (a) Electioneering communications made by a political committee, a party unit, or a principal campaign committee must be disclosed on the periodic reports of receipts and expenditures filed by the association on the schedule and in accordance with the terms of section 10A.20.

(b) An association other than a political committee, party unit, or principal campaign committee may register a political fund with the board and disclose its electioneering communications on the reports of receipts and expenditures filed by the political fund. If it does so, it must disclose its disbursements for electioneering communication on the schedule and in accordance with the terms of section 10A.20.

(c) An association that does not disclose its disbursements for electioneering communication under paragraph (a) or (b) must disclose its electioneering communications according to the requirements of subdivision 4.

Subd. 4. **Statement required for electioneering communications made by unregistered associations.** (a) Except for associations providing disclosure as specified in subdivision 3, paragraph (a) or (b), every person who makes a disbursement for the costs of producing or distributing electioneering communications that aggregate more than $1,500 in a calendar year

must, within 24 hours of each disclosure date, file with the board a disclosure statement containing the information described in this subdivision.

(b) Each statement required to be filed under this section must contain the following information:

(1) the names of: (i) the association making the disbursement; (ii) any person exercising direction or control over the activities of the association with respect to the disbursement; and (iii) the custodian of the financial records of the association making disbursement;

(2) the address of the association making the disbursement;

(3) the amount of each disbursement of more than $200 during the period covered by the statement, a description of the purpose of the disbursement, and the identification of the person to whom the disbursement was made;

(4) the names of the candidates identified or to be identified in the communication;

(5) if the disbursements were paid out of a segregated bank account that consists of funds donated specifically for electioneering communications, the name and address of each person who gave the association more than $200 in aggregate to that account during the period beginning on the first day of the preceding calendar year and ending on the disclosure date; and

(6) if the disbursements for electioneering communications were made using general treasury money of the association, an association that has paid more than $5,000 in aggregate for electioneering communications during the calendar year must file with its disclosure statement a written statement that includes the name, address, and amount attributable to each person that paid the association membership dues or fees, or made donations to the association that, in total, aggregate more than $5,000 of the money used by the association for electioneering communications. The statement must also include the total amount of the disbursements for electioneering communications attributable to persons not subject to itemization under this clause. The statement must be certified as true by an officer of the association that made the disbursements for the electioneering communications.

(c) To determine the amount of the membership dues or fees, or donations made by a person to an association and attributable to the association's disbursements for electioneering communications, the association must separately prorate the total disbursements made for electioneering communications during the calendar year over all general treasury money received during the calendar year.

(d) If the amount spent for electioneering communications exceeds the amount of general treasury money received by the association during that year:

(1) the electioneering communications must be attributed first to all receipts of general treasury money received during the calendar year in which the electioneering communications were made;

(2) any amount of current year electioneering communications that exceeds the total of all receipts of general treasury money during the current calendar year must be prorated over all general treasury money received in the preceding calendar year; and

(3) if the allocation made in clauses (1) and (2) is insufficient to cover the subject electioneering communications, no further allocation is required.

(e) After a portion of the general treasury money received by an association from a person has been designated as the source of a disbursement for electioneering communications, that portion of the association's general treasury money received from that person may not be designated as the source of any other disbursement for electioneering communications or as the source for any contribution to an independent expenditure political committee or fund.

Subd. 5. **Disclosure date.** For purposes of this section, the term "disclosure date" means the earlier of:

(1) the first date on which an electioneering communication is publicly distributed, provided that the person making the electioneering communication has made disbursements for the direct costs of producing or distributing one or more electioneering communication aggregating in excess of $1,500; or

(2) any other date during the same calendar year on which an electioneering communication is publicly distributed, provided that the person making the electioneering communication has made disbursements for the direct costs of distributing one or more electioneering communications aggregating in excess of $1,500 since the most recent disclosure date.

Subd. 6. **Contracts to disburse.** For purposes of this section, a person shall be treated as having made a disbursement if the person has entered into an obligation to make the disbursement.

Subd. 7. **Statement of attribution.** (a) An electioneering communication must include a statement of attribution.

(1) For communications distributed by printed material, signs, and billboards, the statement must say, in conspicuous letters: "Paid for by [association name] [address]."

(2) For communications distributed by television, radio, satellite, or cable broadcasting system, the statement must be included at the end of the communication and must orally state at a volume and speed that a person of ordinary hearing can comprehend: "The preceding communication was paid for by the [association name]."

(3) For communications distributed by telephone communication, the statement must precede the communication and must orally state at a volume and speed that a person of ordinary hearing can comprehend: "The following communication is paid for by the [association name]."

(b) If the communication is paid for by an association registered with the board, the statement of attribution must use the association's name as it is registered with the board. If the communication is paid for by an association not registered with the board, the statement of attribution must use the association's name as it is disclosed to the board on the association's disclosure statement associated with the communication.

Subd. 8. **Failure to file; penalty.** (a) If a person fails to file a statement required by this section by the date the statement is due, the board may impose a late filing fee of $50 per day, not to exceed $1,000, commencing the day after the report was due.

(b) The board must send notice by certified mail to a person who fails to file a statement within ten business days after the statement was due that the person may be subject to a civil penalty for failure to file the statement. A person who fails to file the statement within seven days after the certified mail notice was sent by the board is subject to a civil penalty imposed by the board of up to $1,000.

(c) An association that provides disclosure under section 10A.20 rather than under this section is subject to the late filing fee and civil penalty provisions of section 10A.20 and is not subject to the penalties provided in this subdivision.

(d) An association that makes electioneering communications under this section and willfully fails to provide the statement required by subdivision 4, paragraph (b), clause (6), within the time specified is subject to an additional civil penalty of up to four times the amount of the electioneering communications disbursements that should have been included on the statement.

Sec. 35. Minnesota Statutes 2012, section 10A.241, is amended to read:

10A.241 TRANSFER OF DEBTS.

~~Notwithstanding section 10A.24,~~ A candidate may terminate the candidate's principal campaign committee for one state office by transferring any debts of that committee to the candidate's principal campaign committee for another state office if all outstanding unpaid bills or loans from the committee being terminated are assumed and continuously reported by the committee to which the transfer is being made until paid or forgiven. A loan that is forgiven is covered by section 10A.20 and~~, for purposes of section 10A.324,~~ is a contribution to the principal campaign committee from which the debt was transferred under this section.

Sec. 36. **[10A.243] TERMINATION OF REGISTRATION.**

Subdivision 1. **Termination report.** A political committee, political fund, principal campaign committee, or party unit may terminate its registration with the board after it has disposed of all its assets in excess of $100 by filing a final report of receipts and expenditures. The final report must be identified as a termination report and must include all financial transactions that occurred after the last date included on the most recent report filed with the board. The termination report may be filed at any time after the asset threshold in this section is reached.

Subd. 2. **Asset disposition.** "Assets" include credit balances at vendors, prepaid postage and postage stamps, as well as physical assets. Assets must be disposed of at their fair market value. Assets of a political fund that consist of, or were acquired using, only the general treasury money of the fund's supporting association remain the property of the association upon termination of the association's political fund registration and are not subject to the disposal requirements of this section.

Sec. 37. **[10A.244] VOLUNTARY INACTIVE STATUS; POLITICAL FUNDS.**

Subdivision 1. **Election of voluntary inactive status.** An association that has a political fund registered under this chapter may elect to have the fund placed on voluntary inactive status if the following conditions are met:

(1) the association makes a written request for inactive status;

(2) the association has filed all periodic reports required by this chapter and has received no contributions into its political fund and made no expenditures or disbursements for electioneering communications through its political fund since the last date included on the association's most recent report; and

(3) the association has satisfied all obligations to the state for late filing fees and civil penalties imposed by the board or the board has waived this requirement.

Subd. 2. **Effect of voluntary inactive status.** After an association has complied with the requirements of subdivision 1:

(1) the board must notify the association that its political fund has been placed in voluntary inactive status and of the terms of this section;

(2) the board must stop sending the association reports, forms, and notices of report due dates that are periodically sent to entities registered with the board;

(3) the association is not required to file periodic disclosure reports for its political fund as otherwise required under this chapter;

(4) the association may not accept contributions into its political fund and may not make expenditures, contributions, or disbursements for electioneering communications through its political fund; and

(5) if the association maintains a separate depository account for its political fund, it may continue to pay bank service charges and receive interest paid on that account while its political fund is in inactive status.

Subd. 3. **Resumption of active status or termination.** (a) An association that has placed its political fund in voluntary inactive status may resume active status upon written notice to the board.

(b) A political fund placed in voluntary inactive status must resume active status within 14 days of the date that it has accepted contributions or made expenditures, contributions, or disbursements for electioneering communications that aggregate more than $750 since the political fund was placed on inactive status. If, after meeting this threshold, the association does not notify the board that its fund has resumed active status, the board may place the association's political fund in active status and notify the association of the change in status.

(c) An association that has placed its political fund in voluntary inactive status may terminate the registration of the fund without returning it to active status.

Subd. 4. **Penalty for financial activity while in voluntary inactive status.** If an association fails to notify the board of its political fund's resumption of active status under subdivision 3, the board may impose a civil penalty of $50 per day, not to exceed $1,000 commencing on the 15th calendar day after the fund resumed active status.

Sec. 38. **[10A.245] ADMINISTRATIVE TERMINATION OF INACTIVE COMMITTEES AND FUNDS.**

Subdivision 1. **Inactivity defined.** (a) A principal campaign committee becomes inactive on the later of the following dates:

(1) six years after the last election in which the individual for whom the committee exists was a candidate for the office sought or held at the time the principal campaign committee registered with the board; or

(2) six years after the last day on which the individual for whom the committee exists served in an elective office subject to this chapter.

(b) A political committee, political fund, or party unit becomes inactive when four years have elapsed since the end of a reporting period during which the political committee, political fund, or party unit made an expenditure or disbursement requiring itemized disclosure under this chapter.

(c) A political fund that has elected voluntary inactive status under section 10A.244 becomes inactive within the meaning of this section when four years have elapsed during which the political fund was continuously in voluntary inactive status.

Subd. 2. **Termination by board.** The board may terminate the registration of a principal campaign committee, party unit, political committee, or political fund found to be inactive under this section 60 days after sending written notice of inactivity by certified mail to the affected association at the last address on record with the board for that association. Within 60 days after the board sends notice under this section, the affected association must dispose of its assets as provided in this subdivision. The assets of the principal campaign committee, party unit, or political committee must be used for the purposes authorized by this chapter or section 211B.12 or must be liquidated and deposited in the general account of the state elections campaign account. The assets of an association's political fund that were derived from the association's general treasury money revert to the association's general treasury. Assets of a political fund that resulted from contributions to the political fund must be used for the purposes authorized by this chapter or section 211B.12 or must be liquidated and deposited in the general account of the state elections campaign account.

Sec. 39. **[10A.246] UNPAID DEBT UPON TERMINATION.**

Termination of a registration with the board does not affect the liability, if any, of the association or its candidates, officers, or other individuals for obligations incurred in the name of the association or its political fund.

Sec. 40. Minnesota Statutes 2012, section 10A.25, subdivision 2, is amended to read:

Subd. 2. **Amounts.** (a) In a ~~year in which an election is held for an office sought by a candidate~~ segment of an election cycle, the principal campaign committee of the candidate must not make campaign expenditures nor permit approved expenditures to be made on behalf of the candidate that result in aggregate expenditures in excess of the following:

(1) for governor and lieutenant governor, running together, ~~$2,577,200~~ $3,500,000 in the election segment and $1,500,000 in the nonelection segment;

(2) for attorney general, ~~$429,600~~ $600,000 in the election segment and $200,000 in the nonelection segment;

(3) for secretary of state and state auditor, separately, ~~$214,800~~ $300,000 in the election segment and $100,000 in the nonelection segment;

(4) for state senator, ~~$68,100~~ $90,000 in the election segment and $30,000 in a non-election segment;

(5) for state representative, ~~$34,300~~ $60,000 in the election segment.

(b) In addition to the amount in paragraph (a), clause (1), a candidate for endorsement for the office of lieutenant governor at the convention of a political party may make campaign expenditures and approved expenditures of five percent of that amount to seek endorsement.

(c) If a special election cycle occurs during a general election cycle, expenditures by or on behalf of a candidate in the special election do not count as expenditures by or on behalf of the candidate in the general election.

(d) The expenditure limits in this subdivision for an office are increased by ten percent for a candidate who ~~is running for that~~ has not previously held the same office ~~for the first time~~, whose name has not previously been on the primary or general election ballot for that office, and who has not in the past ten years raised or spent more than $750 in a run ~~previously~~ for any other office whose territory now includes a population that is more than one-third of the population in the territory of the new office. In the case of a legislative candidate, the office is that of a member of the house of representatives or senate without regard to any specific district.

Sec. 41. Minnesota Statutes 2012, section 10A.25, subdivision 2a, is amended to read:

Subd. 2a. **Aggregated expenditures.** If a candidate makes expenditures from more than one principal campaign committee for nomination or election to statewide office in the same segment of an election ~~year~~ cycle, the amount of expenditures from all of the candidate's principal campaign committees for statewide office for that segment of the election ~~year~~ cycle must be aggregated for purposes of applying the limits on expenditures under subdivision 2.

Sec. 42. Minnesota Statutes 2012, section 10A.25, subdivision 3, is amended to read:

Subd. 3. **Governor and lieutenant governor a single candidate.** For the purposes of ~~sections 10A.11 to 10A.34~~ this chapter, a candidate for governor and a candidate for lieutenant governor, running together, are considered a single candidate. Except as provided in subdivision 2, paragraph (b), ~~All~~all expenditures made by or all approved expenditures made on behalf of the candidate for lieutenant governor are considered to be expenditures by or approved expenditures on behalf of the candidate for governor.

Sec. 43. Minnesota Statutes 2012, section 10A.25, subdivision 3a, is amended to read:

Subd. 3a. **Independent expenditures and electioneering communications.** The principal campaign committee of a candidate must not make independent expenditures or disbursements for electioneering communications.

Sec. 44. Minnesota Statutes 2012, section 10A.257, subdivision 1, is amended to read:

Subdivision 1. **Unused funds.** After all campaign expenditures and noncampaign disbursements for an election cycle have been made, an amount up to ~~50~~ 25 percent of the election ~~year~~ cycle expenditure limit for the office may be carried forward. Any remaining amount up to the total amount of the public subsidy from the state elections campaign fund must be returned to the state treasury for credit to the general fund under section 10A.324. Any remaining amount in excess of the total public subsidy must be contributed to the state elections campaign ~~fund~~ account or a political party for multicandidate expenditures as defined in section 10A.275.

Sec. 45. Minnesota Statutes 2012, section 10A.27, subdivision 1, is amended to read:

Subdivision 1. **Contribution limits.** (a) Except as provided in subdivision 2, a candidate must not permit the candidate's principal campaign committee to accept aggregate contributions made or delivered by any individual, political committee, or political fund in excess of the following:

(1) to candidates for governor and lieutenant governor running together, ~~$2,000~~ $4,000 in the election segment of an election ~~year~~ cycle for the office sought and ~~$500~~ $2,000 in ~~other years~~ the nonelection segment of the election cycle;

(2) to a candidate for attorney general, ~~secretary of state, or state auditor, $1,000~~ $2,500 in the election segment of an election ~~year~~ cycle for the office sought and ~~$200~~ $1,500 in ~~other years~~ the nonelection segment of the election cycle;

(3) to a candidate for secretary of state or state auditor, $2,000 in the election segment of an election cycle and $1,000 in the nonelection segment of the election cycle;

~~(3)~~ (4) to a candidate for state senator, ~~$500~~ $1,000 in the election segment of an election ~~year~~ cycle for the office sought and ~~$100~~ $500 in ~~other years~~ a nonelection segment of the election cycle;

~~(4)~~ (5) to a candidate for state representative, ~~$500~~ $1,000 in the election segment of an election ~~year~~ cycle for the office sought ~~and $100 in the other year~~; and

~~(5)~~ (6) to a candidate for judicial office, ~~$2,000~~ $2,500 in the election segment of an election ~~year~~ cycle for the office sought and ~~$500~~ $1,000 in ~~other years~~ a nonelection segment of the election cycle.

(b) The following deliveries are not subject to the bundling limitation in this subdivision:

(1) delivery of contributions collected by a member of the candidate's principal campaign committee, such as a block worker or a volunteer who hosts a fund-raising event, to the committee's treasurer; and

(2) a delivery made by an individual on behalf of the individual's spouse.

(c) A lobbyist, political committee, political party unit, ~~or~~ political fund, or an association not registered with the board must not make a contribution a candidate is prohibited from accepting.

Sec. 46. Minnesota Statutes 2012, section 10A.27, subdivision 10, is amended to read:

Subd. 10. **Limited personal contributions.** A candidate who ~~accepts a public subsidy~~ signs an agreement under section 10A.322 may not contribute to the candidate's own campaign during a ~~year~~ segment of an election cycle more than ~~ten~~ five times the candidate's ~~election year~~ contribution limit for that segment under subdivision 1.

Sec. 47. Minnesota Statutes 2012, section 10A.27, subdivision 11, is amended to read:

Subd. 11. **Contributions from certain types of contributors.** A candidate must not permit the candidate's principal campaign committee to accept a contribution from a political committee, political fund, lobbyist, ~~or~~ large contributor, or association not registered with the board if the contribution will cause the aggregate contributions from those types of contributors during an election cycle segment to exceed an amount equal to 20 percent of the election cycle segment expenditure limits for the office sought by the candidate, provided that the 20 percent limit must be rounded to the nearest $100. For purposes of this subdivision, "large contributor" means an individual, other than the candidate, who contributes an amount that is ~~more than $100 and~~ more than one-half the amount an individual may contribute during the election cycle segment.

Sec. 48. Minnesota Statutes 2012, section 10A.27, subdivision 13, is amended to read:

Subd. 13. **Unregistered association limit; statement; penalty.** (a) The treasurer of a political committee, political fund, principal campaign committee, or party unit must not accept a contribution of more than ~~$100~~ $200 from an association not registered under this chapter unless the contribution is accompanied by a written statement that meets the disclosure and reporting period requirements imposed by section 10A.20. This statement must be certified as true and correct by an officer of the contributing association. The committee, fund, or party unit that accepts the contribution must include a copy of the statement with the report that discloses the contribution to the board. ~~This subdivision does not apply when a national political party contributes money to its affiliate in this state.~~

(b) An unregistered association may provide the written statement required by this subdivision to no more than three committees, funds, or party units in a calendar year. Each statement must cover at least the 30 days immediately preceding and including the date on which the contribution was made. An unregistered association or an officer of it is subject to a civil penalty imposed by the board of up to $1,000, if the association or its officer:

(1) fails to provide a written statement as required by this subdivision; or

(2) fails to register after giving the written statement required by this subdivision to more than three committees, funds, or party units in a calendar year.

(c) The treasurer of a political committee, political fund, principal campaign committee, or party unit who accepts a contribution in excess of ~~$100~~ $200 from an unregistered association without the required written disclosure statement is subject to a civil penalty up to four times the amount in excess of ~~$100~~ $200.

(d) This subdivision does not apply:

(1) when a national political party contributes money to its state committee; or

(2) to purchases by candidates for federal office of tickets to events or space rental at events held by party units in this state (i) if the geographical area represented by the party unit includes any part of the geographical area of the office that the federal candidate is seeking and (ii) the purchase price is not more than that paid by other attendees or renters of similar spaces.

Sec. 49. Minnesota Statutes 2012, section 10A.27, subdivision 14, is amended to read:

Subd. 14. **Contributions of business revenue.** An association may, if not prohibited by other law, contribute revenue from the operation of a business to an independent expenditure or ballot question political committee or ~~an independent expenditure political~~ fund without complying with subdivision 13.

Sec. 50. Minnesota Statutes 2012, section 10A.27, subdivision 15, is amended to read:

Subd. 15. **Contributions ~~of dues or contribution revenue~~ or use of general treasury money.** (a) An association may, if not prohibited by other law, contribute ~~revenue from membership dues or fees, or from contributions received by the association~~ its general treasury money to an independent expenditure or ballot question political committee or ~~an independent expenditure political~~ fund, including its own independent expenditure or ballot question political committee or fund, without complying with subdivision 13.

(b) Before the day when the recipient committee or fund's next report must be filed with the board under section 10A.20, subdivision 2 or 5, an association that has contributed more than $5,000 ~~or more~~ in aggregate to independent expenditure political committees or funds during the calendar year or has contributed more than $5,000 in aggregate to ballot question political committees or funds during the calendar year must provide in writing to the recipient's treasurer a statement that includes the name, address, and amount attributable to each ~~individual or association~~ person that paid the association dues or fees, or made ~~contributions~~ donations to the association that, in total, aggregate ~~$1,000 or more~~ more than $5,000 of the contribution from the association to the independent expenditure or ballot question political committee or fund. The statement must also include the total amount of the contribution ~~from individuals or associations~~ attributable to persons not subject to itemization under this section. The statement must be certified as true ~~and correct~~ by an officer of the donor association.

~~(b)~~ (c) To determine the amount of membership dues or fees, or ~~contributions~~ donations made by ~~an individual or association that exceed $1,000 of the contribution made by the donor association~~ a person to an association and attributable to the association's contribution to the independent expenditure or ballot question political committee or fund, the donor association must~~:~~ separately prorate the total independent expenditures and ballot question expenditures made during the calendar year over all general treasury money received during the calendar year.

~~(1) apply a pro rata calculation to all unrestricted dues, fees, and contributions received by the donor association in the calendar year; or~~

~~(2) as provided in paragraph (c), identify the specific individuals or associations whose dues, fees, or contributions are included in the contribution to the independent expenditure political committee or fund.~~

~~(c) Dues, fees, or contributions from an individual or association must be identified in a contribution to an independent expenditure political committee or fund under paragraph (b) , clause (2), if:~~

~~(1) the individual or association has specifically authorized the donor association to use the individual's or association's dues, fees, or contributions for this purpose; or~~

~~(2) the individual's or association's dues, fees, or contributions to the donor association are unrestricted and the donor association designates them as the source of the subject contribution to the independent expenditure political committee or fund.~~

(d) If the amount contributed to independent expenditure and ballot question political committees or funds in a calendar year exceeds the amount of general treasury money received by the association during that year:

(1) the contributions must be attributed first to all receipts of general treasury money received during the calendar year in which the contributions were made;

(2) any amount of current-year contributions that exceeds the total of all receipts of general treasury money during the current calendar year must be prorated over all general treasury money received in the preceding calendar year; and

(3) if the allocation made in clauses (1) and (2) is insufficient to cover the subject contributions, no further allocation is required.

(e) After a portion of ~~an individual's or association's dues, fees, or contributions to the donor association have~~ the general treasury money received by an association from a person has been designated as the source of a contribution to an independent expenditure or ballot question political committee or fund, that portion of the ~~individual's or association's dues, fees, or contributions to the donor association~~ association's general treasury money received from that person may not be designated as the source of any other contribution to an independent expenditure or ballot question political committee or fund or as the source of funds for a disbursement for electioneering communications made by that association.

~~(d) For the purposes of this section, "donor association" means the association contributing to an independent expenditure political committee or fund that is required to provide a statement under paragraph (a).~~

Sec. 51. Minnesota Statutes 2012, section 10A.323, is amended to read:

10A.323 AFFIDAVIT OF CONTRIBUTIONS.

(a) In addition to the requirements of section 10A.322, to be eligible to receive a public subsidy under section 10A.31 a candidate or the candidate's treasurer must ~~file an affidavit with the board stating that~~:

(1) between January 1 of the previous year and the cutoff date for transactions included in the report of receipts and expenditures due before the primary election ~~the candidate has accumulated~~, accumulate contributions from ~~persons~~ individuals eligible to vote in this state in at least the amount indicated for the office sought, counting only the first $50 received from each contributor, excluding in-kind contributions:

~~(1)~~ (i) candidates for governor and lieutenant governor running together, $35,000;

~~(2)~~ (ii) candidates for attorney general, $15,000;

~~(3)~~ (iii) candidates for secretary of state and state auditor, separately, $6,000;

~~(4)~~ (iv) candidates for the senate, $3,000; and

~~(5)~~ (v) candidates for the house of representatives, $1,500~~.~~;

(2) the candidate or the candidate's treasurer must file an affidavit with the board stating that the principal campaign committee has complied with this paragraph. The affidavit must state the total amount of contributions that have been received from ~~persons~~ individuals eligible to vote in this state, ~~disregarding~~ excluding:

(i) the portion of any contribution in excess of $50~~.~~;

(ii) any in-kind contribution; and

(iii) any contribution for which the name and address of the contributor is not known and recorded; and

(3) the candidate or the candidate's treasurer must submit the affidavit required by this section to the board in writing by the deadline for reporting of receipts and expenditures before a primary under section 10A.20, subdivision 4.

(b) A candidate for a vacancy to be filled at a special election for which the filing period does not coincide with the filing period for the general election must accumulate the contributions specified in paragraph (a) and must submit the affidavit required by this section to the board within five days after the close of the filing period for the special election for which the candidate filed.

Sec. 52. Minnesota Statutes 2012, section 211B.32, subdivision 1, is amended to read:

Subdivision 1. **Administrative remedy; exhaustion.** (a) Except as provided in paragraph (b), a complaint alleging a violation of chapter 211A or 211B must be filed with the office. The complaint must be finally disposed of by the office before the alleged violation may be prosecuted by a county attorney.

(b) Complaints arising under those sections and related to those individuals and associations specified in section 10A.02, subdivision 11, paragraph (a), must be filed with the Campaign Finance and Public Disclosure Board.

Sec. 53. **REPEALER.**

Minnesota Statutes 2012, sections 10A.24; 10A.242; and 10A.25, subdivision 6, are repealed.

Sec. 54. **EFFECTIVE DATE.**

This article is effective the day following final enactment.

ARTICLE 2

TECHNICAL CHANGES

Section 1. Minnesota Statutes 2012, section 10A.01, subdivision 35, is amended to read:

Subd. 35. **Public official.** "Public official" means any:

(1) member of the legislature;

(2) individual employed by the legislature as secretary of the senate, legislative auditor, chief clerk of the house of representatives, revisor of statutes, or researcher, legislative analyst, fiscal analyst, or attorney in the Office of Senate Counsel ~~and~~, Research ~~or~~, and Fiscal Analysis, House Research, or the House Fiscal Analysis Department;

(3) constitutional officer in the executive branch and the officer's chief administrative deputy;

(4) solicitor general or deputy, assistant, or special assistant attorney general;

(5) commissioner, deputy commissioner, or assistant commissioner of any state department or agency as listed in section 15.01 or 15.06, or the state chief information officer;

(6) member, chief administrative officer, or deputy chief administrative officer of a state board or commission that has either the power to adopt, amend, or repeal rules under chapter 14, or the power to adjudicate contested cases or appeals under chapter 14;

(7) individual employed in the executive branch who is authorized to adopt, amend, or repeal rules under chapter 14 or adjudicate contested cases under chapter 14;

(8) executive director of the State Board of Investment;

(9) deputy of any official listed in clauses (7) and (8);

(10) judge of the Workers' Compensation Court of Appeals;

(11) administrative law judge or compensation judge in the State Office of Administrative Hearings or unemployment law judge in the Department of Employment and Economic Development;

(12) member, regional administrator, division director, general counsel, or operations manager of the Metropolitan Council;

(13) member or chief administrator of a metropolitan agency;

(14) director of the Division of Alcohol and Gambling Enforcement in the Department of Public Safety;

(15) member or executive director of the Higher Education Facilities Authority;

(16) member of the board of directors or president of Enterprise Minnesota, Inc.;

(17) member of the board of directors or executive director of the Minnesota State High School League;

(18) member of the Minnesota Ballpark Authority established in section 473.755;

(19) citizen member of the Legislative-Citizen Commission on Minnesota Resources;

(20) manager of a watershed district, or member of a watershed management organization as defined under section 103B.205, subdivision 13;

(21) supervisor of a soil and water conservation district;

(22) director of Explore Minnesota Tourism;

(23) citizen member of the Lessard-Sams Outdoor Heritage Council established in section 97A.056;

(24) citizen member of the Clean Water Council established in section 114D.30; or

(25) member or chief executive of the Minnesota Sports Facilities Authority established in section 473J.07.

Sec. 2. Minnesota Statutes 2012, section 10A.025, subdivision 4, is amended to read:

Subd. 4. **Changes and corrections.** Material changes in information previously submitted and corrections to a report or statement must be reported in writing to the board within ten days following the date of the event prompting the change or the date upon which the person filing became aware of the inaccuracy. The change or correction must identify the form and the paragraph containing the information to be changed or corrected.

A person who willfully fails to report a material change or correction ~~is guilty of a gross misdemeanor and~~ is subject to a civil penalty imposed by the board of up to $3,000. A willful violation of this subdivision is a gross misdemeanor.

The board must send a notice by certified mail to any individual who fails to file a report required by this subdivision. If the individual fails to file the required report within ten business days after the notice was sent, the board may impose a late filing fee of $5 per day up to $100 starting on the

11th day after the notice was sent. The board must send an additional notice by certified mail to an individual who fails to file a report within 14 days after the first notice was sent by the board that the individual may be subject to a civil penalty for failure to file a report. An individual who fails to file a report required by this subdivision within seven days after the second notice was sent by the board is subject to a civil penalty imposed by the board of up to $1,000.

Sec. 3. Minnesota Statutes 2012, section 10A.04, subdivision 5, is amended to read:

Subd. 5. **Late filing.** If a lobbyist or principal fails to file a report required by this section ~~within ten business days after~~ by the date the report was due, the board may impose a late filing fee of ~~$5~~ $25 per day, not to exceed ~~$100~~ $1,000, commencing ~~with~~ the ~~11th~~ day after the report was due. The board must send notice by certified mail to any lobbyist or principal who fails to file a report within ten business days after the report was due that the lobbyist or principal may be subject to a civil penalty for failure to file the report or pay the fee. A lobbyist or principal who fails to file a report or statement or pay a fee within seven days after the certified mail notice was sent by the board is subject to a civil penalty imposed by the board of up to $1,000.

Sec. 4. Minnesota Statutes 2012, section 10A.16, is amended to read:

10A.16 EARMARKING CONTRIBUTIONS PROHIBITED.

An individual, political committee, political fund, principal campaign committee, or party unit may not solicit or accept a contribution from any source with the express or implied condition that the contribution or any part of it be directed to a particular candidate other than the initial recipient. An individual, political committee, political fund, principal campaign committee, or party unit that knowingly accepts any earmarked contribution is ~~guilty of a gross misdemeanor and~~ subject to a civil penalty imposed by the board of up to $3,000. Knowingly accepting any earmarked contribution is a gross misdemeanor.

Sec. 5. Minnesota Statutes 2012, section 10A.20, subdivision 4, is amended to read:

Subd. 4. **Period of report.** A report must cover the period from January 1 of the reporting year to seven days before the filing date, except that the report due on January 31 must cover the period from ~~the last day covered by the previous report~~ January 1 to December 31 of the reporting year.

Sec. 6. Minnesota Statutes 2012, section 10A.20, subdivision 12, is amended to read:

Subd. 12. **Failure to file; penalty.** If an individual fails to file a report required by this section that is due January 31 ~~within ten business days after the report was due~~, the board may impose a late filing fee of $25 per day, not to exceed $1,000, commencing the day after the report was due.

If an individual fails to file a report required by this section that is due before a primary or general election ~~within three days after the date due, regardless of whether the individual has received any notice~~, the board may impose a late filing fee of $50 per day, not to exceed $1,000, commencing on the day after the date the statement was due.

The board must send notice by certified mail to an individual who fails to file a report within ten business days after the report was due that the individual may be subject to a civil penalty for failure to file the report. An individual who fails to file the report within seven days after the certified mail notice was sent by the board is subject to a civil penalty imposed by the board of up to $1,000.

Sec. 7. Minnesota Statutes 2012, section 10A.273, subdivision 1, is amended to read:

Subdivision 1. **Contributions during legislative session.** (a) A candidate for the legislature or for constitutional office, the candidate's principal campaign committee, or a political committee or party unit established by all or a part of the party organization within a house of the legislature, must not solicit or accept a contribution from a registered lobbyist, political committee, political fund, ~~or dissolving principal campaign committee~~ an association not registered with the board, or ~~from~~ a party unit established by the party organization within a house of the legislature, during a regular session of the legislature.

(b) A registered lobbyist, political committee, political fund, ~~or dissolving principal campaign committee~~ an association not registered with the board, or a party unit established by the party organization within a house of the legislature, must not make a contribution to a candidate for the legislature or for constitutional office, the candidate's principal campaign committee, or a political committee or party unit established by all or a part of the party organization within a house of the legislature during a regular session of the legislature.

Sec. 8. Minnesota Statutes 2012, section 10A.273, subdivision 4, is amended to read:

Subd. 4. **Civil penalty.** A candidate, political committee, party unit, political fund, ~~principal campaign committee~~ an association not registered with the board, or a registered lobbyist that violates this section is subject to a civil penalty imposed by the board of up to $1,000. If the board makes a public finding that there is probable cause to believe a violation of this section has occurred, the board ~~must~~ may bring an action, or transmit the finding to a county attorney who must bring an action, in the District Court of Ramsey County, to collect a civil penalty as imposed by the board. Penalties paid under this section must be deposited in the general fund in the state treasury.

Sec. 9. Minnesota Statutes 2012, section 10A.30, is amended to read:

10A.30 STATE ELECTIONS CAMPAIGN ~~FUND~~ ACCOUNT.

Subdivision 1. **Establishment.** An account is established in the special revenue fund of the state known as the "state elections campaign ~~fund~~ account."

Subd. 2. **Separate account.** Within the state elections campaign ~~fund~~ account there must be maintained a separate political party account for the state committee and the candidates of each political party and a general account.

Subd. 3. **Special elections account.** An account is established in the special revenue fund of the state known as the "state special elections campaign account."

Sec. 10. Minnesota Statutes 2012, section 10A.31, subdivision 7, is amended to read:

Subd. 7. **Distribution of general account.** (a) As soon as the board has obtained the results of the primary election from the secretary of state, but no later than one week after certification of the primary results by the State Canvassing Board, the board must distribute the available money in the general account, as certified by the commissioner of revenue ~~on September 1~~ one week before the state primary and according to allocations set forth in subdivision 5, in equal amounts to all candidates of a major political party whose names are to appear on the ballot in the general election and who:

(1) have signed a spending limit agreement under section 10A.322;

(2) have filed the affidavit of contributions required by section 10A.323; and

(3) were opposed in either the primary election or the general election.

(b) The public subsidy under this subdivision may not be paid in an amount that would cause the sum of the public subsidy paid from the party account plus the public subsidy paid from the general account to exceed 50 percent of the expenditure limit for the candidate or 50 percent of the expenditure limit that would have applied to the candidate if the candidate had not been freed from expenditure limits under section 10A.25, subdivision 10. Money from the general account not paid to a candidate because of the 50 percent limit must be distributed equally among all other qualifying candidates for the same office until all have reached the 50 percent limit or the balance in the general account is exhausted.

~~(c) A candidate must expend or become obligated to expend at least an amount equal to 50 percent of the money distributed by the board under this subdivision no later than the end of the final reporting period preceding the general election. Otherwise, the candidate must repay to the board the difference between the amount the candidate spent or became obligated to spend by the deadline and the amount distributed to the candidate under this subdivision. The candidate must make the repayment no later than six months following the general election. The candidate must reimburse the board for all reasonable costs, including litigation costs, incurred in collecting any amount due.~~

~~If the board determines that a candidate has failed to repay money as required by this paragraph, the board may not distribute any additional money to the candidate until the entirety of the repayment has been made.~~

Sec. 11. Minnesota Statutes 2012, section 10A.315, is amended to read:

10A.315 SPECIAL ELECTION SUBSIDY.

(a) Each eligible candidate for a legislative office in a special election must be paid a public subsidy equal to the sum of:

(1) the party account money at the last general election for the candidate's party for the office the candidate is seeking; and

(2) the general account money paid to a candidate for the same office at the last general election.

(b) A candidate who wishes to receive this public subsidy must submit a signed agreement under section 10A.322 to the board and must meet the contribution requirements of section 10A.323. The special election subsidy must be distributed in the same manner as money in the party and general accounts is distributed to legislative candidates in a general election.

(c) The amount necessary to make the payments required by this section is appropriated from the general fund ~~to the board~~ for transfer to the state special elections campaign account for distribution by the board as set forth in this section.

Sec. 12. Minnesota Statutes 2012, section 10A.322, subdivision 4, is amended to read:

Subd. 4. **Refund receipt forms; penalty.** The board must make available to a political party on request and to any candidate for whom an agreement under this section is effective, a supply of official refund receipt forms that state in boldface type that:

(1) a contributor who is given a receipt form is eligible to claim a refund as provided in section 290.06, subdivision 23~~.~~; and

(2) if the contribution is to a candidate, that the candidate has signed an agreement to limit campaign expenditures as provided in this section.

The forms must provide duplicate copies of the receipt to be attached to the contributor's claim. ~~A candidate who does not sign an agreement under this section and who willfully issues~~ The willful issuance of an official refund receipt form or a facsimile of one to any of the candidate's contributors by a candidate or treasurer of a candidate who did not sign an agreement under this section is ~~guilty of~~ a misdemeanor.

Sec. 13. **EFFECTIVE DATE.**

This article is effective the day following final enactment.

ARTICLE 3

TECHNICAL CONFORMING CHANGES

Section 1. Minnesota Statutes 2012, section 10A.242, subdivision 1, is amended to read:

Subdivision 1. **Dissolution required.** A political committee, political fund, or principal campaign committee must be dissolved within 60 days after receiving notice from the board that the committee or fund has become inactive. The assets of the committee or fund must be spent for the purposes authorized by section 211B.12 and other applicable law or liquidated and deposited in the general account of the state elections campaign ~~fund~~ account within 60 days after the board notifies the committee or fund that it has become inactive.

Sec. 2. Minnesota Statutes 2012, section 10A.27, subdivision 9, is amended to read:

Subd. 9. **Contributions to and from other candidates.** (a) A candidate or the treasurer of a candidate's principal campaign committee must not accept a contribution from another candidate's principal campaign committee or from any other committee bearing the contributing candidate's name or title or otherwise authorized by the contributing candidate, unless the contributing candidate's principal campaign committee is being dissolved. A candidate's principal campaign committee must not make a contribution to another candidate's principal campaign committee, except when the contributing committee is being dissolved.

(b) A principal campaign committee that makes a contribution to another principal campaign committee must provide with the contribution a written statement of the committee's intent to dissolve and terminate its registration within 12 months after the contribution was made. If the committee fails to dissolve and terminate its registration by that time, the board may levy a civil penalty up to four times the size of the contribution against the contributing committee. A contribution from a terminating principal campaign committee that is not accepted by another principal campaign committee must be forwarded to the board for deposit in the general account of the state elections campaign ~~fund~~ account.

(c) A candidate's principal campaign committee must not accept a contribution from, or make a contribution to, a committee associated with a person who seeks nomination or election to the office of president, senator, or representative in Congress of the United States.

(d) A candidate or the treasurer of a candidate's principal campaign committee must not accept a contribution from a candidate for political subdivision office in any state, unless the contribution is from the personal funds of the candidate for political subdivision office. A candidate or the treasurer

of a candidate's principal campaign committee must not make a contribution from the principal campaign committee to a candidate for political subdivision office in any state.

Sec. 3. Minnesota Statutes 2012, section 10A.31, subdivision 1, is amended to read:

Subdivision 1. **Designation.** An individual resident of this state who files an income tax return or a renter and homeowner property tax refund return with the commissioner of revenue may designate on their original return that $5 be paid from the general fund of the state into the state elections campaign ~~fund~~ account. If a husband and wife file a joint return, each spouse may designate that $5 be paid. No individual is allowed to designate $5 more than once in any year. The taxpayer may designate that the amount be paid into the account of a political party or into the general account.

Sec. 4. Minnesota Statutes 2012, section 10A.31, subdivision 4, is amended to read:

Subd. 4. **Appropriation.** (a) The amounts designated by individuals for the state elections campaign ~~fund~~ account, less three percent, are appropriated from the general fund, must be transferred and credited to the appropriate account in the state elections campaign ~~fund~~ account, and are annually appropriated for distribution as set forth in subdivisions 5, 5a, 6, and 7. The remaining three percent must be kept in the general fund for administrative costs.

(b) In addition to the amounts in paragraph (a), $1,020,000 for each general election is appropriated from the general fund for transfer to the general account of the state elections campaign ~~fund~~ account.

Sec. 5. Minnesota Statutes 2012, section 10A.321, subdivision 1, is amended to read:

Subdivision 1. **Calculation and certification of estimates.** The commissioner of revenue must calculate and certify to the board one week before the first day for filing for office in each election year an estimate of the total amount in the state general account of the state elections campaign ~~fund~~ account and the amount of money each candidate who qualifies, as provided in section 10A.31, subdivisions 6 and 7, may receive from the candidate's party account in the state elections campaign ~~fund~~ account. This estimate must be based upon the allocations and formulas in section 10A.31, subdivisions 5 and 5a, any necessary vote totals provided by the secretary of state to apply the formulas in section 10A.31, subdivisions 5 and 5a, and the amount of money expected to be available after 100 percent of the tax returns have been processed.

Sec. 6. Minnesota Statutes 2012, section 10A.324, subdivision 1, is amended to read:

Subdivision 1. **When return required.** A candidate must return all or a portion of the public subsidy received from the state elections campaign ~~fund~~ account or the public subsidy received under section 10A.315, under the circumstances in this section or section 10A.257, subdivision 1.

To the extent that the amount of public subsidy received exceeds the aggregate of: (1) actual expenditures made by the principal campaign committee of the candidate; and (2) approved expenditures made on behalf of the candidate, the treasurer of the candidate's principal campaign committee must return an amount equal to the difference to the board. The cost of postage that was not used during an election cycle and payments that created credit balances at vendors at the close of an election cycle are not considered expenditures for purposes of determining the amount to be returned. Expenditures in excess of the candidate's spending limit do not count in determining aggregate expenditures under this paragraph.

Sec. 7. Minnesota Statutes 2012, section 211B.37, is amended to read:

211B.37 COSTS ASSESSED.

Except as otherwise provided in section 211B.36, subdivision 3, the chief administrative law judge shall assess the cost of considering complaints filed under section 211B.32 as provided in this section. Costs of complaints relating to a statewide ballot question or an election for a statewide or legislative office must be assessed against the appropriation from the general fund to the general account of the state elections campaign ~~fund~~ account in section 10A.31, subdivision 4. Costs of complaints relating to any other ballot question or elective office must be assessed against the county or counties in which the election is held. Where the election is held in more than one county, the chief administrative law judge shall apportion the assessment among the counties in proportion to their respective populations within the election district to which the complaint relates according to the most recent decennial federal census.

Sec. 8. **EFFECTIVE DATE.**

This article is effective the day following final enactment."

Amend the title numbers accordingly

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

Senator Bakk, from the Committee on Rules and Administration, to which was referred

H.F. No. 92 for comparison with companion Senate File, reports the following House File was found not identical with companion Senate File as follows:

GENERAL ORDERS		CONSENT CALENDAR		CALENDAR	
H.F. No.	**S.F. No.**	**H.F. No.**	**S.F. No.**	**H.F. No.**	**S.F. No.**
92	3				

Pursuant to Rule 45, the Committee on Rules and Administration recommends that H.F. No. 92 be amended as follows:

Delete all the language after the enacting clause of H.F. No. 92, the fourth engrossment; and insert the language after the enacting clause of S.F. No. 3, the first engrossment; further, delete the title of H.F. No. 92, the fourth engrossment; and insert the title of S.F. No. 3, the first engrossment.

And when so amended H.F. No. 92 will be identical to S.F. No. 3, and further recommends that H.F. No. 92 be given its second reading and substituted for S.F. No. 3, and that the Senate File be indefinitely postponed.

Pursuant to Rule 45, this report was prepared and submitted by the Secretary of the Senate on behalf of the Committee on Rules and Administration. Amendments adopted. Report adopted.

Senator Bakk, from the Committee on Rules and Administration, to which was referred

H.F. No. 634 for comparison with companion Senate File, reports the following House File was found not identical with companion Senate File as follows:

GENERAL ORDERS		CONSENT CALENDAR		CALENDAR	
H.F. No.	S.F. No.	H.F. No.	S.F. No.	H.F. No.	S.F. No.
634	1073				

Pursuant to Rule 45, the Committee on Rules and Administration recommends that H.F. No. 634 be amended as follows:

Delete all the language after the enacting clause of H.F. No. 634, the second engrossment; and insert the language after the enacting clause of S.F. No. 1073, the second engrossment; further, delete the title of H.F. No. 634, the second engrossment; and insert the title of S.F. No. 1073, the second engrossment.

And when so amended H.F. No. 634 will be identical to S.F. No. 1073, and further recommends that H.F. No. 634 be given its second reading and substituted for S.F. No. 1073, and that the Senate File be indefinitely postponed.

Pursuant to Rule 45, this report was prepared and submitted by the Secretary of the Senate on behalf of the Committee on Rules and Administration. Amendments adopted. Report adopted.

Senator Bakk, from the Committee on Rules and Administration, to which was referred

H.F. No. 1117 for comparison with companion Senate File, reports the following House File was found not identical with companion Senate File as follows:

GENERAL ORDERS		CONSENT CALENDAR		CALENDAR	
H.F. No.	S.F. No.	H.F. No.	S.F. No.	H.F. No.	S.F. No.
1117	1077				

Pursuant to Rule 45, the Committee on Rules and Administration recommends that H.F. No. 1117 be amended as follows:

Delete all the language after the enacting clause of H.F. No. 1117, the third engrossment; and insert the language after the enacting clause of S.F. No. 1077, the third engrossment; further, delete the title of H.F. No. 1117, the third engrossment; and insert the title of S.F. No. 1077, the third engrossment.

And when so amended H.F. No. 1117 will be identical to S.F. No. 1077, and further recommends that H.F. No. 1117 be given its second reading and substituted for S.F. No. 1077, and that the Senate File be indefinitely postponed.

Pursuant to Rule 45, this report was prepared and submitted by the Secretary of the Senate on behalf of the Committee on Rules and Administration. Amendments adopted. Report adopted.

SECOND READING OF SENATE BILLS

S.F. No. 661 was read the second time.

SECOND READING OF HOUSE BILLS

H.F. Nos. 92, 634 and 1117 were read the second time.

INTRODUCTION AND FIRST READING OF SENATE BILLS

The following bills were read the first time.

Senator Weber introduced–

S.F. No. 1647: A bill for an act relating to legacy funding; appropriating money for the Fulda Heritage Society.

Referred to the Committee on Finance.

Senators Franzen, Latz, Metzen, Pratt and Fischbach introduced–

S.F. No. 1648: A bill for an act relating to business organizations; regulating the organization and operation of limited liability companies; enacting a revised uniform limited liability company act; providing conforming changes; amending Minnesota Statutes 2012, sections 48A.03, subdivision 4; 181.970, subdivision 2; 270C.721; 273.124, subdivision 8; 290.01, subdivision 3b; 302A.011, by adding subdivisions; 302A.115, subdivision 1; 302A.681; 302A.683; 302A.685; 302A.689; 302A.691; 308A.121, subdivision 1; 308B.801, subdivisions 1, 2, 5; 308B.805, subdivision 1; 308B.835, subdivision 2; 317A.115, subdivision 2; 319B.02, subdivisions 3, 22; 319B.10, subdivision 3; 321.0108; proposing coding for new law in Minnesota Statutes, chapter 302A; proposing coding for new law as Minnesota Statutes, chapter 322C; repealing Minnesota Statutes 2012, sections 302A.687; 322B.01; 322B.02; 322B.03, subdivisions 1, 2, 3, 6, 6a, 7, 8, 10, 11, 12, 13, 14, 15, 17, 17a, 17b, 18, 19, 19a, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 31a, 32, 33, 34, 35, 36, 36a, 37, 38, 39, 40, 41, 41a, 42, 43, 44, 45, 45a, 46, 47, 48, 49, 50, 51; 322B.04; 322B.10; 322B.105; 322B.11; 322B.115; 322B.12, subdivisions 1, 2, 3, 4, 5; 322B.125; 322B.13; 322B.135; 322B.14; 322B.145; 322B.15; 322B.155; 322B.16; 322B.165; 322B.17; 322B.175; 322B.18; 322B.20; 322B.21; 322B.22; 322B.23; 322B.30; 322B.303; 322B.306; 322B.31; 322B.313; 322B.316; 322B.32; 322B.323; 322B.326; 322B.33; 322B.333; 322B.336; 322B.34; 322B.343; 322B.346; 322B.348; 322B.35; 322B.353; 322B.356; 322B.36; 322B.363, subdivisions 1, 2, 3, 4, 5, 6, 7; 322B.366, subdivision 1; 322B.37; 322B.373; 322B.376; 322B.38; 322B.383; 322B.386; 322B.40; 322B.41; 322B.42; 322B.43; 322B.50; 322B.51; 322B.52; 322B.53; 322B.54; 322B.55; 322B.56; 322B.60; 322B.603; 322B.606; 322B.61; 322B.613; 322B.616; 322B.62; 322B.623; 322B.626; 322B.63; 322B.633; 322B.636; 322B.64; 322B.643; 322B.646; 322B.65; 322B.653; 322B.656; 322B.66; 322B.663; 322B.666; 322B.67; 322B.673; 322B.676; 322B.679; 322B.68; 322B.683; 322B.686; 322B.689; 322B.69; 322B.693; 322B.696; 322B.699; 322B.70; 322B.71; 322B.72; 322B.73; 322B.74; 322B.75; 322B.755; 322B.76; 322B.77; 322B.78; 322B.80; 322B.803; 322B.806; 322B.81; 322B.813; 322B.816, subdivisions 1, 2, 4, 5, 6; 322B.82; 322B.823; 322B.826; 322B.83; 322B.833; 322B.836; 322B.84; 322B.843; 322B.846; 322B.85; 322B.853; 322B.856; 322B.86; 322B.863; 322B.866; 322B.87; 322B.873, subdivisions 1, 4; 322B.876, subdivision 1; 322B.88; 322B.883; 322B.90; 322B.905; 322B.91, subdivisions 1, 2; 322B.915; 322B.92; 322B.925; 322B.93; 322B.935; 322B.94; 322B.945; 322B.95; 322B.955; 322B.960, subdivisions 1, 4, 5; 322B.975.

Referred to the Committee on Judiciary.

MOTIONS AND RESOLUTIONS

Senator Dibble moved that the name of Senator Skoe be added as a co-author to S.F. No. 1173. The motion prevailed.

RECESS

Senator Bakk moved that the Senate do now recess subject to the call of the President. The motion prevailed.

After a brief recess, the President called the Senate to order.

CALL OF THE SENATE

Senator Bakk imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

APPOINTMENTS

Senator Bakk from the Subcommittee on Conference Committees recommends that the following Senators be and they hereby are appointed as a Conference Committee on:

H.F. No. 459: Senators Sieben, Eaton and Ruud.

Senator Bakk moved that the foregoing appointments be approved. The motion prevailed.

MOTIONS AND RESOLUTIONS - CONTINUED

Without objection, remaining on the Order of Business of Motions and Resolutions, the Senate reverted to the Orders of Business of Reports of Committees, Second Reading of Senate Bills and Second Reading of House Bills.

REPORTS OF COMMITTEES

Senator Bakk moved that the Committee Reports at the Desk be now adopted. The motion prevailed.

Senator Cohen from the Committee on Finance, to which was referred

H.F. No. 779: A bill for an act relating to health plan regulation; regulating policy and contract coverages; conforming state law to federal requirements; establishing health plan market rules; modifying the designation of essential community providers; amending Minnesota Statutes 2012, sections 43A.23, subdivision 1; 43A.317, subdivision 6; 60A.08, subdivision 15; 62A.011, subdivision 3, by adding subdivisions; 62A.02, by adding a subdivision; 62A.03, subdivision 1; 62A.04, subdivision 2; 62A.047; 62A.049; 62A.136; 62A.149, subdivision 1; 62A.17, subdivisions 2, 6; 62A.21, subdivision 2b; 62A.28, subdivision 2; 62A.302; 62A.615; 62A.65, subdivisions 3, 5, 6, 7, by adding subdivisions; 62C.14, subdivision 5; 62C.142, subdivision 2; 62D.07, subdivision 3; 62D.095; 62D.124, subdivision 4; 62D.181, subdivision 7; 62E.02, by adding a subdivision; 62E.04, subdivision 4, by adding a subdivision; 62E.06, subdivision 1; 62E.09; 62E.10, subdivision 7; 62H.04; 62L.02, subdivisions 11, 14a, 26, by adding a subdivision; 62L.03, subdivisions 1, 3, 4, 6; 62L.045, subdivisions 2, 4; 62L.05, subdivision 10; 62L.06; 62L.08; 62L.12, subdivision

2; 62M.05, subdivision 3a; 62M.06, subdivision 1; 62Q.01, by adding subdivisions; 62Q.021; 62Q.17, subdivision 6; 62Q.18, by adding a subdivision; 62Q.19, subdivision 1; 62Q.23; 62Q.43, subdivision 2; 62Q.47; 62Q.52; 62Q.55; 62Q.68, subdivision 1; 62Q.69, subdivision 3; 62Q.70, subdivisions 1, 2; 62Q.71; 62Q.73; 62Q.75, subdivision 1; 62Q.80, subdivision 2; 72A.20, subdivision 35; 145.414; 471.61, subdivision 1a; proposing coding for new law in Minnesota Statutes, chapters 62A; 62Q; proposing coding for new law as Minnesota Statutes, chapter 62K; repealing Minnesota Statutes 2012, sections 62A.615; 62A.65, subdivision 6; 62E.02, subdivision 7; 62E.16; 62E.20; 62L.02, subdivisions 4, 18, 19, 23, 24; 62L.05, subdivisions 1, 2, 3, 4, 4a, 5, 6, 7, 11, 12, 13; 62L.081; 62L.10, subdivision 5; 62Q.37, subdivision 5.

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

Delete everything after the enacting clause and insert:

"ARTICLE 1

CONFORMING STATE LAW TO AFFORDABLE CARE ACT

Section 1. Minnesota Statutes 2012, section 43A.23, subdivision 1, is amended to read:

Subdivision 1. **General.** (a) The commissioner is authorized to request proposals or to negotiate and to enter into contracts with parties which in the judgment of the commissioner are best qualified to provide service to the benefit plans. Contracts entered into are not subject to the requirements of sections 16C.16 to 16C.19. The commissioner may negotiate premium rates and coverage. The commissioner shall consider the cost of the plans, conversion options relating to the contracts, service capabilities, character, financial position, and reputation of the carriers, and any other factors which the commissioner deems appropriate. Each benefit contract must be for a uniform term of at least one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. A carrier licensed under chapter 62A is exempt from the taxes imposed by chapter 297I on premiums paid to it by the state.

(b) All self-insured hospital and medical service products must comply with coverage mandates, data reporting, and consumer protection requirements applicable to the licensed carrier administering the product, had the product been insured, including chapters 62J, 62M, and 62Q. Any self-insured products that limit coverage to a network of providers or provide different levels of coverage between network and nonnetwork providers shall comply with section 62D.123 and geographic access standards for health maintenance organizations adopted by the commissioner of health in rule under chapter 62D.

(c) Notwithstanding paragraph (b), a self-insured hospital and medical product offered under sections 43A.22 to 43A.30 is ~~not~~ required to extend dependent coverage to an eligible employee's ~~unmarried~~ child ~~under the age of 25~~ to the full extent required under chapters 62A and 62L. Dependent child coverage must, at a minimum, extend to an eligible employee's ~~unmarried~~ dependent child ~~who is under the age of 19 or an unmarried child under the age of 25 who is a full-time student. A person who is at least 19 years of age but who is under the age of 25 and who is not a full-time student must be permitted to be enrolled as a dependent of an eligible employee until age 25 if the person:~~ to the limiting age as defined in section 62Q.01, subdivision 9, disabled children to the extent required in sections 62A.14 and 62A.141, and dependent grandchildren to the extent required in sections 62A.042 and 62A.302.

~~(1) was a full-time student immediately prior to being ordered into active military service, as defined in section 190.05, subdivision 5b or 5c;~~

~~(2) has been separated or discharged from active military service; and~~

~~(3) would be eligible to enroll as a dependent of an eligible employee, except that the person is not a full-time student.~~

~~The definition of "full-time student" for purposes of this paragraph includes any student who by reason of illness, injury, or physical or mental disability as documented by a physician is unable to carry what the educational institution considers a full-time course load so long as the student's course load is at least 60 percent of what otherwise is considered by the institution to be a full-time course load. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this definition of "full-time student."~~

(d) Beginning January 1, 2010, the health insurance benefit plans offered in the commissioner's plan under section 43A.18, subdivision 2, and the managerial plan under section 43A.18, subdivision 3, must include an option for a health plan that is compatible with the definition of a high-deductible health plan in section 223 of the United States Internal Revenue Code.

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

Sec. 2. Minnesota Statutes 2012, section 43A.317, subdivision 6, is amended to read:

Subd. 6. **Individual eligibility.** (a) **Procedures.** The commissioner shall establish procedures for eligible employees and other eligible individuals to apply for coverage through the program.

(b) **Employees.** An employer shall determine when it applies to the program the criteria its employees must meet to be eligible for coverage under its plan. An employer may subsequently change the criteria annually or at other times with approval of the commissioner. The criteria must provide that new employees become eligible for coverage after a probationary period of at least 30 days, but no more than 90 days.

(c) **Other individuals.** An employer may elect to cover under its plan:

(1) the spouse, dependent children to the limiting age as defined in section 62Q.01, subdivision 9, disabled children to the extent required in sections 62A.14 and 62A.141, and dependent grandchildren ~~of a covered employee~~ to the extent required in sections 62A.042 and 62A.302;

(2) a retiree who is eligible to receive a pension or annuity from the employer and a covered retiree's spouse, dependent children to the limiting age as defined in section 62Q.01, subdivision 9, disabled children to the extent required in sections 62A.14 and 62A.141, and dependent grandchildren to the extent required in sections 62A.042 and 62A.302;

(3) the surviving spouse, dependent children to the limiting age as defined in section 62Q.01, subdivision 9, disabled children, and dependent grandchildren of a deceased employee or retiree, if the spouse, children, or grandchildren were covered at the time of the death;

(4) a covered employee who becomes disabled, as provided in sections 62A.147 and 62A.148; or

(5) any other categories of individuals for whom group coverage is required by state or federal law.

An employer shall determine when it applies to the program the criteria individuals in these categories must meet to be eligible for coverage. An employer may subsequently change the criteria annually, or at other times with approval of the commissioner. The criteria for dependent children to the limiting age as defined in section 62Q.01, subdivision 9, disabled children, and dependent grandchildren may be no more inclusive than the criteria under section 43A.18, subdivision 2. This paragraph shall not be interpreted as relieving the program from compliance with any federal and state continuation of coverage requirements.

(d) **Waiver and late entrance.** An eligible individual may waive coverage at the time the employer joins the program or when coverage first becomes available. The commissioner may establish a preexisting condition exclusion of not more than 18 months for late entrants as defined in section 62L.02, subdivision 19.

(e) **Continuation coverage.** The program shall provide all continuation coverage required by state and federal law.

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

Sec. 3. Minnesota Statutes 2012, section 60A.08, subdivision 15, is amended to read:

Subd. 15. **Classification of insurance filings data.** (a) All forms, rates, and related information filed with the commissioner under section 61A.02 shall be nonpublic data until the filing becomes effective.

(b) All forms, rates, and related information filed with the commissioner under section 62A.02 shall be nonpublic data until the filing becomes effective.

(c) All forms, rates, and related information filed with the commissioner under section 62C.14, subdivision 10, shall be nonpublic data until the filing becomes effective.

(d) All forms, rates, and related information filed with the commissioner under section 70A.06 shall be nonpublic data until the filing becomes effective.

(e) All forms, rates, and related information filed with the commissioner under section 79.56 shall be nonpublic data until the filing becomes effective.

(f) Notwithstanding paragraphs (b) and (c), for all rate increases subject to review under section 2794 of the Public Health Services Act and any amendments to, or regulations, or guidance issued under the act that are filed with the commissioner on or after September 1, 2011, the commissioner:

(1) may acknowledge receipt of the information;

(2) may acknowledge that the corresponding rate filing is pending review;

(3) must provide public access from the Department of Commerce's Web site to parts I and II of the Preliminary Justifications of the rate increases subject to review; and

(4) must provide notice to the public on the Department of Commerce's Web site of the review of the proposed rate, which must include a statement that the public has 30 calendar days to submit written comments to the commissioner on the rate filing subject to review.

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

Sec. 4. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 1a. **Affordable Care Act.** "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance or regulations issued under, these acts.

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

Sec. 5. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 1b. **Grandfathered plan.** "Grandfathered plan" means a health plan in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with the Affordable Care Act. Unless otherwise specified, grandfathered plans include both individual and group health plans.

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

Sec. 6. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 1c. **Group health plan.** "Group health plan" means a policy or certificate issued to an employer or an employee organization that is both:

(1) a health plan as defined in subdivision 3; and

(2) an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, United States Code, title 29, section 1002, if the plan provides payment for medical care to employees, including both current and former employees, or their dependents, directly or through insurance, reimbursement, or otherwise, including employee welfare benefit plans specifically exempt from the provisions of the Employee Retirement Income Security Act of 1974 under United States Code, title 29, section 1003.

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

Sec. 7. Minnesota Statutes 2012, section 62A.011, subdivision 3, is amended to read:

Subd. 3. **Health plan.** "Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self-insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified. Health plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) ~~supplemental~~ liability insurance, including general liability insurance and automobile liability insurance, or coverage issued as a supplement to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, including coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity insurance, if the benefits are provided under a separate policy, certificate, or contract for insurance; there is no coordination between the provision of benefits and any exclusion of benefits

under any group health plan maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor;

(5) credit accident and health insurance as defined in section 62B.02;

(6) designed solely to provide hearing, dental, or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident-only coverage;

(9) a long-term care policy as defined in section 62A.46 or 62S.01;

(10) issued as a supplement to Medicare, as defined in sections 62A.3099 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876, section 1851, et seq.; or section 1860D-1, et seq., of title XVIII of the federal Social Security Act, ~~United States Code, title 42, section 1395,~~ et seq., as amended;

(11) workers' compensation insurance; ~~or~~

(12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health plan~~.~~;

(13) coverage for on-site medical clinics; or

(14) coverage supplemental to the coverage provided under United States Code, title 10, chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

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

Sec. 8. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 4. **Individual health plan.** "Individual health plan" means a health plan as defined in subdivision 3 that is offered to individuals in the individual market as defined in subdivision 5, but does not mean short-term coverage as defined in section 62A.65, subdivision 7. For purposes of this chapter, a health carrier shall not be deemed to be offering individual health plan coverage solely because the carrier maintains a conversion policy in connection with a group health plan.

EFFECTIVE DATE. This section is effective for coverage effective on or after January 1, 2014.

Sec. 9. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 5. **Individual market.** "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

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

Sec. 10. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 6. **Minnesota Insurance Marketplace.** "Minnesota Insurance Marketplace" means the Minnesota Insurance Marketplace as defined in section 62V.02.

Sec. 11. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 7. **Qualified health plan.** "Qualified health plan" means a health plan that meets the definition in section 1301(a) of the Affordable Care Act and has been certified by the board of the Minnesota Insurance Marketplace in accordance with chapter 62V to be offered through the Minnesota Insurance Marketplace.

Sec. 12. Minnesota Statutes 2012, section 62A.02, is amended by adding a subdivision to read:

Subd. 8. **Filing by health carriers for purposes of complying with the certification requirements of the Minnesota Insurance Marketplace.** No qualified health plan shall be offered through the Minnesota Insurance Marketplace until its form and the premium rates pertaining to the form have been approved by the commissioner of commerce or health, as appropriate, and the health plan has been determined to comply with the certification requirements of the Minnesota Insurance Marketplace in accordance with an agreement between the commissioners of commerce and health and the Minnesota Insurance Marketplace.

EFFECTIVE DATE. This section is effective for coverage effective on or after January 1, 2014.

Sec. 13. Minnesota Statutes 2012, section 62A.03, subdivision 1, is amended to read:

Subdivision 1. **Conditions.** No policy of individual accident and sickness insurance may be delivered or issued for delivery to a person in this state unless:

(1) **Premium.** The entire money and other considerations therefor are expressed therein.

(2) **Time effective.** The time at which the insurance takes effect and terminates is expressed therein.

(3) **One person.** It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family deemed the policyholder, any two or more eligible members of that family, including:

(a) husband,

(b) wife,

(c) dependent children as described in sections 62A.302 and 62A.3021, or

~~(d) any children under a specified age of 19 years or less, or~~

~~(e)~~ (d) any other person dependent upon the policyholder.

(4) **Appearance.** The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-face type of a style in general use. The type size must be uniform and not less than ten point with a lowercase unspaced alphabet length not less than 120 point. The "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, the reference to renewal or cancellation by a separate statement, if any, and the captions and subcaptions.

(5) **Description of policy.** The policy, on the first page, indicates or refers to its provisions for renewal or cancellation either in the brief description, if any, or by a separate statement printed in type not smaller than the type used for captions or a separate provision bearing a caption which accurately describes the renewability or cancelability of the policy.

(6) **Exceptions in policy.** The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 62A.04, printed, at the insurer's option, either with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS." However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(7) **Form number.** Each form, including riders and endorsements, is identified by a form number in the lower left hand corner of the first page thereof.

(8) **No incorporation by reference.** It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates, classification of risks, or short rate table filed with the commissioner.

(9) **Medical benefits.** If the policy contains a provision for medical expense benefits, the term "medical benefits" or similar terms as used therein includes treatments by all licensed practitioners of the healing arts unless, subject to the qualifications contained in clause (10), the policy specifically states the practitioners whose services are covered.

(10) **Osteopath, optometrist, chiropractor, or registered nurse services.** With respect to any policy of individual accident and sickness insurance issued or entered into subsequent to August 1, 1974, notwithstanding the provisions of the policy, if it contains a provision providing for reimbursement for any service which is in the lawful scope of practice of a duly licensed osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, the person entitled to benefits or person performing services under the policy is entitled to reimbursement on an equal basis for the service, whether the service is performed by a physician, osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, licensed under the laws of this state.

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

Sec. 14. Minnesota Statutes 2012, section 62A.04, subdivision 2, is amended to read:

Subd. 2. **Required provisions.** Except as provided in subdivision 4 each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subdivision in the words in which the same appear in this section. The insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) A provision as follows:

TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of clauses (1), (2), (3), (4) and (5), in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3)(a) Except as required for qualified health plans sold through the Minnesota Insurance Marketplace to individuals receiving advance payments of the premium tax credit, a provision as follows:

GRACE PERIOD: A grace period of ..... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy which contains a cancellation provision may add, at the end of the above provision,

subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

(b) For qualified health plans sold through the Minnesota Insurance Marketplace to individuals receiving advance payments of the premium tax credit, a grace period provision must be included that complies with the Affordable Care Act and is no less restrictive than the grace period required by the Affordable Care Act.

(4) A provision as follows:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. For health plans described in section 62A.011, subdivision 3, clause (10), an insurer must accept payment of a renewal premium and reinstate the policy, if the insured applies for reinstatement no later than 60 days after the due date for the premium payment, unless:

(1) the insured has in the interim left the state or the insurer's service area; or

(2) the insured has applied for reinstatement on two or more prior occasions.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

(5) A provision as follows:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

(6) A provision as follows:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(7) A provision as follows:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) A provision as follows:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the

time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

(10) A provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) A provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy. The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 15. Minnesota Statutes 2012, section 62A.047, is amended to read:

62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES.

A policy of individual or group health and accident insurance regulated under this chapter, or individual or group subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or health benefit certificate regulated under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota resident, must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, co-payment, or other coinsurance or dollar limitation requirement. Nothing in this section prohibits a health carrier that has a network of providers from imposing a deductible, co-payment, or other coinsurance or dollar limitation requirement for child health supervision services and prenatal care services that are delivered by an out-of-network provider. This section does not prohibit the use of policy waiting periods ~~or preexisting condition limitations~~ for these services. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section subject to the schedule set forth in this section. Nothing in this section applies to a policy designed primarily to provide coverage payable on a per diem, fixed indemnity, or non-expense-incurred basis, or a policy that provides only accident coverage. A policy, contract, or certificate described under this section may not apply to preexisting condition limitations to individuals under 19 years of age. This section does not apply to individual coverage under a grandfathered plan.

"Child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months.

"Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

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

Sec. 16. Minnesota Statutes 2012, section 62A.049, is amended to read:

62A.049 LIMITATION ON PREAUTHORIZATIONS; EMERGENCIES.

No policy of accident and sickness insurance or group subscriber contract regulated under chapter 62C issued or renewed in this state may contain a provision that makes an insured person ineligible to receive full benefits because of the insured's failure to obtain preauthorization, if that failure occurs because of the need for emergency confinement or emergency treatment. The insured or an authorized representative of the insured shall notify the insurer as soon after the beginning of emergency confinement or emergency treatment as reasonably possible. However, to the extent that the insurer suffers actual prejudice caused by the failure to obtain preauthorization, the insured may be denied all or part of the insured's benefits. ~~This provision does not apply to admissions for treatment of chemical dependency and nervous and mental disorders.~~

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 17. Minnesota Statutes 2012, section 62A.136, is amended to read:

62A.136 HEARING, DENTAL, AND VISION PLAN COVERAGE.

The following provisions do not apply to health plans as defined in section 62A.011, subdivision 3, clause (6), providing hearing, dental, or vision coverage only: sections 62A.041; 62A.0411; 62A.047; 62A.149; 62A.151; 62A.152; 62A.154; 62A.155; 62A.17, subdivision 6; 62A.21, subdivision 2b; 62A.26; 62A.28; 62A.285; 62A.30; 62A.304; and 62A.3093~~; and 62E.16~~.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 18. Minnesota Statutes 2012, section 62A.149, subdivision 1, is amended to read:

Subdivision 1. **Application.** The provisions of this section apply to all group policies of accident and health insurance and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, and to a plan or policy that is individually underwritten or provided for a specific individual and family members as a nongroup policy ~~unless the individual elects in writing to refuse benefits under this subdivision in exchange for an appropriate reduction in premiums or subscriber charges under the policy or plan~~, when the policies or subscriber contracts are issued or delivered in Minnesota or provide benefits to Minnesota residents enrolled thereunder.

This section does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis or policies that provide accident only coverage.

Every insurance policy or subscriber contract included within the provisions of this subdivision, upon issuance or renewal, shall provide coverage that complies with the requirements of section 62Q.47, paragraphs (b) and (c), for the treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident entitled to coverage.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 19. Minnesota Statutes 2012, section 62A.17, subdivision 2, is amended to read:

Subd. 2. **Responsibility of employee.** Every covered employee electing to continue coverage shall pay the former employer, on a monthly basis, the cost of the continued coverage. The policy, contract, or plan must require the group policyholder or contract holder to, upon request, provide the employee with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. If the policy, contract, or health care plan is administered by a trust, every covered employee electing to continue coverage shall pay the trust the cost of continued coverage according to the eligibility rules established by the trust. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for similarly situated employees with respect to whom neither termination nor layoff has occurred, without regard to whether such cost is paid by the employer or employee. The employee shall be eligible to continue the coverage until the employee becomes covered under another group health plan, or for a period of 18 months after the termination of or lay off from employment, whichever is shorter. For an individual age 19 or older, if the employee becomes covered under another group policy, contract, or health plan and the new group policy, contract, or health plan contains any preexisting condition limitations, the employee may, subject to the 18-month maximum continuation limit, continue coverage with the former employer until the preexisting condition limitations have been satisfied. The new policy, contract, or health plan is primary except as to the preexisting condition. In the case of a newborn child who is a dependent of the employee, the new policy, contract, or health plan is primary upon the date of birth of the child, regardless of which policy, contract, or health plan coverage is deemed primary for the mother of the child.

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

Sec. 20. Minnesota Statutes 2012, section 62A.17, subdivision 6, is amended to read:

Subd. 6. **Conversion to individual policy.** ~~A group insurance policy that provides posttermination or layoff coverage as required by this section shall also include a provision allowing a covered employee, surviving spouse, or dependent at the expiration of the posttermination or layoff coverage provided by subdivision 2 to obtain from the insurer offering the group policy or group subscriber contract, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual policy of insurance or an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, and a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the insurer within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate premium. The required conversion contract must treat pregnancy the same as any other covered illness~~

~~under the conversion contract. A health maintenance contract issued by a health maintenance organization that provides posttermination or layoff coverage as required by this section shall also include a provision allowing a former employee, surviving spouse, or dependent at the expiration of the posttermination or layoff coverage provided in subdivision 2 to obtain from the health maintenance organization, at the former employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual health maintenance contract. Effective January 1, 1985, enrollees who have become nonresidents of the health maintenance organization's service area shall be given the option, to be arranged by the health maintenance organization, of a number three qualified plan, a number two qualified plan, or a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3. This option shall be made available at the enrollee's expense, without further evidence of insurability and without interruption of coverage.~~

~~A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, the spouse, or a dependent in lieu of the optional coverage otherwise required by this subdivision.~~

~~The~~ An individual policy or contract issued as a conversion policy prior to January 1, 2014, shall be renewable at the option of the individual as long as the individual is not covered under another qualified plan as defined in section 62E.02, subdivision 4. Any revisions in the table of rate for the individual policy shall apply to the covered person's original age at entry and shall apply equally to all similar conversion policies issued by the insurer.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 21. Minnesota Statutes 2012, section 62A.21, subdivision 2b, is amended to read:

Subd. 2b. **Conversion privilege.** ~~Every policy described in subdivision 1 shall contain a provision allowing a former spouse and dependent children of an insured, without providing evidence of insurability, to obtain from the insurer at the expiration of any continuation of coverage required under subdivision 2a or sections 62A.146 and 62A.20, conversion coverage providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the insurer within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate premium. The~~ An individual policy or contract issued as a conversion policy prior to January 1, 2014, shall be renewable at the option of the covered person as long as the covered person is not covered under another qualified plan as defined in section 62E.02, subdivision 4. Any revisions in the table of rate for the individual policy shall apply to the covered person's original age at entry and shall apply equally to all similar conversion policies issued by the insurer.

~~A policy providing reduced benefits at a reduced premium rate may be accepted by the covered person in lieu of the optional coverage otherwise required by this subdivision.~~

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 22. Minnesota Statutes 2012, section 62A.28, subdivision 2, is amended to read:

Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1987, must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata.

The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items under the policy, plan, certificate, or contract~~, and is limited to a maximum of $350 in any benefit year~~ and may be limited to one prosthesis per benefit year.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 23. Minnesota Statutes 2012, section 62A.302, is amended to read:

62A.302 COVERAGE OF DEPENDENTS.

Subdivision 1. **Scope of coverage.** This section applies to:

(1) a health plan as defined in section 62A.011; and

~~(2) coverage described in section 62A.011, subdivision 3, clauses (4), (6), (7), (8), (9), and (10); and~~

~~(3)~~ (2) a policy, contract, or certificate issued by a community integrated service network licensed under chapter 62N.

Subd. 2. **Required coverage.** Every health plan included in subdivision 1 that provides dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02, subdivision 11.

Subd. 3. **No additional restrictions permitted.** Any health plan included in subdivision 1 that provides dependent coverage of children shall make that coverage available to children until the child attains 26 years of age. A health carrier must not place restrictions on this coverage and must comply with the following requirements:

(1) with respect to a child who has not attained 26 years of age, a health carrier shall not define dependent for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the enrollee or spouse of the enrollee;

(2) a health carrier must not deny or restrict coverage for a child who has not attained 26 years of age based on (i) the presence or absence of the child's financial dependency upon the participant, primary subscriber, or any other person; (ii) residency with the participant and in the individual market the primary subscriber, or with any other person; (iii) marital status; (iv) student status; (v) employment; or (vi) any combination of those factors; and

(3) a health carrier must not deny or restrict coverage of a child based on eligibility for other coverage, except as provided in subdivision 5.

Subd. 4. **Grandchildren.** Nothing in this section requires a health carrier to make coverage available for a grandchild, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild or unless the grandchild meets the requirements of section 62A.042. For grandchildren included under a grandparent's policy pursuant to section 62A.042, coverage for the grandchild may terminate if the grandchild does not continue to reside with the covered grandparent continuously from birth, if the grandchild does not remain financially dependent upon the covered grandparent, or when the grandchild reaches age 25, except as provided in section 62A.14 or if coverage is continued under section 62A.20.

Subd. 5. **Terms of coverage of dependents.** The terms of coverage in a health plan offered by a health carrier providing dependent coverage of children cannot vary based on age except for children who are 26 years of age or older.

Subd. 6. **Opportunity to enroll.** A health carrier must comply with all provisions of the Affordable Care Act in regards to providing an opportunity to enroll in coverage to any child whose coverage ended, or was not eligible for coverage under a group health plan or individual health plan because, under the terms of the coverage, the availability of dependent coverage of a child ended before age 26.

Subd. 7. **Grandfathered plan coverage.** (a) For plan years beginning before January 1, 2014, a group health plan that is a grandfathered plan and makes available dependent coverage of children may exclude an adult child who has not attained 26 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.

(b) For plan years beginning on or after January 1, 2014, a group health plan that is a grandfathered plan must comply with all requirements of this section.

Subd. 8. **Compliance.** This section does not require compliance with any provision of the Affordable Care Act before the effective date provided for that provision in the Affordable Care Act.

Subd. 9. **Enforcement.** The commissioner shall enforce this section.

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

Sec. 24. **[62A.3021] COVERAGE OF DEPENDENTS BY PLANS OTHER THAN HEALTH PLANS.**

Subdivision 1. **Scope of coverage.** This section applies to coverage described in section 62A.011, subdivision 3, clauses (4), (6), (7), (8), (9), and (10).

Subd. 2. **Dependent.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 25, dependent child of any age who is disabled and who meets the eligibility criteria in section 62A.14, subdivision 2, or any other person whom state or federal law requires to be treated as a dependent for purposes of health plans. For the purpose of this definition, a child includes a child for whom the employee or the employee's spouse has been appointed legal guardian and an adoptive child as provided in section 62A.27. A child also includes grandchildren as provided in section 62A.042 with continued eligibility of grandchildren as provided in section 62A.302, subdivision 4.

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

Sec. 25. Minnesota Statutes 2012, section 62A.615, is amended to read:

62A.615 PREEXISTING CONDITIONS DISCLOSED AT TIME OF APPLICATION.

No insurer may cancel or rescind a health insurance policy for a preexisting condition of which the application or other information provided by the insured reasonably gave the insurer notice. No insurer may restrict coverage for a preexisting condition of which the application or other information provided by the insured reasonably gave the insurer notice unless the coverage is restricted at the time the policy is issued and the restriction is disclosed in writing to the insured at the time the policy is issued. In addition, no health plan may restrict coverage for a preexisting

condition for an individual who is under 19 years of age. This section does not apply to individual health plans that are grandfathered plans.

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

Sec. 26. Minnesota Statutes 2012, section 62A.65, subdivision 3, is amended to read:

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

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

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

~~(c) A health carrier may request approval by the commissioner to establish separate geographic regions determined by the health carrier and to establish separate index rates for each such region.~~

(b) Premium rates may vary based upon geographic rating area. The commissioner shall grant approval if the following conditions are met:

(1) ~~the geographic regions must be applied uniformly by the health carrier~~ the areas are established in accordance with the Affordable Care Act;

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

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

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

(c) Premium rates may vary based upon tobacco use, in accordance with the provisions of the Affordable Care Act.

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

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

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

(e) The premium charged with respect to any particular individual health plan shall not be adjusted more frequently than annually or January 1 of the year following initial enrollment, except that the premium rates may be changed to reflect:

(1) changes to the family composition of the policyholder;

(2) changes in geographic rating area of the policyholder, as provided in paragraph (b);

(3) changes in age, as provided in paragraph (a);

(4) changes in tobacco use, as provided in paragraph (c);

(5) transfer to a new health plan requested by the policyholder; or

(6) other changes required by or otherwise expressly permitted by state or federal law or regulations.

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

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

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

(i) ~~An insurer~~ A health carrier may, as part of a minimum lifetime loss ratio guarantee filing under section 62A.02, subdivision 3a, include a rating practices guarantee as provided in this paragraph. The rating practices guarantee must be in writing and must guarantee that the policy form will be offered, sold, issued, and renewed only with premium rates and premium rating practices that comply with subdivisions 2, 3, 4, and 5. The rating practices guarantee must be accompanied by an actuarial memorandum that demonstrates that the premium rates and premium rating system used in connection with the policy form will satisfy the guarantee. The guarantee must guarantee refunds of any excess premiums to policyholders charged premiums that exceed those permitted under subdivision 2, 3, 4, or 5. ~~An insurer~~ A health carrier that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs ~~(c)~~ (b), (f), and (h).

(j) The commissioner may establish regulations to implement the provisions of this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 27. Minnesota Statutes 2012, section 62A.65, is amended by adding a subdivision to read:

Subd. 3a. **Disclosure.** (a) In connection with the offering for sale of a health plan in the individual market, a health carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) the provisions of the coverage concerning the health carrier's right to change premium rates and the factors that may affect changes in premium rates; and

(2) a listing of and descriptive information, including benefits and premiums, about all individual health plans actively marketed by the health carrier and the availability of the individual health plans for which the individual is qualified.

(b) Paragraph (a), clause (1), may be satisfied by referring individuals to the Health and Human Services Web portal, as defined under the Affordable Care Act.

Sec. 28. Minnesota Statutes 2012, section 62A.65, is amended by adding a subdivision to read:

Subd. 3b. **Single risk pool.** A health carrier shall consider all enrollees in all health plans, other than short-term and grandfathered plan coverage, offered by the health carrier in the individual market, including those enrollees who enroll in qualified health plans offered through the Minnesota Insurance Marketplace, to be members of a single risk pool.

Sec. 29. Minnesota Statutes 2012, section 62A.65, subdivision 5, is amended to read:

Subd. 5. **Portability and conversion of coverage.** (a) For plan years beginning on or after January 1, 2014, no individual health plan may be offered, sold, issued, or ~~with respect to children age 18 or under~~ renewed, to a Minnesota resident that contains a preexisting condition limitation, preexisting condition exclusion, or exclusionary rider~~, unless the limitation or exclusion is permitted under this subdivision and under chapter 62L, provided that, except for children age 18 or under, underwriting restrictions may be retained on individual contracts that are issued without evidence of insurability as a replacement for prior individual coverage that was sold before May 17, 1993~~. ~~The~~ An individual age 19 or older may be subjected to an 18-month preexisting condition limitation during plan years beginning prior to January 1, 2014, unless the individual has maintained continuous coverage as defined in section 62L.02. The individual must not be subjected to an exclusionary rider. During plan years beginning prior to January 1, 2014, an individual who is age 19 or older and who has maintained continuous coverage may be subjected to a onetime preexisting condition limitation of up to 12 months, with credit for time covered under qualifying coverage as defined in section 62L.02, at the time that the individual first is covered under an individual health plan by any health carrier. Credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. The individual must not be subjected to an exclusionary rider. Thereafter, the individual who is age 19 or older must not be subject to any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage as defined in section 62L.02. The prohibition on preexisting condition limitations for children age 18 or under does not apply to individual health plans that are grandfathered plans. The prohibition on preexisting condition limitations for adults age 19 and over beginning for plan years on or after January 1, 2014, does not apply to individual health plans that are grandfathered plans.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health plan issued by that health carrier, regardless of the size of the group, so long

as the individual maintained continuous coverage as defined in section 62L.02. If the individual has available any continuation coverage provided under sections 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or 62D.105, or continuation coverage provided under federal law, the health carrier need not offer coverage under this paragraph until the individual has exhausted the continuation coverage. The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this paragraph must be a qualified plan as defined in section 62E.02 and must not contain any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The offer of coverage by the health carrier must inform the individual that the coverage, including what is covered and the health care providers from whom covered care may be obtained, may not be the same as the individual's coverage under the group health plan. The offer of coverage by the health carrier must also inform the individual that the individual, if a Minnesota resident, may be eligible to obtain coverage from (i) other private sources of health coverage, or (ii) the Minnesota Comprehensive Health Association, without a preexisting condition limitation, and must provide the telephone number used by that association for enrollment purposes. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. In no event shall the premium rate exceed 100 percent of the premium charged for comparable individual coverage by the Minnesota Comprehensive Health Association, and the premium rate must be less than that amount if necessary to otherwise comply with this section. ~~An individual health plan offered under this paragraph to a person satisfies the health carrier's obligation to offer conversion coverage under section 62E.16, with respect to that person.~~ Coverage issued under this paragraph must provide that it cannot be canceled or nonrenewed as a result of the health carrier's subsequent decision to leave the individual, small employer, or other group market. Section 72A.20, subdivision 28, applies to this paragraph.

EFFECTIVE DATE. This section is effective the day following final enactment, except that the amendment to paragraph (b) is effective January 1, 2014.

Sec. 30. Minnesota Statutes 2012, section 62A.65, subdivision 6, is amended to read:

Subd. 6. **Guaranteed issue ~~not~~ required.** (a) Nothing in this section requires a health carrier to initially issue a health plan to a Minnesota resident who is age 19 or older on the date the health plan becomes effective if the effective date is prior to January 1, 2014, except as otherwise expressly provided in subdivision 4 or 5.

(b) Guaranteed issue is required for all health plans, except grandfathered plans, beginning January 1, 2014.

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

Sec. 31. Minnesota Statutes 2012, section 62A.65, subdivision 7, is amended to read:

Subd. 7. **Short-term coverage.** (a) For purposes of this section, "short-term coverage" means an individual health plan that:

(1) is issued to provide coverage for a period of 185 days or less, except that the health plan may permit coverage to continue until the end of a period of hospitalization for a condition for which the covered person was hospitalized on the day that coverage would otherwise have ended;

(2) is nonrenewable, provided that the health carrier may provide coverage for one or more subsequent periods that satisfy clause (1), if the total of the periods of coverage do not exceed a total of 365 days out of any 555-day period, plus any additional days covered as a result of hospitalization on the day that a period of coverage would otherwise have ended;

(3) does not cover any preexisting conditions, including ones that originated during a previous identical policy or contract with the same health carrier where coverage was continuous between the previous and the current policy or contract; and

(4) is available with an immediate effective date without underwriting upon receipt of a completed application indicating eligibility under the health carrier's eligibility requirements, provided that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(b) Short-term coverage is not subject to subdivisions 2 and 5. Short-term coverage may exclude as a preexisting condition any injury, illness, or condition for which the covered person had medical treatment, symptoms, or any manifestations before the effective date of the coverage, but dependent children born or placed for adoption during the policy period must not be subject to this provision.

(c) Notwithstanding subdivision 3, and section 62A.021, a health carrier may combine short-term coverage with its most commonly sold individual qualified plan, as defined in section 62E.02, other than short-term coverage, for purposes of complying with the loss ratio requirement.

(d) The 365-day coverage limitation provided in paragraph (a) applies to the total number of days of short-term coverage that covers a person, regardless of the number of policies, contracts, or health carriers that provide the coverage. A written application for short-term coverage must ask the applicant whether the applicant has been covered by short-term coverage by any health carrier within the 555 days immediately preceding the effective date of the coverage being applied for. Short-term coverage issued in violation of the 365-day limitation is valid until the end of its term and does not lose its status as short-term coverage, in spite of the violation. A health carrier that knowingly issues short-term coverage in violation of the 365-day limitation is subject to the administrative penalties otherwise available to the commissioner of commerce or the commissioner of health, as appropriate.

~~(e) Time spent under short-term coverage counts as time spent under a preexisting condition limitation for purposes of group or individual health plans, other than short-term coverage, subsequently issued to that person, or to cover that person, by any health carrier, if the person maintains continuous coverage as defined in section 62L.02. Short-term coverage is a health plan and is qualifying coverage as defined in section 62L.02. Notwithstanding any other law to the contrary, a health carrier is not required under any circumstances to provide a person covered by short-term coverage the right to obtain coverage on a guaranteed issue basis under another health plan offered by the health carrier, as a result of the person's enrollment in short-term coverage.~~

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

Sec. 32. Minnesota Statutes 2012, section 62C.14, subdivision 5, is amended to read:

Subd. 5. **Disabled dependents.** A subscriber's individual contract or any group contract delivered or issued for delivery in this state and providing that coverage of a dependent child of the subscriber or a dependent child of a covered group member shall terminate upon attainment of a specified limiting age as defined in section 62Q.01, subdivision 9, shall also provide in

substance that attainment of that age shall not terminate coverage while the child is (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability, and (b) chiefly dependent upon the subscriber or employee for support and maintenance, provided proof of incapacity and dependency is furnished by the subscriber within 31 days of attainment of the limiting age as defined in section 62Q.01, subdivision 9, and subsequently as required by the corporation, but not more frequently than annually after a two-year period following attainment of the age. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this provision.

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

Sec. 33. Minnesota Statutes 2012, section 62C.142, subdivision 2, is amended to read:

Subd. 2. **Conversion privilege.** ~~Every subscriber contract, other than a contract whose continuance is contingent upon continued employment or membership, which contains a provision for termination of coverage of the spouse upon dissolution of marriage shall contain a provision allowing a former spouse and dependent children of a subscriber, without providing evidence of insurability, to obtain from the corporation at the expiration of any continuation of coverage required under subdivision 2a or section 62A.146, or upon termination of coverage by reason of an entry of a valid decree of dissolution which does not require the insured to provide continued coverage for the former spouse, an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the corporation within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate fee. A subscriber contract providing reduced benefits at a reduced fee may be accepted by the former spouse and dependent children in lieu of the optional coverage otherwise required by this subdivision. The~~ An individual subscriber contract issued as conversion coverage shall be renewable at the option of the former spouse as long as the former spouse is not covered under another qualified plan as defined in section 62E.02, subdivision 4. Any revisions in the table of rate for the individual subscriber contract shall apply to the former spouse's original age at entry and shall apply equally to all similar contracts issued as conversion coverage by the corporation.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 34. Minnesota Statutes 2012, section 62D.07, subdivision 3, is amended to read:

Subd. 3. **Required provisions.** Contracts and evidences of coverage shall contain:

(a) no provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which are untrue, misleading, or deceptive as defined in section 62D.12, subdivision 1;

(b) a clear, concise and complete statement of:

(1) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health maintenance contract;

(2) any exclusions or limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or co-payment feature and requirements for referrals, prior authorizations, and second opinions;

(3) where and in what manner information is available as to how services, including emergency and out of area services, may be obtained;

(4) the total amount of payment and co-payment, if any, for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates; and

(5) a description of the health maintenance organization's method for resolving enrollee complaints and a statement identifying the commissioner as an external source with whom complaints may be registered; and

(c) on the cover page of the evidence of coverage and contract, a clear and complete statement of enrollees' rights. The statement must be in bold print and captioned "Important Enrollee Information and Enrollee Bill of Rights" and must include but not be limited to the following provisions in the following language or in substantially similar language approved in advance by the commissioner, except that paragraph (8) does not apply to prepaid health plans providing coverage for programs administered by the commissioner of human services:

ENROLLEE INFORMATION

(1) COVERED SERVICES: Services provided by (name of health maintenance organization) will be covered only if services are provided by participating (name of health maintenance organization) providers or authorized by (name of health maintenance organization). Your contract fully defines what services are covered and describes procedures you must follow to obtain coverage.

(2) PROVIDERS: Enrolling in (name of health maintenance organization) does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of (name of health maintenance organization), you must choose among remaining (name of the health maintenance organization) providers.

(3) REFERRALS: Certain services are covered only upon referral. See section (section number) of your contract for referral requirements. All referrals to non-(name of health maintenance organization) providers and certain types of health care providers must be authorized by (name of health maintenance organization).

(4) EMERGENCY SERVICES: Emergency services from providers who are not affiliated with (name of health maintenance organization) will be covered ~~only if proper procedures are followed~~. Your contract explains the procedures and benefits associated with emergency care from (name of health maintenance organization) and non-(name of health maintenance organization) providers.

(5) EXCLUSIONS: Certain services or medical supplies are not covered. You should read the contract for a detailed explanation of all exclusions.

(6) CONTINUATION: You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your contract.

(7) CANCELLATION: Your coverage may be canceled by you or (name of health maintenance organization) only under certain conditions. Your contract describes all reasons for cancellation of coverage.

(8) NEWBORN COVERAGE: If your health plan provides for dependent coverage, a newborn infant is covered from birth, but only if services are provided by participating (name of health maintenance organization) providers or authorized by (name of health maintenance organization). Certain services are covered only upon referral. (Name of health maintenance organization) will not automatically know of the infant's birth or that you would like coverage under your plan. You should notify (name of health maintenance organization) of the infant's birth and that you would like coverage. If your contract requires an additional premium for each dependent, (name of health maintenance organization) is entitled to all premiums due from the time of the infant's birth until the time you notify (name of health maintenance organization) of the birth. (Name of health maintenance organization) may withhold payment of any health benefits for the newborn infant until any premiums you owe are paid.

(9) PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT: Enrolling in (name of health maintenance organization) does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the contract year.

ENROLLEE BILL OF RIGHTS

(1) Enrollees have the right to available and accessible services including emergency services, as defined in your contract, 24 hours a day and seven days a week;

(2) Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;

(3) Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law;

(4) Enrollees have the right to file a complaint with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers;

(5) Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force;

(6) Medicare enrollees have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law; and

(7) Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

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

Sec. 35. Minnesota Statutes 2012, section 62D.095, is amended to read:

62D.095 ENROLLEE COST SHARING.

Subdivision 1. **General application.** A health maintenance contract may contain enrollee cost-sharing provisions as specified in this section. Co-payment and deductible provisions in a group contract must not discriminate on the basis of age, sex, race, disability, economic status, or

length of enrollment in the health plan. During an open enrollment period in which all offered health plans fully participate without any underwriting restrictions, co-payment and deductible provisions must not discriminate on the basis of preexisting health status.

Subd. 2. **Co-payments.** ~~(a)~~ A health maintenance contract may impose a co-payment ~~as authorized under Minnesota Rules, part 4685.0801, or under this section~~ and coinsurance consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

~~(b) A health maintenance organization may impose a flat fee co-payment on outpatient office visits not to exceed 40 percent of the median provider's charges for similar services or goods received by the enrollees as calculated under Minnesota Rules, part 4685.0801. A health maintenance organization may impose a flat fee co-payment on outpatient prescription drugs not to exceed 50 percent of the median provider's charges for similar services or goods received by the enrollees as calculated under Minnesota Rules, part 4685.0801.~~

~~(c) If a health maintenance contract is permitted to impose a co-payment for preexisting health status under sections 62D.01 to 62D.30, these provisions may vary with respect to length of enrollment in the health plan.~~

Subd. 3. **Deductibles.** ~~(a)~~ A health maintenance contract ~~issued by a health maintenance organization that is assessed less than three percent of the total annual amount assessed by the Minnesota comprehensive health association may impose deductibles not to exceed $3,000 per person, per year and $6,000 per family, per year. For purposes of the percentage calculation, a health maintenance organization's assessments include those of its affiliates~~ may impose a deductible consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

~~(b) All other health maintenance contracts may impose deductibles not to exceed $2,250 per person, per year and $4,500 per family, per year.~~

Subd. 4. **Annual out-of-pocket maximums.** ~~(a)~~ A health maintenance contract ~~issued by a health maintenance organization that is assessed less than three percent of the total annual amount assessed by the Minnesota comprehensive health association must include a limitation not to exceed $4,500 per person and $7,500 per family on total annual out-of-pocket enrollee cost-sharing expenses. For purposes of the percentage calculation, a health maintenance organization's assessments include those of its affiliates~~ may impose an annual out-of-pocket maximum consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

~~(b) All other health maintenance contracts must include a limitation not to exceed $3,000 per person and $6,000 per family on total annual out-of-pocket enrollee cost-sharing expenses.~~

Subd. 5. **Exceptions.** No co-payments or deductibles may be imposed on preventive health care services ~~as described in Minnesota Rules, part 4685.0801, subpart 8~~ consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

Subd. 6. **Public programs.** This section does not apply to the prepaid medical assistance program, the MinnesotaCare program, ~~the prepaid general assistance program,~~ the federal Medicare program, or the health plans provided through any of those programs.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 36. Minnesota Statutes 2012, section 62D.181, subdivision 7, is amended to read:

Subd. 7. **Replacement coverage; limitations.** The association is not obligated to offer replacement coverage under this chapter ~~or conversion coverage under section 62E.16~~ at the end of the periods specified in subdivision 6. Any continuation obligation arising under this chapter or chapter 62A will cease at the end of the periods specified in subdivision 6.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 37. Minnesota Statutes 2012, section 62E.02, is amended by adding a subdivision to read:

Subd. 2a. **Essential health benefits.** "Essential health benefits" has the meaning given under section 62Q.81, subdivision 4.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 38. Minnesota Statutes 2012, section 62E.04, subdivision 4, is amended to read:

Subd. 4. **Major medical coverage.** Each insurer and fraternal shall affirmatively offer coverage of major medical expenses to every applicant who applies to the insurer or fraternal for a new unqualified policy, which has a lifetime benefit limit of less than $1,000,000, at the time of application and annually to every holder of such an unqualified policy of accident and health insurance renewed by the insurer or fraternal. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any co-payment authorized by the commissioner, ~~up to a maximum lifetime limit of not less than $1,000,000~~ and shall not contain a lifetime maximum on essential health benefits. The offer of coverage of major medical expenses may consist of the offer of a rider on an existing unqualified policy or a new policy which is a qualified plan.

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

Sec. 39. Minnesota Statutes 2012, section 62E.04, is amended by adding a subdivision to read:

Subd. 11. **Essential health benefits package.** For individual or small group health plans that include the essential health benefits package and are offered, sold, issued, or renewed on or after January 1, 2014, the requirements of this section do not apply.

Sec. 40. Minnesota Statutes 2012, section 62E.06, subdivision 1, is amended to read:

Subdivision 1. **Number three plan.** A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A, 62C, and 62Q, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall not be subject to a ~~maximum lifetime benefit of not less than $1,000,000~~ lifetime maximum on essential health benefits.

The prohibition on lifetime maximums for essential health benefits and $3,000 limitation on total annual out-of-pocket expenses ~~and the $1,000,000 maximum lifetime benefit~~ shall not be subject to change or substitution by use of an actuarially equivalent benefit.

(b) Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) hospital services;

(2) professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a physician or at the physician's direction;

(3) drugs requiring a physician's prescription;

(4) services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under Medicare;

(5) services of a home health agency if the services would qualify as reimbursable services under Medicare;

(6) use of radium or other radioactive materials;

(7) oxygen;

(8) anesthetics;

(9) prostheses other than dental but including scalp hair prostheses worn for hair loss suffered as a result of alopecia areata;

(10) rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids, unless coverage is required under section 62Q.675;

(11) diagnostic x-rays and laboratory tests;

(12) oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) services of a physical therapist;

(14) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment; and

(15) services of an occupational therapist.

(c) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance, Medicare, or any other governmental program except as otherwise provided by section 62A.04, subdivision 3, clause (4);

(2) any charge for treatment for cosmetic purposes other than for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part or when such service is performed on a covered dependent child because

of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician;

(3) care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under Medicare;

(4) any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semiprivate rooms, its most common semiprivate room charge shall be considered to be 90 percent of its lowest private room charge;

(5) that part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

(6) any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (e), benefits for well baby care, effective July 1, 1980, subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations.

(e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in addition to those benefits specified in clause (a), a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory, and hospital fees, provided that the coverage need not include the repetition of any diagnostic tests.

(f) Effective August 1, 1985, the minimum benefits of a qualified plan must include, in addition to the benefits specified in clauses (a), (d), and (e), coverage for special dietary treatment for phenylketonuria when recommended by a physician.

(g) Outpatient mental health coverage is subject to section 62A.152, subdivision 2.

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

Sec. 41. Minnesota Statutes 2012, section 62E.09, is amended to read:

62E.09 DUTIES OF COMMISSIONER.

The commissioner may:

(a) formulate general policies to advance the purposes of sections 62E.01 to 62E.19;

(b) supervise the creation of the Minnesota Comprehensive Health Association within the limits described in section 62E.10;

(c) approve the selection of the writing carrier by the association, approve the association's contract with the writing carrier, and approve the state plan coverage;

(d) appoint advisory committees;

(e) conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;

(f) contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmental assistance programs;

(g) undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of sections 62E.01 to ~~62E.16~~ 62E.15, so that the residents of this state may best avail themselves of the health care benefits provided by these sections;

(h) contract with insurers and others for administrative services; and

(i) adopt, amend, suspend and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of sections 62E.01 to 62E.19.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 42. Minnesota Statutes 2012, section 62E.10, subdivision 7, is amended to read:

Subd. 7. **General powers.** The association may:

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

(b) Sue or be sued;

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

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

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

(1) individual qualified plans, excluding group conversions;

(2) group conversions;

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

(4) major medical coverage.

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

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

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 43. Minnesota Statutes 2012, section 62H.04, is amended to read:

62H.04 COMPLIANCE WITH OTHER LAWS.

(a) A joint self-insurance plan is subject to the requirements of chapters 62A, 62E, 62L, and 62Q, and sections 72A.17 to 72A.32 unless otherwise specifically exempt. A joint self-insurance plan must pay assessments made by the Minnesota Comprehensive Health Association, as required under section 62E.11.

(b) A joint self-insurance plan is exempt from providing the mandated health benefits described in chapters 62A, 62E, 62L, and 62Q if it otherwise provides the benefits required under the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001, et seq., for all employers and not just for the employers with 50 or more employees who are covered by that federal law.

(c) A joint self-insurance plan is exempt from section 62L.03, subdivision 1, if the plan offers an annual open enrollment period of no less than 15 days during which all employers that qualify for membership may enter the plan without preexisting condition limitations or exclusions except those permitted under chapter 62L.

(d) A joint self-insurance plan is exempt from sections 62A.146, 62A.16, 62A.17, 62A.20, 62A.21, and 62A.65, subdivision 5, paragraph (b), ~~and 62E.16~~ if the joint self-insurance plan complies with the continuation requirements under the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001, et seq., for all employers and not just for the employers with 20 or more employees who are covered by that federal law.

(e) A joint self-insurance plan must provide to all employers the maternity coverage required by federal law for employers with 15 or more employees.

(f) A joint self-insurance plan must comply with all the provisions and requirements of the Affordable Care Act as defined under section 62A.011, subdivision 1a, to the extent that they apply to such plans.

EFFECTIVE DATE. This section is effective the day following final enactment, except that the amendment to paragraph (d) is effective January 1, 2014.

Sec. 44. Minnesota Statutes 2012, section 62L.02, subdivision 11, is amended to read:

Subd. 11. **Dependent.** "Dependent" means an eligible employee's spouse, ~~unmarried child who is under the age of 25 years~~ dependent child to the limiting age as defined in section 62Q.01, subdivision 9, dependent child of any age who is disabled and who meets the eligibility criteria in section 62A.14, subdivision 2, or any other person whom state or federal law requires to be treated

as a dependent for purposes of health plans. For the purpose of this definition, a dependent child to the limiting age as defined in section 62Q.01, subdivision 9, includes a child for whom the employee or the employee's spouse has been appointed legal guardian and an adoptive child as provided in section 62A.27. A child also means a grandchild as provided in section 62A.042 with continued eligibility of grandchildren as provided in section 62A.302, subdivision 4.

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

Sec. 45. Minnesota Statutes 2012, section 62L.02, subdivision 14a, is amended to read:

Subd. 14a. **Guaranteed issue.** "Guaranteed issue" means that a health carrier shall not decline an application by a small employer for any health benefit plan offered by that health carrier and shall not decline to cover under a health benefit plan any eligible employee or eligible dependent, including persons who become eligible employees or eligible dependents after initial issuance of the health benefit plan~~, subject to the health carrier's right to impose preexisting condition limitations permitted under this chapter~~.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 46. Minnesota Statutes 2012, section 62L.02, is amended by adding a subdivision to read:

Subd. 17a. **Individual health plan.** "Individual health plan" has the meaning given in section 62A.011, subdivision 4.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 47. Minnesota Statutes 2012, section 62L.02, subdivision 26, is amended to read:

Subd. 26. **Small employer.** (a) "Small employer" means, with respect to a calendar year and a plan year, a person, firm, corporation, partnership, association, or other entity actively engaged in business in Minnesota, including a political subdivision of the state, that employed an average of ~~no fewer than two nor~~ at least one, not including a sole proprietor, but not more than 50 current employees on business days during the preceding calendar year and that employs at least ~~two~~ one current ~~employees~~ employee, not including a sole proprietor, on the first day of the plan year. ~~If an employer has only one eligible employee who has not waived coverage, the sale of a health plan to or for that eligible employee is not a sale to a small employer and is not subject to this chapter and may be treated as the sale of an individual health plan.~~ A small employer plan may be offered through a domiciled association to self-employed individuals and small employers who are members of the association, even if the self-employed individual or small employer has fewer than two current employees. Entities that are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the federal Internal Revenue Code are considered a single employer for purposes of determining the number of current employees. Small employer status must be determined on an annual basis as of the renewal date of the health benefit plan. The provisions of this chapter continue to apply to an employer who no longer meets the requirements of this definition until the annual renewal date of the employer's health benefit plan. If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based upon the average number of current employees that it is reasonably expected that the employer will employ on business days in the current calendar year. For purposes of this definition, the term employer includes any predecessor of the employer. An employer that has more than 50 current employees but has 50 or fewer employees, as "employee" is defined under United States Code, title 29, section 1002(6), is a small employer under this subdivision.

(b) Where an association, as defined in section 62L.045, comprised of employers contracts with a health carrier to provide coverage to its members who are small employers, the association and health benefit plans it provides to small employers, are subject to section 62L.045, with respect to small employers in the association, even though the association also provides coverage to its members that do not qualify as small employers.

(c) If an employer has employees covered under a trust specified in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq., as amended, or employees whose health coverage is determined by a collective bargaining agreement and, as a result of the collective bargaining agreement, is purchased separately from the health plan provided to other employees, those employees are excluded in determining whether the employer qualifies as a small employer. Those employees are considered to be a separate small employer if they constitute a group that would qualify as a small employer in the absence of the employees who are not subject to the collective bargaining agreement.

(d) Small group health plans offered through the Minnesota Insurance Marketplace under chapter 62V to employees of a small employer are not considered individual health plans, regardless of whether the health plan is purchased using a defined contribution from the small employer.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 48. Minnesota Statutes 2012, section 62L.03, subdivision 1, is amended to read:

Subdivision 1. **Guaranteed issue and reissue.** (a) Every health carrier shall, as a condition of authority to transact business in this state in the small employer market, affirmatively market, offer, sell, issue, and renew any of its health benefit plans, on a guaranteed issue basis, to any small employer, including a small employer covered by paragraph (b), that meets the participation and contribution requirements of subdivision 3, as provided in this chapter.

(b) A small employer that ~~has its~~ no longer meets the definition of small employer because of a reduction in workforce ~~reduced to one employee~~ may continue coverage as a small employer for 12 months from the date the group is reduced to one employee.

(c) Notwithstanding paragraph (a), a health carrier may, at the time of coverage renewal, modify the health coverage for a product offered in the small employer market if the modification is consistent with state law, approved by the commissioner, and effective on a uniform basis for all small employers purchasing that product other than through a qualified association in compliance with section 62L.045, subdivision 2.

~~Paragraph (a) does not apply to a health benefit plan designed for a small employer to comply with a collective bargaining agreement, provided that the health benefit plan otherwise complies with this chapter and is not offered to other small employers, except for other small employers that need it for the same reason. This paragraph applies only with respect to collective bargaining agreements entered into prior to August 21, 1996, and only with respect to plan years beginning before the later of July 1, 1997, or the date upon which the last of the collective bargaining agreements relating to the plan terminates determined without regard to any extension agreed to after August 21, 1996.~~

~~(d) Every health carrier participating in the small employer market shall make available both of the plans described in section 62L.05 to small employers and shall fully comply with the underwriting and the rate restrictions specified in this chapter for all health benefit plans issued to small employers.~~

~~(c)~~ (d) A health carrier may cease to transact business in the small employer market as provided under section 62L.09.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 49. Minnesota Statutes 2012, section 62L.03, subdivision 3, is amended to read:

Subd. 3. **Minimum participation and contribution.** (a) A small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan and that contributes at least 50 percent toward the cost of coverage of each eligible employee must be guaranteed coverage on a guaranteed issue basis from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. A health carrier must not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdivision, waiver of coverage includes only waivers due to: (1) coverage under another group health plan; (2) coverage under Medicare Parts A and B; or (3) coverage under medical assistance under chapter 256B or general assistance medical care under chapter 256D.

(b) If a small employer does not satisfy the contribution or participation requirements under this subdivision, a health carrier may voluntarily issue or renew individual health plans, or a health benefit plan which must fully comply with this chapter. A health carrier that provides a health benefit plan to a small employer that does not meet the contribution or participation requirements of this subdivision must maintain this information in its files for audit by the commissioner. A health carrier may not offer an individual health plan, purchased through an arrangement between the employer and the health carrier, to any employee unless the health carrier also offers the individual health plan, on a guaranteed issue basis, to all other employees of the same employer. An arrangement permitted under section 62L.12, subdivision 2, paragraph ~~(k)~~ (l), is not an arrangement between the employer and the health carrier for purposes of this paragraph.

(c) Nothing in this section obligates a health carrier to issue coverage to a small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer. This paragraph does not apply if the small employer will meet the required participation level with respect to the new coverage.

(d) If a small employer cannot meet either the participation or contribution requirement, the small employer may purchase coverage only during an open enrollment period each year between November 15 and December 15.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 50. Minnesota Statutes 2012, section 62L.03, subdivision 4, is amended to read:

Subd. 4. **Underwriting restrictions.** ~~(a) Health carriers may apply underwriting restrictions to coverage for health benefit plans for small employers, including any preexisting condition limitations, only as expressly permitted under this chapter. For purposes of this section, "underwriting restrictions" means any refusal of the health carrier to issue or renew coverage, any premium rate higher than the lowest rate charged by the health carrier for the same coverage, any preexisting condition limitation, preexisting condition exclusion, or any exclusionary rider.~~

~~(b)~~ Health carriers may collect information relating to the case characteristics and demographic composition of small employers, as well as health status and health history information about employees, and dependents of employees, of small employers.

~~(c) Except as otherwise authorized for late entrants, preexisting conditions may be excluded by a health carrier for a period not to exceed 12 months from the enrollment date of an eligible employee or dependent, but exclusionary riders must not be used. Late entrants may be subject to a preexisting condition limitation not to exceed 18 months from the enrollment date of the late entrant, but must not be subject to any exclusionary rider or preexisting condition exclusion. When calculating any length of preexisting condition limitation, a health carrier shall credit the time period an eligible employee or dependent was previously covered by qualifying coverage, provided that the individual maintains continuous coverage. The credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. Section 60A.082, relating to replacement of group coverage, and the rules adopted under that section apply to this chapter, and this chapter's requirements are in addition to the requirements of that section and the rules adopted under it. A health carrier shall, at the time of first issuance or renewal of a health benefit plan on or after July 1, 1993, credit against any preexisting condition limitation or exclusion permitted under this section, the time period prior to July 1, 1993, during which an eligible employee or dependent was covered by qualifying coverage, if the person has maintained continuous coverage.~~

~~(d) Health carriers shall not use pregnancy as a preexisting condition under this chapter.~~

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 51. Minnesota Statutes 2012, section 62L.03, subdivision 6, is amended to read:

Subd. 6. **MCHA enrollees.** Health carriers shall offer coverage to any eligible employee or dependent enrolled in MCHA at the time of the health carrier's issuance or renewal of a health benefit plan to a small employer. The health benefit plan must require that the employer permit MCHA enrollees to enroll in the small employer's health benefit plan as of the first date of renewal of a health benefit plan occurring on or after July 1, 1993, and as of each date of renewal after that, or, in the case of a new group, as of the initial effective date of the health benefit plan and as of each date of renewal after that. ~~Unless otherwise permitted by this chapter,~~ Health carriers must not impose any underwriting restrictions, including any preexisting condition limitations or exclusions, on any eligible employee or dependent previously enrolled in MCHA and transferred to a health benefit plan ~~so long as continuous coverage is maintained, provided that the health carrier may impose any unexpired portion of a preexisting condition limitation under the person's MCHA coverage. An MCHA enrollee is not a late entrant, so long as the enrollee has maintained continuous coverage~~.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 52. Minnesota Statutes 2012, section 62L.045, subdivision 2, is amended to read:

Subd. 2. **Qualified associations.** (a) A qualified association, as defined in this section, and health coverage offered by it, to it, or through it, to a small employer in this state must comply with the requirements of this chapter regarding guaranteed issue, guaranteed renewal, preexisting condition limitations, ~~credit against preexisting condition limitations for continuous coverage,~~ treatment of MCHA enrollees, and the definition of dependent, and with section 62A.65, subdivision 5, paragraph

(b). They must also comply with all other requirements of this chapter not specifically exempted in paragraph (b) or (c).

(b) A qualified association and a health carrier offering, selling, issuing, or renewing health coverage to, or to cover, a small employer in this state through the qualified association, may, but are not, in connection with that health coverage, required to:

(1) offer the two small employer plans described in section 62L.05; and

(2) offer to small employers that are not members of the association, health coverage offered to, by, or through the qualified association.

~~(c) A qualified association, and a health carrier offering, selling, issuing, and renewing health coverage to, or to cover, a small employer in this state must comply with section 62L.08, except that:~~

~~(1) a separate index rate may be applied by a health carrier to each qualified association, provided that:~~

~~(i) the premium rate applied to participating small employer members of the qualified association is no more than 25 percent above and no more than 25 percent below the index rate applied to the qualified association, irrespective of when members applied for health coverage; and~~

~~(ii) the index rate applied by a health carrier to a qualified association is no more than 20 percent above and no more than 20 percent below the index rate applied by the health carrier to any other qualified association or to any small employer. In comparing index rates for purposes of this clause, the 20 percent shall be calculated as a percent of the larger index rate; and~~

~~(2) a qualified association described in subdivision 1, paragraph (a), clauses (2) to (4), providing health coverage through a health carrier, or on a self-insured basis in compliance with section 471.617 and the rules adopted under that section, may cover small employers and other employers within the same pool and may charge premiums to small employer members on the same basis as it charges premiums to members that are not small employers, if the premium rates charged to small employers do not have greater variation than permitted under section 62L.08. A qualified association operating under this clause shall annually prove to the commissioner of commerce that it complies with this clause through a sampling procedure acceptable to the commissioner. If the qualified association fails to prove compliance to the satisfaction of the commissioner, the association shall agree to a written plan of correction acceptable to the commissioner. The qualified association is considered to be in compliance under this clause if there is a premium rate that would, if used as an index rate, result in all premium rates in the sample being in compliance with section 62L.08. This clause does not exempt a qualified association or a health carrier providing coverage through the qualified association from the loss ratio requirement of section 62L.08, subdivision 11.~~

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 53. Minnesota Statutes 2012, section 62L.045, subdivision 4, is amended to read:

Subd. 4. **Principles; association coverage.** (a) This subdivision applies to associations as defined in this section, whether qualified associations or not, and is intended to clarify subdivisions 1 to 3.

(b) This section applies only to associations that provide health coverage to small employers.

(c) ~~A health carrier is not required under this chapter to comply with guaranteed issue and guaranteed renewal with respect to its relationship with the association itself.~~ An arrangement between the health carrier and the association, once entered into, must comply with guaranteed issue and guaranteed renewal with respect to members of the association that are small employers and persons covered through them.

(d) When an arrangement between a health carrier and an association has validly terminated, the health carrier has no continuing obligation to small employers and persons covered through them, except as otherwise provided in:

(1) section 62A.65, subdivision 5, paragraph (b);

(2) any other continuation or conversion rights applicable under state or federal law; and

(3) section 60A.082, relating to group replacement coverage, and rules adopted under that section.

(e) When an association's arrangement with a health carrier has terminated and the association has entered into a new arrangement with that health carrier or a different health carrier, the new arrangement is subject to section 60A.082 and rules adopted under it, with respect to members of the association that are small employers and persons covered through them.

(f) An association that offers its members more than one plan of health coverage may have uniform rules restricting movement between the plans of health coverage, if the rules do not discriminate against small employers.

(g) This chapter does not require or prohibit separation of an association's members into one group consisting only of small employers and another group or other groups consisting of all other members. The association must comply with this section with respect to the small employer group.

(h) For purposes of this section, "member" of an association includes an employer participant in the association.

(i) For purposes of this section, health coverage issued to, or to cover, a small employer includes a certificate of coverage issued directly to the employer's employees and dependents, rather than to the small employer.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 54. Minnesota Statutes 2012, section 62L.05, subdivision 10, is amended to read:

Subd. 10. **Medical expense reimbursement.** Health carriers may reimburse or pay for medical services, supplies, or articles provided under a small employer plan in accordance with the health carrier's provider contract requirements including, but not limited to, salaried arrangements, capitation, the payment of usual and customary charges, fee schedules, discounts from fee-for-service, per diems, diagnosis-related groups (DRGs), and other payment arrangements. Nothing in this chapter requires a health carrier to develop, implement, or change its provider contract requirements for a small employer plan. Coinsurance, deductibles, and out-of-pocket maximums~~, and maximum lifetime benefits~~ must be calculated and determined in accordance with each health carrier's standard business practices.

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

Sec. 55. Minnesota Statutes 2012, section 62L.06, is amended to read:

62L.06 DISCLOSURE OF UNDERWRITING RATING PRACTICES.

When offering or renewing a health benefit plan, health carriers shall disclose in all solicitation and sales materials:

(1) ~~the case characteristics and other rating factors used to determine initial and renewal rates;~~

~~(2) the extent to which premium rates for a small employer are established or adjusted based upon actual or expected variation in claim experience;~~

~~(3)~~ provisions concerning the health carrier's right to change premium rates ~~and the factors other than claim experience that affect changes in premium rates~~;

~~(4)~~ (2) provisions relating to renewability of coverage;

~~(5) the use and effect of any preexisting condition provisions, if permitted;~~

~~(6)~~ (3) the application of any provider network limitations and their effect on eligibility for benefits; and

~~(7)~~ (4) the ability of small employers to insure eligible employees and dependents currently receiving coverage from the Comprehensive Health Association ~~through health benefit plans~~.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 56. Minnesota Statutes 2012, section 62L.08, is amended to read:

62L.08 RESTRICTIONS RELATING TO PREMIUM RATES.

Subdivision 1. **Rate restrictions.** Premium rates for all health benefit plans sold or issued to small employers are subject to the restrictions specified in this section.

~~Subd. 2. **General premium variations.** Beginning July 1, 1993, each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the index rate charged to small employers for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this subdivision must be based only on health status, claims experience, industry of the employer, and duration of coverage from the date of issue. For purposes of this subdivision, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined to be actuarially valid and approved by the commissioner. Variations permitted under this subdivision must not be based upon age or applied differently at different ages. This subdivision does not prohibit use of a constant percentage adjustment for factors permitted to be used under this subdivision.~~

~~Subd. 2a. **Renewal premium increases limited.** (a) Beginning January 1, 2003, the percentage increase in the premium rate charged to a small employer for a new rating period must not exceed the sum of the following:~~

~~(1) the percentage change in the index rate measured from the first day of the prior rating period to the first day of the new rating period;~~

~~(2) an adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than one year, due to the claims experience, health status, or duration of coverage of the employees or dependents of the employer; and~~

~~(3) any adjustment due to change in coverage or in the case characteristics of the employer.~~

~~(b) This subdivision does not apply if the employer, employee, or any applicant provides the health carrier with false, incomplete, or misleading information.~~

Subd. 3. **Age-based premium variations.** ~~Beginning July 1, 1993,~~ Each health carrier may offer premium rates to small employers that vary based upon the ages of the eligible employees and dependents of the small employer only as provided in this subdivision. ~~In addition to the variation permitted by subdivision 2, each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.~~ Premium rates may vary based upon the ages of the eligible employees and dependents of the small employer in accordance with the provisions of the Affordable Care Act as defined in section 62A.011, subdivision 1a.

Subd. 4. **Geographic premium variations.** ~~A health carrier may request approval by the commissioner to establish separate geographic regions determined by the health carrier and to establish separate index rates for each such region~~ Premium rates may vary based on geographic rating areas set by the commissioner. The commissioner shall grant approval if ~~the following conditions are met:~~

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

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

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

Subd. 5. **Gender-based rates prohibited.** ~~Beginning July 1, 1993,~~ No health carrier may determine premium rates through a method that is in any way based upon the gender of eligible employees or dependents. Rates must not in any way reflect marital status or generalized differences in expected costs between employees and spouses.

Subd. 6. **~~Rate cells permitted~~ Tobacco rating.** ~~Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based on the number of adults and children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect marital status or differences in expected costs between employees and spouses~~ Premium rates may vary based upon tobacco use in accordance with the provisions of the Affordable Care Act as defined in section 62A.011, subdivision 1a.

Subd. 7. **~~Index and~~ Premium rate development.** (a) In developing its ~~index~~ rates and premiums, a health carrier may take into account only the following factors:

(1) actuarially valid differences in benefit designs of health benefit plans; and

~~(2) actuarially valid differences in the rating factors permitted in subdivisions 2 and 3;~~

~~(3)~~ (2) actuarially valid geographic variations if approved by the commissioner as provided in subdivision 4.

(b) All premium variations permitted under this section must be based upon actuarially valid differences in expected cost to the health carrier of providing coverage. The variation must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All premium variations are subject to approval by the commissioner.

Subd. 8. **Filing requirement.** A health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the ~~index~~ rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include ~~the allowable range of rates from the index rates and~~ a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates. The rates shall not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, and actuarially valid changes in risk associated with the enrollee population~~, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549~~.

Subd. 9. **Effect of assessments.** Premium rates must comply with the rating requirements of this section, notwithstanding the imposition of any assessments or premiums paid by health carriers as provided under sections 62L.13 to 62L.22.

~~Subd. 10. **Rating report.** Beginning January 1, 1995, and annually thereafter, the commissioners of health and commerce shall provide a joint report to the legislature on the effect of the rating restrictions required by this section and the appropriateness of proceeding with additional rate reform. Each report must include an analysis of the availability of health care coverage due to the rating reform, the equitable and appropriate distribution of risk and associated costs, the effect on the self-insurance market, and any resulting or anticipated change in health plan design and market share and availability of health carriers.~~

Subd. 11. **Loss ratio standards.** Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, each policy or contract form used with respect to a health benefit plan offered, or issued in the small employer market, is subject, beginning July 1, 1993, to section 62A.021. The commissioner of health has, with respect to carriers under that commissioner's jurisdiction, all of the powers of the commissioner of commerce under that section.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 57. Minnesota Statutes 2012, section 62L.12, subdivision 2, is amended to read:

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

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

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

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

(e) A health carrier may sell, issue, or renew individual health plans if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group health plan or due to the person's need for health care services not covered under the employer's group health plan.

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

(g) A health carrier may sell, issue, or renew an individual health plan if coverage provided by the employer is determined to be unaffordable under the provisions of the Affordable Care Act as defined in section 62A.011, subdivision 1a.

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

~~(h)~~ (i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage issued as a supplement to Medicare under sections 62A.3099 to 62A.44, or policies or contracts that supplement Medicare issued by health maintenance organizations, or those contracts governed by sections 1833, 1851 to 1859, 1860D, or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., as amended.

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

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

~~(k)~~ (l) A health carrier may offer, sell, issue, or renew an individual health plan to one or more employees of a small employer if the individual health plan is marketed directly to all employees of the small employer and the small employer does not contribute directly or indirectly to the premiums or facilitate the administration of the individual health plan. The requirement to market an individual health plan to all employees does not require the health carrier to offer or issue an individual health plan to any employee. For purposes of this paragraph, an employer is not contributing to the premiums or facilitating the administration of the individual health plan if the employer does not contribute to the premium and merely collects the premiums from an employee's wages or salary through payroll deductions and submits payment for the premiums of one or more employees in a lump sum to the health carrier. Except for coverage under section 62A.65, subdivision 5, paragraph (b), ~~or 62E.16,~~ at the request of an employee, the health carrier may bill the employer for the premiums payable by the employee, provided that the employer is not liable for payment except from payroll deductions for that purpose. If an employer is submitting payments under this paragraph, the health carrier shall provide a cancellation notice directly to the primary insured at least ten days prior to termination of coverage for nonpayment of premium. Individual coverage under this paragraph may be offered only if the small employer has not provided coverage under section 62L.03 to the employees within the past 12 months.

~~The employer must provide a written and signed statement to the health carrier that the employer is not contributing directly or indirectly to the employee's premiums. The health carrier may rely on the employer's statement and is not required to guarantee-issue individual health plans to the employer's other current or future employees.~~

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 58. Minnesota Statutes 2012, section 62M.05, subdivision 3a, is amended to read:

Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, an initial determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number." For purposes of this subdivision, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

(c) When an initial determination is made not to certify, notification must be provided by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional and hospital as applicable. Written notification must also be sent to the hospital as applicable and attending health care professional if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification must be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the provider or enrollee.

(d) When an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

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

Sec. 59. Minnesota Statutes 2012, section 62M.06, subdivision 1, is amended to read:

Subdivision 1. **Procedures for appeal.** (a) A utilization review organization must have written procedures for appeals of determinations not to certify. The right to appeal must be available to the enrollee and to the attending health care professional.

(b) The enrollee shall be allowed to review the information relied upon in the course of the appeal, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process. This paragraph does not apply to managed care plans or county-based purchasing plans serving state public health care program enrollees under section 256B.69, 256B.692, or chapter 256L, or to grandfathered plans as defined under section 62A.011, subdivision 1c. Nothing in this paragraph shall be construed to limit or restrict the appeal rights of state public health care program enrollees provided under section 256.045 and Code of Federal Regulations, title 42, section 438.420(d).

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

Sec. 60. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 1a. **Affordable Care Act.** "Affordable Care Act" means the Affordable Care Act as defined in section 62A.011, subdivision 1a.

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

Sec. 61. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 1b. **Bona fide association.** "Bona fide association" means an association that meets all of the following criteria:

(1) serves a single profession that requires a significant amount of education, training, or experience, or a license or certificate from a state authority to practice that profession;

(2) has been actively in existence for five years;

(3) has a constitution and bylaws or other analogous governing documents;

(4) has been formed and maintained in good faith for purposes other than obtaining insurance;

(5) is not owned or controlled by a health plan company or affiliated with a health plan company;

(6) does not condition membership in the association on any health status-related factor;

(7) has at least 1,000 members if it is a national association, 500 members if it is a state association, or 200 members if it is a local association;

(8) all members and dependents of members are eligible for coverage regardless of any health status-related factor;

(9) does not make health plans offered through the association available other than in connection with a member of the association;

(10) is governed by a board of directors and sponsors an annual meeting of its members; and

(11) produces only market association memberships, accepts applications for membership, or signs up members in the professional association where the subject individuals are actively engaged in, or directly related to, the profession represented by the association.

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

Sec. 62. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 2b. **Grandfathered plan.** "Grandfathered plan" means a health plan as defined in section 62A.011, subdivision 1b.

Sec. 63. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 2c. **Group health plan.** "Group health plan" means a group health plan as defined in section 62A.011, subdivision 1c.

Sec. 64. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 4b. **Individual health plan.** "Individual health plan" means an individual health plan as defined in section 62A.011, subdivision 4.

Sec. 65. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 7. **Life-threatening condition.** "Life-threatening condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

Sec. 66. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 8. **Primary care provider.** "Primary care provider" means a health care professional who specializes in the practice of family medicine, general internal medicine, obstetrics and gynecology, or general pediatrics and is a licensed physician, a licensed and certified advanced practice registered nurse, or a licensed physician assistant.

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

Sec. 67. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 9. **Dependent child to the limiting age.** "Dependent child to the limiting age" or "dependent children to the limiting age" means those individuals who are eligible and covered as a dependent child under the terms of a health plan who have not yet attained 26 years of age. A health plan company must not deny or restrict eligibility for a dependent child to the limiting age based on financial dependency, residency, marital status, or student status. For coverage under plans offered by the Minnesota Comprehensive Health Association, dependent to the limiting age means dependent as defined in section 62A.302, subdivision 3. Notwithstanding the provisions in this subdivision, a health plan may include:

(1) eligibility requirements regarding the absence of other health plan coverage as permitted by the Affordable Care Act for grandfathered plan coverage; or

(2) an age greater than 26 in its policy, contract, or certificate of coverage.

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

Sec. 68. Minnesota Statutes 2012, section 62Q.021, is amended to read:

62Q.021 FEDERAL ACT; COMPLIANCE REQUIRED.

Subdivision 1. **Compliance with 1996 federal law.** Each health plan company shall comply with the federal Health Insurance Portability and Accountability Act of 1996, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this ~~section~~ subdivision.

Subd. 2. **Compliance with 2010 federal law.** Each health plan company shall comply with the Affordable Care Act to the extent that it imposes a requirement that applies in this state but is not required under the laws of this state. This section does not require compliance with any provision of the Affordable Care Act before the effective date provided for that provision in the Affordable Care Act. The commissioner shall enforce this subdivision.

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

Sec. 69. Minnesota Statutes 2012, section 62Q.17, subdivision 6, is amended to read:

Subd. 6. **Employer-based purchasing pools.** Employer-based purchasing pools must, with respect to small employers as defined in section 62L.02, meet all the requirements of chapter 62L. The experience of the pool must be pooled and the rates blended across all groups. ~~Pools may decide to create tiers within the pool, based on experience of group members. These tiers must be designed within the requirements of section 62L.08. The governing structure may establish criteria limiting movement between tiers. Tiers must be phased out within two years of the pool's creation.~~

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 70. Minnesota Statutes 2012, section 62Q.18, is amended by adding a subdivision to read:

Subd. 8. **Guaranteed issue.** No health plan company shall offer, sell, or issue any health plan that does not make coverage available on a guaranteed issue basis in accordance with the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 71. **[62Q.186] PROHIBITION ON RESCISSIONS OF HEALTH PLANS.**

Subdivision 1. **Definitions.** (a) "Rescission" means a cancellation or discontinuance of coverage under a health plan that has a retroactive effect.

(b) "Rescission" does not include:

(1) a cancellation or discontinuance of coverage under a health plan if:

(i) the cancellation or discontinuance of coverage has only a prospective effect; or

(ii) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage; or

(2) when the health plan covers only active employees and, if applicable, dependents and those covered under continuation coverage provisions, the employee pays no premiums for coverage

after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative record keeping.

Subd. 2. **Prohibition on rescissions.** (a) A health plan company shall not rescind coverage under a health plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the health plan, unless:

(1) the individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud; or

(2) the individual makes an intentional misrepresentation or omission of material fact, as prohibited by the terms of the health plan.

For purposes of this section, a person seeking coverage on behalf of an individual does not include an insurance producer or employee or authorized representative of the health carrier.

(b) This section does not apply to any benefits classified as excepted benefits under United States Code, title 42, section 300gg-91(c), or regulations enacted thereunder from time to time.

Subd. 3. **Notice required.** A health plan company shall provide at least 30 days' advance written notice to each individual who would be affected by the proposed rescission of coverage before coverage under the health plan may be terminated retroactively.

Subd. 4. **Compliance with other restrictions on rescissions.** Nothing in this section allows rescission if rescission would otherwise be prohibited under section 62A.04, subdivision 2, clause (2), or 62A.615.

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

Sec. 72. Minnesota Statutes 2012, section 62Q.23, is amended to read:

62Q.23 GENERAL SERVICES.

(a) Health plan companies shall comply with all continuation and conversion of coverage requirements applicable to health maintenance organizations under state or federal law.

(b) Health plan companies shall comply with sections 62A.047, 62A.27, and any other coverage required under chapter 62A of newborn infants, dependent children ~~who do not reside with a covered person~~ to the limiting age as defined in section 62Q.01, subdivision 9, disabled ~~children and dependents~~ dependent children, and adopted children. A health plan company providing dependent coverage shall comply with section 62A.302.

(c) Health plan companies shall comply with the equal access requirements of section 62A.15.

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

Sec. 73. Minnesota Statutes 2012, section 62Q.43, subdivision 2, is amended to read:

Subd. 2. **Access requirement.** Every closed-panel health plan must allow enrollees ~~who are full-time students~~ under the age of ~~25~~ 26 years to change their designated clinic or physician at least once per month, as long as the clinic or physician is part of the health plan company's statewide clinic or physician network. A health plan company shall not charge enrollees who choose this option

higher premiums or cost sharing than would otherwise apply to enrollees who do not choose this option. A health plan company may require enrollees to provide 15 days' written notice of intent to change their designated clinic or physician.

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

Sec. 74. **[62Q.46] PREVENTIVE ITEMS AND SERVICES.**

Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and services" has the meaning specified in the Affordable Care Act.

(b) A health plan company must provide coverage for preventive items and services at a participating provider without imposing cost-sharing requirements, including a deductible, coinsurance, or co-payment. Nothing in this section prohibits a health plan company that has a network of providers from excluding coverage or imposing cost-sharing requirements for preventive items or services that are delivered by an out-of-network provider.

(c) A health plan company is not required to provide coverage for any items or services specified in any recommendation or guideline described in paragraph (a) if the recommendation or guideline is no longer included as a preventive item or service as defined in paragraph (a). Annually, a health plan company must determine whether any additional items or services must be covered without cost-sharing requirements or whether any items or services are no longer required to be covered.

(d) Nothing in this section prevents a health plan company from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for a preventive item or service to the extent not specified in the recommendation or guideline.

(e) This section does not apply to grandfathered plans.

(f) This section does not apply to plans offered by the Minnesota Comprehensive Health Association.

Subd. 2. **Coverage for office visits in conjunction with preventive items and services.** (a) A health plan company may impose cost-sharing requirements with respect to an office visit if a preventive item or service is billed separately or is tracked separately as individual encounter data from the office visit.

(b) A health plan company must not impose cost-sharing requirements with respect to an office visit if a preventive item or service is not billed separately or is not tracked separately as individual encounter data from the office visit and the primary purpose of the office visit is the delivery of the preventive item or service.

(c) A health plan company may impose cost-sharing requirements with respect to an office visit if a preventive item or service is not billed separately or is not tracked separately as individual encounter data from the office visit and the primary purpose of the office visit is not the delivery of the preventive item or service.

Subd. 3. **Additional services not prohibited.** Nothing in this section prohibits a health plan company from providing coverage for preventive items and services in addition to those specified in the Affordable Care Act, or from denying coverage for preventive items and services that are not recommended as preventive items and services under the Affordable Care Act. A health plan company may impose cost-sharing requirements for a treatment not described in the Affordable

Care Act even if the treatment results from a preventive item or service described in the Affordable Care Act.

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

Sec. 75. Minnesota Statutes 2012, section 62Q.47, is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

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

Sec. 76. Minnesota Statutes 2012, section 62Q.52, is amended to read:

62Q.52 DIRECT ACCESS TO OBSTETRIC AND GYNECOLOGIC SERVICES.

Subdivision 1. **Direct access.** (a) Health plan companies shall allow female enrollees direct access to ~~obstetricians and gynecologists~~ providers who specialize in obstetrics and gynecology for the following services:

(1) ~~annual preventive health examinations, which shall include a gynecologic examination, and any subsequent obstetric or gynecologic visits determined to be medically necessary by the examining obstetrician or gynecologist, based upon the findings of the examination~~ evaluation and necessary treatment for obstetric conditions or emergencies;

(2) maternity care; and

(3) evaluation and necessary treatment for ~~acute~~ gynecologic conditions or emergencies, including annual preventive health examinations.

(b) For purposes of this section, "direct access" means that a female enrollee may obtain the obstetric and gynecologic services specified in paragraph (a) from ~~obstetricians and gynecologists~~ providers who specialize in obstetrics and gynecology in the enrollee's network without a referral

from, or prior approval through a primary care provider, another physician, the health plan company, or its representatives.

(c) The health plan company shall treat the provision of obstetrical and gynecological care and the ordering of related obstetrical and gynecological items and services, pursuant to paragraph (a), by a participating health care provider who specializes in obstetrics or gynecology as the authorization of a primary care provider.

(d) The health plan company may require the health care provider to agree to otherwise adhere to the health plan company's policies and procedures, including procedures for obtaining prior authorization and for providing services in accordance with a treatment plan, if any, approved by the health plan company.

~~(c)~~ (e) Health plan companies shall not require higher co-payments, coinsurance, deductibles, or other enrollee cost-sharing for direct access.

~~(d)~~ (f) This section applies only to services described in paragraph (a) that are covered by the enrollee's coverage, but coverage of a preventive health examination for female enrollees must not exclude coverage of a gynecologic examination.

(g) For purposes of this section, a health care provider who specializes in obstetrics or gynecology means any individual, including an individual other than a physician, who is authorized under state law to provide obstetrical or gynecological care.

(h) This section does not:

(1) waive any exclusions of coverage under the terms and conditions of the health plan with respect to coverage of obstetrical or gynecological care; or

(2) preclude the health plan company from requiring that the participating health care provider providing obstetrical or gynecological care notify the primary care provider or the health plan company of treatment decisions.

Subd. 2. **Notice.** A health plan company shall provide notice to enrollees of the provisions of subdivision 1 in accordance with the requirements of the Affordable Care Act.

Subd. 3. **Enforcement.** The commissioner of health shall enforce this section.

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

Sec. 77. **[62Q.526] COVERAGE FOR PARTICIPATION IN APPROVED CLINICAL TRIALS.**

Subdivision 1. **Definitions.** As used in this section, the following definitions apply:

(a) "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or a life-threatening condition and is not designed exclusively to test toxicity or disease pathophysiology and must be:

(1) conducted under an investigational new drug application reviewed by the United States Food and Drug Administration (FDA);

(2) exempt from obtaining an investigational new drug application; or

(3) approved or funded by:

(i) the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperating group or center of any of the entities described in this item;

(ii) a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;

(iii) a qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants; or

(iv) the United States Departments of Veterans Affairs, Defense, or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to:

(A) be comparable to the system of peer review of studies and investigations used by the NIH; and

(B) provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.

(b) "Qualified individual" means an individual with health plan coverage who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or a life-threatening condition because:

(1) the referring health care professional is participating in the trial and has concluded that the individual's participation in the trial would be appropriate; or

(2) the individual provides medical and scientific information establishing that the individual's participation in the trial is appropriate because the individual meets the conditions described in the trial protocol.

(c)(1) "Routine patient costs" includes all items and services covered by the health benefit plan of individual market health insurance coverage when the items or services are typically covered for an enrollee who is not a qualified individual enrolled in an approved clinical trial.

(2) Routine patient costs does not include:

(i) an investigational item, device, or service that is part of the trial;

(ii) an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient;

(iii) a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or

(iv) an item or service customarily provided and paid for by the sponsor of a trial.

Subd. 2. **Prohibited acts.** A health plan company that offers a health plan to a Minnesota resident may not:

(1) deny participation by a qualified individual in an approved clinical trial;

(2) deny, limit, or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the trial; or

(3) discriminate against an individual on the basis of an individual's participation in an approved clinical trial.

Subd. 3. **Network plan conditions.** A health plan company that designates a network or networks of contracted providers may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a health care provider who is part of the plan's network if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

Subd. 4. **Application to clinical trials outside of the state.** This section applies to a qualified individual residing in this state who participates in an approved clinical trial that is conducted outside of this state.

Subd. 5. **Construction.** (a) This section shall not be construed to require a health plan company offering health plan coverage through a network or networks of contracted providers to provide benefits for routine patient costs if the services are provided outside of the plan's network unless the out-of-network benefits are otherwise provided under the coverage.

(b) This section shall not be construed to limit a health plan company's coverage with respect to clinical trials.

(c) This section shall apply to all health plan companies offering a health plan to a Minnesota resident, unless otherwise amended by federal regulations under the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 78. Minnesota Statutes 2012, section 62Q.55, is amended to read:

62Q.55 EMERGENCY SERVICES.

Subdivision 1. **Access to emergency services.** (a) Enrollees have the right to available and accessible emergency services, 24 hours a day and seven days a week. The health plan company shall inform its enrollees how to obtain emergency care ~~and, if prior authorization for emergency services is required, shall make available a toll-free number, which is answered 24 hours a day, to answer questions about emergency services and to receive reports and provide authorizations, where appropriate,~~ for treatment of emergency medical conditions. Emergency services shall be covered whether provided by participating or nonparticipating providers and whether provided within or outside the health plan company's service area. In reviewing a denial for coverage of emergency services, the health plan company shall take the following factors into consideration:

(1) a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment;

(2) the time of day and day of the week the care was provided;

(3) the presenting symptoms, including, but not limited to, severe pain, to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis;

(4) the enrollee's efforts to follow the health plan company's established procedures for obtaining emergency care; and

(5) any circumstances that precluded use of the health plan company's established procedures for obtaining emergency care.

(b) The health plan company may require enrollees to notify the health plan company of nonreferred emergency care as soon as possible, but not later than 48 hours, after the emergency care is initially provided. However, emergency care which would have been covered under the contract had notice been provided within the set time frame must be covered.

(c) Notwithstanding paragraphs (a) and (b), a health plan company~~, health insurer, or health coverage plan~~ that is in compliance with the rules regarding accessibility of services adopted under section 62D.20 is in compliance with this section.

Subd. 2. **Emergency medical condition.** For purposes of this section, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii), of section 1867(e)(1)(A) of the Social Security Act.

Subd. 3. **Emergency services.** As used in this section, "emergency services" means, with respect to an emergency medical condition:

(1) a medical screening examination, as required under section 1867 of the Social Security Act, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient.

Subd. 4. **Stabilize.** For purposes of this section, "stabilize," with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the Social Security Act, United States Code, title 42, section 1395dd(e)(3).

Subd. 5. **Coverage restrictions or limitations.** If emergency services are provided by a nonparticipating provider, with or without prior authorization, the health plan company shall not impose coverage restrictions or limitations that are more restrictive than apply to emergency services received from a participating provider. Cost-sharing requirements that apply to emergency services received out-of-network must be the same as the cost-sharing requirements that apply to services received in-network.

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

Sec. 79. **[62Q.57] DESIGNATION OF PRIMARY CARE PROVIDER.**

Subdivision 1. **Choice of primary care provider.** (a) If a health plan company offering a group health plan, or an individual health plan that is not a grandfathered plan, requires or provides for the designation by an enrollee of a participating primary care provider, the health plan company shall permit each enrollee to:

(1) designate any participating primary care provider available to accept the enrollee; and

(2) for a child, designate any participating physician who specializes in pediatrics as the child's primary care provider and is available to accept the child.

(b) This section does not waive any exclusions of coverage under the terms and conditions of the health plan with respect to coverage of pediatric care.

Subd. 2. **Notice.** A health plan company shall provide notice to enrollees of the provisions of subdivision 1 in accordance with the requirements of the Affordable Care Act.

Subd. 3. **Enforcement.** The commissioner shall enforce this section.

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

Sec. 80. **[62Q.677] LIFETIME AND ANNUAL LIMITS.**

Subdivision 1. **Applicability and scope.** Except as provided in subdivision 2, this section applies to a health plan company providing coverage under an individual or group health plan. For purposes of this section, essential health benefits is defined under section 62Q.81.

Subd. 2. **Grandfathered plan limits.** (a) The prohibition on lifetime limits applies to grandfathered plans providing individual health plan coverage or group health plan coverage.

(b) The prohibition and limits on annual limits apply to grandfathered plans providing group health plan coverage, but do not apply to grandfathered plans providing individual health plan coverage.

Subd. 3. **Prohibition on lifetime and annual limits.** (a) Except as provided in subdivisions 4 and 5, a health plan company offering coverage under an individual or group health plan shall not establish a lifetime limit on the dollar amount of essential health benefits for any individual.

(b) Except as provided in subdivisions 4, 5, and 6, a health plan company shall not establish any annual limit on the dollar amount of essential health benefits for any individual.

Subd. 4. **Nonessential benefits; out-of-network providers.** (a) Subdivision 3 does not prevent a health plan company from placing annual or lifetime dollar limits for any individual on specific covered benefits that are not essential health benefits as defined in section 62Q.81, subdivision 4, to the extent that the limits are otherwise permitted under applicable federal or state law.

(b) Subdivision 3 does not prevent a health plan company from placing an annual or lifetime limit for services provided by out-of-network providers.

Subd. 5. **Excluded benefits.** This section does not prohibit a health plan company from excluding all benefits for a given condition.

Subd. 6. **Annual limits prior to January 1, 2014.** For plan or policy years beginning before January 1, 2014, for any individual, a health plan company may establish an annual limit on the dollar amount of benefits that are essential health benefits provided the limit is no less than the following:

(1) for a plan or policy year beginning after September 22, 2010, but before September 23, 2011, $750,000;

(2) for a plan or policy year beginning after September 22, 2011, but before September 23, 2012, $1,250,000; and

(3) for a plan or policy year beginning after September 22, 2012, but before January 1, 2014, $2,000,000.

In determining whether an individual has received benefits that meet or exceed the allowable limits, a health plan company shall take into account only essential health benefits.

Subd. 7. **Waivers.** For plan or policy years beginning before January 1, 2014, a health plan is exempt from the annual limit requirements if the health plan is approved for a waiver from the requirements by the United States Department of Health and Human Services, but the exemption only applies for the specified period of time that the waiver from the United States Department of Health and Human Services is applicable.

Subd. 8. **Notices.** (a) At the time a health plan company receives a waiver from the United States Department of Health and Human Services, the health plan company shall notify prospective applicants and affected policyholders and the commissioner in each state where prospective applicants and any affected insured are known to reside.

(b) At the time the waiver expires or is otherwise no longer in effect, the health plan company shall notify affected policyholders and the commissioner in each state where any affected insured is known to reside.

Subd. 9. **Reinstatement.** A health plan company shall comply with all provisions of the Affordable Care Act with regard to reinstatement of coverage for individuals whose coverage or benefits under a health plan ended by reason of reaching a lifetime dollar limit on the dollar value of all benefits for the individual.

Subd. 10. **Compliance.** This section does not require compliance with any provision of the Affordable Care Act before the effective date provided for that provision in the Affordable Care Act. The commissioner shall enforce this section.

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

Sec. 81. Minnesota Statutes 2012, section 62Q.68, subdivision 1, is amended to read:

Subdivision 1. **Application.** For purposes of sections 62Q.68 to 62Q.72, the terms defined in this section have the meanings given them. For purposes of sections 62Q.69 and 62Q.70, the term "health plan company" does not include an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01 or a nonprofit health service plan corporation regulated under chapter 62C that only provides dental coverage or vision coverage. For purposes of sections 62Q.69 through 62Q.73, the term "health plan company" does not include the Comprehensive Health Association created under chapter 62E. Section 62Q.70 does not apply to individual coverage. However, a health plan company offering individual coverage may, pursuant to section 62Q.69, subdivision 3, paragraph (c), follow the process outlined in section 62Q.70.

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

Sec. 82. Minnesota Statutes 2012, section 62Q.69, subdivision 3, is amended to read:

Subd. 3. **Notification of complaint decisions.** (a) The health plan company must notify the complainant in writing of its decision and the reasons for it as soon as practical but in no case later than 30 days after receipt of a written complaint. If the health plan company cannot make a decision within 30 days due to circumstances outside the control of the health plan company, the health plan company may take up to 14 additional days to notify the complainant of its decision. If the health plan company takes any additional days beyond the initial 30-day period to make its decision, it must inform the complainant, in advance, of the extension and the reasons for the extension.

(b) For group health plans, if the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the health plan company's internal appeal process described in section 62Q.70 and the procedure for initiating an appeal.

(c) For individual health plans, if the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to submit the complaint decision to the external review process described in section 62Q.73 and the procedure for initiating the external review process. Notwithstanding the provisions in this subdivision, a health plan company offering individual coverage may instead follow the process for group health plans outlined in paragraph (b).

~~(c)~~ (d) The notification must also inform the complainant of the right to submit the complaint at any time to either the commissioner of health or commerce for investigation and the toll-free telephone number of the appropriate commissioner.

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

Sec. 83. Minnesota Statutes 2012, section 62Q.70, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** (a) Each health plan company shall establish an internal appeal process for reviewing a health plan company's decision regarding a complaint filed in accordance with section 62Q.69. The appeal process must meet the requirements of this section. This section applies only to group health plans. However, a health plan company offering individual coverage may, pursuant to section 62Q.69, subdivision 3, paragraph (c), follow the process outlined in this section.

(b) The person or persons with authority to resolve or recommend the resolution of the internal appeal must not be solely the same person or persons who made the complaint decision under section 62Q.69.

(c) The internal appeal process must permit the enrollee to review the information relied upon in the course of the appeal and the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons investigating or presiding over the appeal.

(d) The enrollee must be allowed to receive continued coverage pending the outcome of the appeals process.

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

Sec. 84. Minnesota Statutes 2012, section 62Q.70, subdivision 2, is amended to read:

Subd. 2. **Procedures for filing an appeal.** The health plan company must provide notice to enrollees of its internal appeals process in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act. If a complainant notifies the health plan company of the complainant's desire to appeal the health plan company's decision regarding the complaint through the internal appeal process, the health plan company must provide the complainant the option for the appeal to occur either in writing or by hearing.

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

Sec. 85. Minnesota Statutes 2012, section 62Q.71, is amended to read:

62Q.71 NOTICE TO ENROLLEES.

Each health plan company shall provide to enrollees a clear and concise description of its complaint resolution procedure, if applicable under section 62Q.68, subdivision 1, and the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. If the health plan company does not issue a member handbook, the health plan company may provide the description in another written document. The description must specifically inform enrollees:

(1) how to submit a complaint to the health plan company;

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain certification for health care services;

(3) how to request an appeal either through the procedures described in ~~sections 62Q.69 and~~ section 62Q.70, if applicable, or through the procedures described in chapter 62M;

(4) of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process;

(5) of the toll-free telephone number of the appropriate commissioner; and

(6) of the right, for individual and group coverage, to obtain an external review under section 62Q.73 and a description of when and how that right may be exercised~~.~~, including that under most circumstances an enrollee must exhaust the internal complaint or appeal process prior to external review. However, an enrollee may proceed to external review without exhausting the internal complaint or appeal process under the following circumstances:

(i) the health plan company waives the exhaustion requirement;

(ii) the health plan company is considered to have waived the exhaustion requirement by failing to substantially comply with any requirements including, but not limited to, time limits for internal complaints or appeals; or

(iii) the enrollee has applied for an expedited external review at the same time the enrollee qualifies for and has applied for an expedited internal review under chapter 62M.

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

Sec. 86. Minnesota Statutes 2012, section 62Q.73, is amended to read:

62Q.73 EXTERNAL REVIEW OF ADVERSE DETERMINATIONS.

Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:

(1) for individual health plans, a complaint decision relating to a health care service or claim that is partially or wholly adverse to the complainant;

(2) an individual health plan that is grandfathered plan coverage may instead apply the definition of adverse determination for group coverage in clause (3);

(3) for group health plans, a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant;

~~(2)~~ (4) any initial determination not to certify that has been appealed in accordance with section 62M.06 and the appeal did not reverse the initial determination not to certify; ~~or~~

~~(3)~~ (5) a decision relating to a health care service made by a health plan company licensed under chapter 60A that denies the service on the basis that the service was not medically necessary~~.~~; or

(6) the enrollee has met the requirements of subdivision 6, paragraph (e).

An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

Subd. 2. **Exception.** (a) This section does not apply to governmental programs except as permitted under paragraph (b). For purposes of this subdivision, "governmental programs" means the prepaid medical assistance program, the MinnesotaCare program, the prepaid general assistance medical care program, the demonstration project for people with disabilities, and the federal Medicare program.

(b) In the course of a recipient's appeal of a medical determination to the commissioner of human services under section 256.045, the recipient may request an expert medical opinion be arranged by the external review entity under contract to provide independent external reviews under this section. If such a request is made, the cost of the review shall be paid by the commissioner of human services. Any medical opinion obtained under this paragraph shall only be used by a state human services referee as evidence in the recipient's appeal to the commissioner of human services under section 256.045.

(c) Nothing in this subdivision shall be construed to limit or restrict the appeal rights provided in section 256.045 for governmental program recipients.

Subd. 3. **Right to external review.** (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination, if applicable under section 62Q.68, subdivision 1, or 62M.06, to the commissioner of health if the request involves a health plan company regulated by that commissioner or to the commissioner of commerce if the request involves a health plan company regulated by that commissioner. Notification of the enrollee's right to external review must accompany the denial issued by the insurer. The written request must be accompanied by a filing fee of $25. The fee may be waived by the commissioner of health or commerce in cases of financial hardship and must be refunded if the adverse determination is completely reversed. No enrollee may be subject to filing fees totaling more than $75 during a plan year for group coverage or policy year for individual coverage.

(b) Nothing in this section requires the commissioner of health or commerce to independently investigate an adverse determination referred for independent external review.

(c) If an enrollee requests an external review, the health plan company must participate in the external review. The cost of the external review in excess of the filing fee described in paragraph (a) shall be borne by the health plan company.

(d) The enrollee must request external review within six months from the date of the adverse determination.

Subd. 4. **Contract.** Pursuant to a request for proposal, the commissioner of administration, in consultation with the commissioners of health and commerce, shall contract with ~~an organization~~ at least three organizations or business ~~entity~~ entities to provide independent external reviews of all adverse determinations submitted for external review. The contract shall ensure that the fees for services rendered in connection with the reviews ~~be~~ are reasonable.

Subd. 5. **Criteria.** ~~(a)~~ The request for proposal must require that the entity demonstrate:

(1) no conflicts of interest in that it is not owned, a subsidiary of, or affiliated with a health plan company ~~or~~, utilization review organization, or a trade organization of health care providers;

(2) an expertise in dispute resolution;

(3) an expertise in health-related law;

(4) an ability to conduct reviews using a variety of alternative dispute resolution procedures depending upon the nature of the dispute;

(5) an ability to maintain written records, for at least three years, regarding reviews conducted and provide data to the commissioners of health and commerce upon request on reviews conducted; ~~and~~

(6) an ability to ensure confidentiality of medical records and other enrollee information.~~;~~

(7) accreditation by nationally recognized private accrediting organization; and

(8) the ability to provide an expedited external review process.

~~(b) The commissioner of administration shall take into consideration, in awarding the contract according to subdivision 4, any national accreditation standards that pertain to an external review entity.~~

Subd. 6. **Process.** (a) Upon receiving a request for an external review, the commissioner shall assign an external review entity on a random basis. The assigned external review entity must provide immediate notice of the review to the enrollee and to the health plan company. Within ten business days of receiving notice of the review, the health plan company and the enrollee must provide the assigned external review entity with any information that they wish to be considered. Each party shall be provided an opportunity to present its version of the facts and arguments. The assigned external review entity must furnish to the health plan company any additional information submitted by the enrollee within one business day of receipt. An enrollee may be assisted or represented by a person of the enrollee's choice.

(b) As part of the external review process, any aspect of an external review involving a medical determination must be performed by a health care professional with expertise in the medical issue being reviewed.

(c) An external review shall be made as soon as practical but in no case later than ~~40~~ 45 days after receiving the request for an external review and must promptly send written notice of the decision and the reasons for it to the enrollee, the health plan company, and the commissioner who is responsible for regulating the health plan company.

(d) The external review entity and the clinical reviewer assigned must not have a material professional, familial, or financial conflict of interest with:

(1) the health plan company that is the subject of the external review;

(2) the enrollee, or any parties related to the enrollee, whose treatment is the subject of the external review;

(3) any officer, director, or management employee of the health plan company;

(4) a plan administrator, plan fiduciaries, or plan employees;

(5) the health care provider, the health care provider's group, or practice association recommending treatment that is the subject of the external review;

(6) the facility at which the recommended treatment would be provided; or

(7) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

(e)(1) An expedited external review must be provided if the enrollee requests it after receiving:

(i) an adverse determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function and the enrollee has simultaneously requested an expedited internal appeal;

(ii) an adverse determination that concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services but has not been discharged from a facility; or

(iii) an adverse determination that involves a medical condition for which the standard external review time would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function.

(2) The external review entity must make its expedited determination to uphold or reverse the adverse determination as expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited review and notify the enrollee and the health plan company of the determination.

(3) If the external review entity's notification is not in writing, the external review entity must provide written confirmation of the determination within 48 hours of the notification.

Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse determination that does not require a medical necessity determination, the external review must be based on whether the adverse determination was in compliance with the enrollee's health benefit plan.

(b) For an external review of any issue in an adverse determination by a health plan company licensed under chapter 62D that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

(c) For an external review of any issue in an adverse determination by a health plan company, other than a health plan company licensed under chapter 62D, that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2.

(d) For an external review of an adverse determination involving experimental or investigational treatment, the external review entity must base its decision on all documents submitted by the health plan company and enrollee, including medical records, the attending physician or health care professional's recommendation, consulting reports from health care professionals, the terms of coverage, federal Food and Drug Administration approval, and medical or scientific evidence or evidence-based standards.

Subd. 8. **Effects of external review.** A decision rendered under this section shall be nonbinding on the enrollee and binding on the health plan company. The health plan company may seek judicial review of the decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

Subd. 9. **Immunity from civil liability.** A person who participates in an external review by investigating, reviewing materials, providing technical expertise, or rendering a decision shall not be civilly liable for any action that is taken in good faith, that is within the scope of the person's duties, and that does not constitute willful or reckless misconduct.

Subd. 10. **Data reporting.** The commissioners shall make available to the public, upon request, summary data on the decisions rendered under this section, including the number of reviews heard and decided and the final outcomes. Any data released to the public must not individually identify the enrollee initiating the request for external review.

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

Sec. 87. Minnesota Statutes 2012, section 62Q.75, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given to them.

(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, including, but not limited to, coordination of benefits information, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim under this section. A special circumstance includes, but is not limited to, a claim held pending payment of an overdue premium for the time period during which the expense was incurred as allowed by the Affordable Care Act. Nothing in this section alters an enrollee's obligation to disclose information as required by law.

(c) "Third-party administrator" means a third-party administrator or other entity subject to section 60A.23, subdivision 8, and Minnesota Rules, chapter 2767.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 88. Minnesota Statutes 2012, section 62Q.80, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Community-based" means located in or primarily relating to the community, as determined by the board of a community-based health initiative that is served by the community-based health care coverage program.

(b) "Community-based health care coverage program" or "program" means a program administered by a community-based health initiative that provides health care services through provider members of a community-based health network or combination of networks to eligible individuals and their dependents who are enrolled in the program.

(c) "Community-based health initiative" or "initiative" means a nonprofit corporation that is governed by a board that has at least 80 percent of its members residing in the community and includes representatives of the participating network providers and employers, or a county-based purchasing organization as defined in section 256B.692.

(d) "Community-based health network" means a contract-based network of health care providers organized by the community-based health initiative to provide or support the delivery of health care services to enrollees of the community-based health care coverage program on a risk-sharing or nonrisk-sharing basis.

(e) "Dependent" means an eligible employee's spouse or ~~unmarried~~ child who is under the age of ~~19~~ 26 years.

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

Sec. 89. **[62Q.81] ESSENTIAL HEALTH BENEFIT PACKAGE REQUIREMENTS.**

Subdivision 1. **Essential health benefits package.** (a) Health plan companies offering individual and small group health plans must include the essential health benefits package required under section 1302(a) of the Affordable Care Act and as described in this subdivision.

(b) The essential health benefits package means coverage that:

(1) provides essential health benefits as outlined in the Affordable Care Act;

(2) limits cost-sharing for such coverage in accordance with the Affordable Care Act, as described in subdivision 2; and

(3) subject to subdivision 3, provides bronze, silver, gold, or platinum level of coverage in accordance with the Affordable Care Act.

Subd. 2. **Coverage for enrollees under the age of 21.** If a health plan company offers health plans in any level of coverage specified under section 1302(d) of the Affordable Care Act, as described in subdivision 1, paragraph (b), clause (3), the health plan company shall also offer coverage in that level to individuals who have not attained 21 years of age as of the beginning of a policy year.

Subd. 3. **Alternative compliance for catastrophic plans.** A health plan company that does not provide an individual or small group health plan in the bronze, silver, gold, or platinum level of coverage, as described in subdivision 1, paragraph (b), clause (3), shall be treated as meeting the requirements of section 1302(d) of the Affordable Care Act with respect to any policy year if the health plan company provides a catastrophic plan that meets the requirements of section 1302(e) of the Affordable Care Act.

Subd. 4. **Essential health benefits; definition.** For purposes of this section, "essential health benefits" has the meaning given under section 1302(b) of the Affordable Care Act and includes:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

(6) mental health and substance use disorder services, including behavioral health treatment;

(7) pediatric services, including oral and vision care;

(8) prescription drugs;

(9) preventive and wellness services and chronic disease management;

(10) rehabilitative and habilitative services and devices; and

(11) additional essential health benefits included in the EHB-benchmark plan, as defined under the Affordable Care Act.

Subd. 5. **Exception.** This section does not apply to a dental plan described in section 1311(d)(2)(B)(ii) of the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 90. **[62Q.82] BENEFITS AND COVERAGE EXPLANATION.**

Subdivision 1. **Summary.** Health plan companies offering health plans shall provide a summary of benefits and coverage explanation as required by the Affordable Care Act to:

(1) an applicant at the time of application;

(2) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

(3) a policyholder at the time of issuance of the policy.

Subd. 2. **Compliance.** A health plan company described in subdivision 1 shall be deemed to have complied with subdivision 1 if the summary of benefits and coverage explanation is provided in paper or electronic form as required under the Affordable Care Act.

Subd. 3. **Notice of modification.** Except in connection with a policy renewal or reissuance, if a health plan company makes any material modifications in any of the terms of the coverage, as defined for purposes of section 102 of the federal Employee Retirement Income Security Act of 1974, as amended, that is not reflected in the most recently provided summary of benefits and coverage explanation, the health plan company shall provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective.

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

Sec. 91. Minnesota Statutes 2012, section 72A.20, subdivision 35, is amended to read:

Subd. 35. **Determination of health plan policy limits.** Any health plan under section 62A.011, subdivision 3, that includes a specific policy limit within its insurance policy, certificate, or subscriber agreement shall calculate the policy limit by using the amount actually paid on behalf of the insured, subscriber, or dependents for services covered under the policy, subscriber agreement, or certificate unless the amount paid is greater than the billed charge. This provision does not permit the application of a specific policy limit within a health plan where the limit is prohibited under the Affordable Care Act as defined in section 62A.011, subdivision 1a.

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

Sec. 92. Minnesota Statutes 2012, section 471.61, subdivision 1a, is amended to read:

Subd. 1a. **Dependents.** Notwithstanding the provisions of Minnesota Statutes 1969, section 471.61, as amended by Laws 1971, chapter 451, section 1, the word "dependents" as used therein shall mean spouse and ~~minor unmarried~~ children under the age of ~~18~~ 26 years ~~and dependent students under the age of 25 years actually dependent upon the employee~~.

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

Sec. 93. **REPEALER.**

(a) Minnesota Statutes 2012, section 62E.02, subdivision 7, is repealed effective the day following final enactment.

(b) Minnesota Statutes 2012, sections 62A.615; 62A.65, subdivision 6; 62E.16; 62E.20; 62L.02, subdivisions 4, 18, 19, 23, and 24; 62L.05, subdivisions 1, 2, 3, 4, 4a, 5, 6, 7, 11, 12, and 13; 62L.081; 62L.10, subdivision 5; and 62Q.37, subdivision 5, are repealed effective January 1, 2014.

ARTICLE 2

MARKET RULES FOR AFFORDABLE CARE ACT

Section 1. Minnesota Statutes 2012, section 62D.124, subdivision 4, is amended to read:

Subd. 4. **Application.** (a) Subdivisions 1 and 2 do not apply if an enrollee is referred to a referral center for health care services.

(b) Subdivision 1 does not apply:

(1) if an enrollee has chosen a health plan with full knowledge that the health plan has no participating providers within 30 miles or 30 minutes of the enrollee's place of residence; or

(2) to service areas approved before May 24, 1993.

(c) Beginning for coverage effective on or after January 1, 2015, subdivisions 1 to 4 shall only apply to individual or small group health plans that are grandfathered plans, as defined under section 62A.011, subdivision 1c.

Sec. 2. **[62K.01] TITLE.**

This chapter may be cited as the "Minnesota Health Plan Market Rules."

Sec. 3. **[62K.02] PURPOSE AND SCOPE.**

Subdivision 1. **Purpose.** The market rules set forth in this chapter serve to clarify and provide guidance on the application of state law and certain requirements of the Affordable Care Act on all health carriers offering health plans in Minnesota, whether or not through the Minnesota Insurance Marketplace, to ensure fair competition for all health carriers in Minnesota, to minimize adverse selection, and to ensure that health plans are offered in a manner that protects consumers and promotes the provision of high-quality affordable health care, and improved health outcomes. This chapter contains the regulatory requirements as specified in section 62V.05, subdivision 5, paragraph (b), and shall fully satisfy the requirements of section 62V.05, subdivision 5, paragraph (b).

Subd. 2. **Scope.** (a) This chapter applies only to health plans offered in the individual market or the small group market.

(b) This chapter applies to health carriers with respect to individual health plans and small group health plans, unless otherwise specified.

(c) If a health carrier issues or renews individual or small group health plans in other states, this chapter applies only to health plans issued or renewed in this state to a Minnesota resident, or to cover a resident of the state, or issued or renewed to a small employer that is actively engaged in business in this state, unless otherwise specified.

(d) This chapter does not apply to short-term coverage as defined in section 62A.65, subdivision 7, or grandfathered plan coverage as defined in section 62A.011, subdivision 1b.

EFFECTIVE DATE. This section is effective for health plans that are offered, sold, issued or renewed on or after January 1, 2014.

Sec. 4. **[62K.03] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. **Affordable Care Act.** "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments, and any federal guidance or regulations issued under these acts.

Subd. 3. **Dental plan.** "Dental plan" means a dental plan as defined in section 62Q.76, subdivision 3.

Subd. 4. **Enrollee.** "Enrollee" means a natural person covered by a health plan and includes an insured policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Subd. 5. **Health carrier.** "Health carrier" means a health carrier as defined in section 62A.011, subdivision 2.

Subd. 6. **Health plan.** "Health plan" means a health plan as defined in section 62A.011, subdivision 3.

Subd. 7. **Individual health plan.** "Individual health plan" means an individual health plan as defined in Minnesota Statutes, section 62A.011, subdivision 4.

Subd. 8. **Limited-scope pediatric dental plan.** "Limited-scope pediatric dental plan" means a dental plan meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986, as amended, that provides only pediatric dental benefits meeting the requirements of the Affordable Care Act and is offered by a health carrier. A limited-scope pediatric dental plan includes a dental plan that is offered separately or in conjunction with an individual or small group health plan to individuals who have not attained the age of 19 years as of the beginning of the policy year or to a family.

Subd. 9. **Minnesota Insurance Marketplace.** "Minnesota Insurance Marketplace" means the Minnesota Insurance Marketplace as defined in section 62V.02.

Subd. 10. **Preferred provider organization.** "Preferred provider organization" means a health plan that provides discounts to enrollees or subscribers for services they receive from certain health care providers.

Subd. 11. **Qualified health plan.** "Qualified health plan" means a health plan that meets the definition in the Affordable Care Act and has been certified by the board of the Minnesota Insurance Marketplace in accordance with chapter 62V to be offered through the Minnesota Insurance Marketplace.

Subd. 12. **Small group health plan.** "Small group health plan" means a health plan issued by a health carrier to a small employer as defined in section 62L.02, subdivision 26.

EFFECTIVE DATE. This section is effective for health plans that are offered, sold, issued, or renewed on or after January 1, 2014.

Sec. 5. **[62K.04] MARKET RULES; VIOLATION.**

Subdivision 1. **Compliance.** (a) A health carrier issuing an individual health plan to a Minnesota resident or a small group health plan to provide coverage to a small employer that is actively engaged in business in Minnesota shall meet all of the requirements set forth in this chapter. The failure to meet any of the requirements under this chapter constitutes a violation of section 72A.20.

(b) The requirements of this chapter do not apply to short-term coverage as defined in section 62A.65, subdivision 7, or grandfathered plan coverage as defined in section 62A.011, subdivision 1c.

Subd. 2. **Penalties.** In addition to any other penalties provided by the laws of this state or by federal law, a health carrier or any other person found to have violated any requirement of this chapter may be subject to the administrative procedures, enforcement actions, and penalties provided under section 45.027 and chapters 62D and 72A.

EFFECTIVE DATE. This section is effective for health plans that are offered, sold, issued, or renewed on or after January 1, 2014.

Sec. 6. **[62K.05] FEDERAL ACT; COMPLIANCE REQUIRED.**

A health carrier shall comply with all provisions of the Affordable Care Act to the extent that it imposes a requirement that applies in this state. Compliance with any provision of the Affordable Care Act is required as of the effective date established for that provision in the federal act, except as otherwise specifically stated earlier in state law.

EFFECTIVE DATE. This section is effective for health plans that are offered, sold, issued, or renewed on or after January 1, 2014.

Sec. 7. **[62K.06] METAL LEVEL MANDATORY OFFERINGS.**

Subdivision 1. **Identification.** A health carrier that offers individual or small group health plans in Minnesota must provide documentation to the commissioner of commerce to justify actuarial value levels as specified in section 1302(d) of the Affordable Care Act for all individual and small group health plans offered inside and outside of the Minnesota Insurance Marketplace.

Subd. 2. **Minimum levels.** (a) A health carrier that offers a catastrophic plan or a bronze level health plan within a service area in either the individual or small group market must also offer a silver level and a gold level health plan in that market and within that service area.

(b) A health carrier with less than five percent market share in the respective individual or small group market in Minnesota is exempt from paragraph (a), until January 1, 2017, unless the health carrier offers a qualified health plan through the Minnesota Insurance Marketplace. If the health carrier offers a qualified health plan through the Minnesota Insurance Marketplace, the health carrier must comply with paragraph (a).

Subd. 3. **Minnesota Insurance Marketplace restriction.** The Minnesota Insurance Marketplace may not, by contract or otherwise, mandate the types of health plans to be offered by a health carrier to individuals or small employers purchasing health plans outside of the Minnesota Insurance Marketplace. Solely for purposes of this subdivision, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clause (6).

Subd. 4. **Metal level defined.** For purposes of this section, the metal levels and catastrophic plans are defined in section 1302(d) and (e) of the Affordable Care Act.

Subd. 5. **Enforcement.** The commissioner of commerce shall enforce this section.

Sec. 8. **[62K.07] INFORMATION DISCLOSURES.**

(a) A health carrier offering individual or small group health plans must submit the following information in a format determined by the commissioner of commerce:

(1) claims payment policies and practices;

(2) periodic financial disclosures;

(3) data on enrollment;

(4) data on disenrollment;

(5) data on the number of claims that are denied;

(6) data on rating practices;

(7) information on cost-sharing and payments with respect to out-of-network coverage; and

(8) other information required by the secretary of the United States Department of Health and Human Services under the Affordable Care Act.

(b) A health carrier offering an individual or small group health plan must comply with all information disclosure requirements of all applicable state and federal law, including the Affordable Care Act.

(c) Except for qualified health plans sold on the Minnesota Insurance Marketplace, information reported under paragraph (a), clauses (3) and (4), is nonpublic data as defined under section 13.02, subdivision 9. Information reported under paragraph (a), clauses (1) through (8), must be reported by the Minnesota Insurance Marketplace for qualified health plans sold through the Minnesota Insurance Marketplace.

(d) The commissioner of commerce shall enforce this section.

Sec. 9. **[62K.08] MARKETING STANDARDS.**

Subdivision 1. **Marketing.** (a) A health carrier offering individual or small group health plans must comply with all applicable provisions of the Affordable Care Act, including, but not limited to, the following:

(1) compliance with all state laws pertaining to the marketing of individual or small group health plans; and

(2) establishing marketing practices and benefit designs that will not have the effect of discouraging the enrollment of individuals with significant health needs in the health plan.

(b) No marketing materials may lead consumers to believe that all health care needs will be covered.

Subd. 2. **Enforcement.** The commissioner of commerce shall enforce this section.

EFFECTIVE DATE. This section is effective for health plans offered, sold, issued, or renewed on or after January 1, 2014.

Sec. 10. **[62K.09] ACCREDITATION STANDARDS.**

Subdivision 1. **Accreditation; general.** (a) A health carrier that offers any individual or small group health plans in Minnesota outside of the Minnesota Insurance Marketplace must be accredited in accordance with this subdivision. A health carrier must obtain accreditation through URAC, the National Committee for Quality Assurance (NCQA), or any entity recognized by the United States Department of Health and Human Services for accreditation of health insurance issuers or health plans by January 1, 2018. Proof of accreditation must be submitted to the commissioner of health in a form prescribed by the commissioner of health.

(b) A health carrier that rents a provider network is exempt from this subdivision, unless it is part of a holding company as defined in section 60D.15 that in aggregate exceeds ten percent market share in either the individual or small group market in Minnesota.

Subd. 2. **Accreditation; Minnesota Insurance Marketplace.** (a) The Minnesota Insurance Marketplace shall require all health carriers offering a qualified health plan through the Minnesota Insurance Marketplace to obtain the appropriate level of accreditation no later than the third year after the first year the health carrier offers a qualified health plan through the Minnesota Insurance Marketplace. A health carrier must take the first step of the accreditation process during the first

year in which it offers a qualified health plan. A health carrier that offers a qualified health plan on January 1, 2014, must obtain accreditation by the end of the 2016 plan year.

(b) To the extent a health carrier cannot obtain accreditation due to low volume of enrollees, an exception to this accreditation criterion may be granted by the Minnesota Insurance Marketplace until such time as the health carrier has a sufficient volume of enrollees.

Subd. 3. **Oversight.** A health carrier shall comply with a request from the commissioner of health to confirm accreditation or progress toward accreditation.

Subd. 4. **Enforcement.** The commissioner of health shall enforce this section.

Sec. 11. **[62K.10] GEOGRAPHIC ACCESSIBILITY; PROVIDER NETWORK ADEQUACY.**

Subdivision 1. **Applicability.** (a) This section applies to all health carriers that either require an enrollee to use or that create incentives, including financial incentives, for an enrollee to use, health care providers that are managed, owned, under contract with, or employed by the health carrier. A health carrier that does not manage, own, or contract directly with providers in Minnesota is exempt from this section, unless it is part of a holding company as defined in section 60D.15 that in aggregate exceeds ten percent in either the individual or small group market in Minnesota.

(b) Health carriers renting provider networks from other entities must submit the rental agreement or contract to the commissioner of health for approval. In reviewing the agreements or contracts, the commissioner shall review the agreement or contract to ensure that the entity contracting with health care providers accepts responsibility to meet the requirements in this section.

Subd. 2. **Primary care; mental health services; general hospital services.** The maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services.

Subd. 3. **Other health services.** The maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 2.

Subd. 4. **Network adequacy.** Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay. In determining network adequacy, the commissioner of health shall consider availability of services, including the following:

(1) primary care physician services are available and accessible 24 hours per day, seven days per week, within the network area;

(2) a sufficient number of primary care physicians have hospital admitting privileges at one or more participating hospitals within the network area so that necessary admissions are made on a timely basis consistent with generally accepted practice parameters;

(3) specialty physician service is available through the network or contract arrangement;

(4) mental health and substance use disorder treatment providers are available and accessible through the network or contract arrangement;

(5) to the extent that primary care services are provided through primary care providers other than physicians, and to the extent permitted under applicable scope of practice in state law for a given provider, these services shall be available and accessible; and

(6) the network has available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of enrollees for covered health care services.

Subd. 5. **Waiver.** A health carrier or preferred provider organization may apply to the commissioner of health for a waiver of the requirements in subdivision 2 or 3 if it is unable to meet the statutory requirements. A waiver application must be submitted on a form provided by the commissioner and must:

(1) demonstrate with specific data that the requirement of subdivision 2 or 3 is not feasible in a particular service area or part of a service area; and

(2) include information as to the steps that were and will be taken to address the network inadequacy.

The waiver shall automatically expire after four years. If a renewal of the waiver is sought, the commissioner of health shall take into consideration steps that have been taken to address network adequacy.

Subd. 6. **Referral centers.** Subdivisions 2 and 3 shall not apply if an enrollee is referred to a referral center for health care services. A referral center is a medical facility that provides highly specialized medical care, including but not limited to organ transplants. A health carrier or preferred provider organization may consider the volume of services provided annually, case mix, and severity adjusted mortality and morbidity rates in designating a referral center.

Subd. 7. **Essential community providers.** Each health carrier must comply with section 62Q.19.

Subd. 8. **Enforcement.** The commissioner of health shall enforce this section.

Sec. 12. **[62K.11] BALANCE BILLING PROHIBITED.**

(a) A network provider is prohibited from billing an enrollee for any amount in excess of the allowable amount the health carrier has contracted for with the provider as total payment for the health care service. A network provider is permitted to bill an enrollee the approved co-payment, deductible, or coinsurance.

(b) A network provider is permitted to bill an enrollee for services not covered by the enrollee's health plan as long as the enrollee agrees in writing in advance before the service is performed to pay for the noncovered service.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 13. **[62K.12] QUALITY ASSURANCE AND IMPROVEMENT.**

Subdivision 1. **General.** (a) All health carriers offering an individual health plan or small group health plan must have a written internal quality assurance and improvement program that, at a minimum:

(1) provides for ongoing evaluation of the quality of health care provided to its enrollees;

(2) periodically reports the evaluation of the quality of health care to the health carrier's governing body;

(3) follows policies and procedures for the selection and credentialing of network providers that is consistent with community standards;

(4) conducts focused studies directed at problems, potential problems, or areas with potential for improvements in care;

(5) conducts enrollee satisfaction surveys and monitors oral and written complaints submitted by enrollees or members; and

(6) collects and reports Health Effectiveness Data and Information Set (HEDIS) measures and conducts other quality assessment and improvement activities as directed by the commissioner of health.

(b) The commissioner of health shall submit a report to the chairs and ranking minority members of senate and house of representatives committees with primary jurisdiction over commerce and health policy by February 15, 2015, with recommendations for specific quality assurance and improvement standards for all Minnesota health carriers. The recommended standards must not require duplicative data gathering, analysis, or reporting by health carriers.

Subd. 2. **Exemption.** A health carrier that rents a provider network is exempt from this section, unless it is part of a holding company as defined in section 60D.15 that in aggregate exceeds ten percent market share in either the individual or small group market in Minnesota.

Subd. 3. **Waiver.** A health carrier that has obtained accreditation through the URAC for network management; quality improvement; credentialing; member protection; and utilization management, or has achieved an excellent or commendable level ranking from the National Committee for Quality Assurance (NCQA), shall be deemed to meet the requirements of subdivision 1. Proof of accreditation must be submitted to the commissioner of health in a form prescribed by the commissioner. The commissioner may adopt rules to recognize similar accreditation standards from any entity recognized by the United States Department of Health and Human Services for accreditation of health insurance issuers or health plans.

Subd. 4. **Enforcement.** The commissioner of health shall enforce this section.

Sec. 14. **[62K.13] SERVICE AREA REQUIREMENTS.**

(a) Any health carrier that offers an individual or small group health plan, must offer the health plan in a service area that is at least the entire geographic area of a county unless serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of enrollees. The service area for any individual or small group health plan must be established without regard to racial,

ethnic, language, concentrated poverty, or health status-related factors, or other factors that exclude specific high-utilizing, high-cost, or medically underserved populations.

(b) If a health carrier that offers an individual or small group health plan requests to serve less than the entire county, the request must be made to the commissioner of health on a form and manner determined by the commissioner and must provide specific data demonstrating that the service area is not discriminatory, is necessary, and is in the best interest of enrollees.

(c) The commissioner of health shall enforce this section.

Sec. 15. **[62K.14] LIMITED-SCOPE PEDIATRIC DENTAL PLANS.**

(a) Limited-scope pediatric dental plans must be offered to the extent permitted under the Affordable Care Act: (1) on a guaranteed issue and guaranteed renewable basis; (2) with premiums rated on allowable rating factors used for health plans; and (3) without any exclusions or limitations based on preexisting conditions.

(b) Notwithstanding paragraph (a), a health carrier may discontinue a limited scope pediatric dental plan if the health carrier provides written notice to enrollees at least 90 calendar days before coverage is to be discontinued that the particular plan is being discontinued and the health carrier offers enrollees other dental plan options that are the same or substantially similar to the dental plan being discontinued in terms of premiums, benefits, cost-sharing requirements, and network adequacy.

(c) Limited-scope pediatric dental plans must ensure primary care dental services are available within 60 miles or 60 minutes' travel time.

(d) If a stand-alone dental plan as defined under the Affordable Care Act or a limited-scope pediatric dental plan is offered, either separately or in conjunction with a health plan offered to individuals or small employers, the health plan shall not be considered in noncompliance with the requirements of the essential benefit package in the Affordable Care Act because the health plan does not offer coverage of pediatric dental benefits if these benefits are covered through the stand-alone or limited-scope pediatric dental plan, to the extent permitted under the Affordable Care Act.

(e) Health carriers offering limited-scope pediatric dental plans must comply with this section and sections 62K.07, 62K.08, 62K.13, and 62K.15.

(f) The commissioner of commerce shall enforce paragraphs (a) and (b). Any limited scope pediatric dental plan that is to be offered to replace a discontinued dental plan under paragraph (b) must be approved by the commissioner of commerce in terms of cost and benefit similarity, and the commissioner of health in terms of network adequacy similarity. The commissioner of health shall enforce paragraph (c).

EFFECTIVE DATE. This section is effective for health plans and dental plans that are offered, sold, issued, or renewed on or after January 1, 2014, with the exception of paragraphs (a) and (b), which are effective for health plans and dental plans that are offered, sold, issued, or renewed on or after January 1, 2015.

Sec. 16. **[62K.15] ANNUAL OPEN ENROLLMENT PERIODS.**

(a) Health carriers offering individual health plans must limit annual enrollment in the individual market to the annual open enrollment periods for the Minnesota Insurance Marketplace. Nothing in

this section limits the application of special or limited open enrollment periods as defined under the Affordable Care Act.

(b) Health carriers offering individual health plans must inform all applicants at the time of application and enrollees at least annually of the open and special enrollment periods as defined under the Affordable Care Act.

(c) The commissioner of commerce shall enforce this section.

Sec. 17. Minnesota Statutes 2012, section 62Q.19, subdivision 1, is amended to read:

Subdivision 1. **Designation.** (a) The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

(1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high-risk and special needs populations, underserved, and other special needs populations; and

(2) a commitment to serve low-income and underserved populations by meeting the following requirements:

(i) has nonprofit status in accordance with chapter 317A;

(ii) has tax-exempt status in accordance with the Internal Revenue Service Code, section 501(c)(3);

(iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and

(iv) does not restrict access or services because of a client's financial limitation;

(3) status as a local government unit as defined in section 62D.02, subdivision 11, a hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal government, an Indian health service unit, or a community health board as defined in chapter 145A;

(4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions;

(5) a sole community hospital. For these rural hospitals, the essential community provider designation applies to all health services provided, including both inpatient and outpatient services. For purposes of this section, "sole community hospital" means a rural hospital that:

(i) is eligible to be classified as a sole community hospital according to Code of Federal Regulations, title 42, section 412.92, or is located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services;

(ii) has experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available; and

(iii) consists of 40 or fewer licensed beds; ~~or~~

(6) a birth center licensed under section 144.615~~.~~; or

(7) a hospital and affiliated specialty clinics that predominately serve patients who are under 21 years of age, and meet the following criteria: (i) provides intensive specialty pediatric services that are routinely provided in fewer than five hospitals in the state; and (ii) serves children from at least half the counties in the state.

(b) Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

(c) The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

(d) For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

EFFECTIVE DATE. This section is effective for health plans offered, sold, issued, or renewed on or after January 1, 2014.

Sec. 18. **EFFECTIVE DATE.**

Sections 1 to 17 are effective for health plans offered, sold, issued, or renewed on or after January 1, 2015, unless otherwise specified."

Amend the title numbers accordingly

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

Senator Cohen from the Committee on Finance, to which was re-referred

S.F. No. 925: A bill for an act relating to marriage; providing for marriage between two persons; providing for exemptions based on religious association; amending Minnesota Statutes 2012, sections 363A.26; 517.01; 517.03, subdivision 1; 517.08, subdivision 1a; 517.09; 518.07; proposing coding for new law in Minnesota Statutes, chapter 517.

Reports the same back with the recommendation that the bill do pass. Report adopted.

Senator Cohen from the Committee on Finance, to which was re-referred

S.F. No. 901: A bill for an act relating to energy; promoting renewable energy; regulating the distributed generation of electric energy; establishing a requirement for utilities to generate solar energy; providing various incentives for the production of solar energy; requiring several studies related to electric energy; regulating utility cost recovery for certain transmission, emission reduction, and gas infrastructure investments; providing state energy policies; regulating various energy conservation investment programs; amending Minnesota Statutes 2012, sections 16C.144, subdivision 2; 216B.02, subdivision 4; 216B.16, subdivision 7b; 216B.1635; 216B.164, subdivisions 3, 4, 6, by adding subdivisions; 216B.1692, subdivisions 1, 8, by adding a subdivision; 216B.1695, subdivision 5, by adding a subdivision; 216B.2401; 216B.241, subdivisions 1, 1e, by adding a subdivision; 216B.2422, subdivision 4; 216C.05; 216C.435, subdivision 8, by adding a subdivision; 216C.436, subdivisions 2, 7, 8; 429.101, subdivision 2; Laws 2005, chapter 97, article 10, section 3; proposing coding for new law in Minnesota Statutes, chapters 3; 216B; 216C; repealing Minnesota Statutes 2012, section 216B.1637.

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

Delete everything after the enacting clause and insert:

"**ARTICLE 1**

STATE ENERGY POLICY

Section 1. **[3.8852] PLANNING STRATEGY FOR SUSTAINABLE ENERGY FUTURE.**

(a) The Legislative Energy Commission, in consultation with the commissioner of commerce, shall develop a framework for the state of Minnesota to transition to a renewable energy economy that ends Minnesota's contribution to greenhouse gases from burning fossil fuels within the next few decades. The framework and strategy should aim to make Minnesota the first state in the nation to use only renewable energy.

(b) In developing the framework for this transition, the commission must consult with stakeholders, including, but not limited to, representatives from cooperative, municipal, and investor-owned utilities, natural resources and environmental advocacy groups, labor and industry, and technical and scientific experts to examine the challenges and opportunities involved to develop a strategy and timeline to protect the environment and create jobs. The timeline must establish goals and strategies to reach the state's renewable energy standards and prepare for the steps beyond reaching those standards. The Department of Commerce, Division of Energy Resources shall provide technical support.

(c) The commission and its stakeholders must consider the following in creating the framework:

(1) the economic and environmental costs of continued reliance on fossil fuels;

(2) the creation of jobs and industry in the state that result from moving ahead of other states in transitioning to a sustainable energy economy;

(3) the appropriate energy efficiency and renewable energy investments in Minnesota to reduce the economic losses to the Minnesota economy from importation of fossil fuels; and

(4) the new technologies for energy efficiency, storage, transmission, and renewable generation needed to reliably meet the demand for energy.

(d) The framework shall be modified as needed to take advantage of new technological developments to facilitate ending fossil fuel use in power generation, heating and cooling, industry, and transportation.

(e) The commission shall report to the legislative committees and divisions with jurisdiction over energy policy by January 15, 2014, and annually thereafter, on progress towards achieving the framework goals.

Sec. 2. **SCOPING FOR RENEWABLE ENERGY STUDY.**

The commissioner of commerce, in consultation with the Legislative Energy Commission, shall develop the scope for a Minnesota energy future study on how Minnesota can achieve a sustainable energy system that does not rely on the burning of fossil fuels.

The study must include energy use in the electrical, transportation, thermal and industrial sectors of the state economy. The study shall evaluate options for different mixes of renewable energy,

efficiency, energy storage, and new technologies that can best transform each sector of energy use to become fully sustainable and no longer rely on fossil fuels in a cost-effective manner.

The study must analyze both costs and benefits. The study must include at least the following considerations: system reliability, utility rates, energy prices, jobs, economic development, public health, and environmental quality. Calculation of costs and benefits must be based on full cost, life-cycle accounting methods that include the benefits of avoided externalities. The study must be designed to develop appropriate timelines and accommodate modifications that will occur as new technologies and efficiencies develop.

In developing the scope, the commissioner shall engage stakeholders concerning the study's parameters and assumptions. The commissioner must report the results of the scoping process to the Legislative Energy Commission by January 1, 2014. The commissioner may assess up to $100,000 under Minnesota Statutes, section 216B.62, to scope and develop this energy study proposal.

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

ARTICLE 2

DISTRIBUTED GENERATION; SOLAR STANDARD

Section 1. Minnesota Statutes 2012, section 216B.02, subdivision 4, is amended to read:

Subd. 4. **Public utility.** "Public utility" means persons, corporations, or other legal entities, their lessees, trustees, and receivers, now or hereafter operating, maintaining, or controlling in this state equipment or facilities for furnishing at retail natural, manufactured, or mixed gas or electric service to or for the public or engaged in the production and retail sale thereof but does not include (1) a municipality or a cooperative electric association, organized under the provisions of chapter 308A, producing or furnishing natural, manufactured, or mixed gas or electric service; (2) a retail seller of compressed natural gas used as a vehicular fuel which purchases the gas from a public utility; or (3) a retail seller of electricity used to recharge a battery that powers an electric vehicle, as defined in section 169.011, subdivision 26a, and that is not otherwise a public utility under this chapter. Except as otherwise provided, the provisions of this chapter shall not be applicable to any sale of natural, manufactured, or mixed gas or electricity by a public utility to another public utility for resale. In addition, the provisions of this chapter shall not apply to a public utility whose total natural gas business consists of supplying natural, manufactured, or mixed gas to not more than 650 customers within a city pursuant to a franchise granted by the city, provided a resolution of the city council requesting exemption from regulation is filed with the commission. The city council may rescind the resolution requesting exemption at any time, and, upon the filing of the rescinding resolution with the commission, the provisions of this chapter shall apply to the public utility. No person shall be deemed to be a public utility if it furnishes its services only to tenants or cooperative or condominium owners in buildings owned, leased, or operated by such person. No person shall be deemed to be a public utility if it furnishes service to occupants of a manufactured home or trailer park owned, leased, or operated by such person. No person shall be deemed to be a public utility if it produces or furnishes service to less than 25 persons. No persons shall be deemed to be a public utility solely as a result of financing or ownership of distributed generation equipment located on a customer's property, provided all of the output of the generating equipment is delivered or sold to the utility that serves the customers.

Sec. 2. Minnesota Statutes 2012, section 216B.164, subdivision 2, is amended to read:

Subd. 2. **Applicability.** This section as well as any rules promulgated by the commission to implement this section or the Public Utility Regulatory Policies Act of 1978, Public Law 95-617, Statutes at Large, volume 92, page 3117, and the Federal Energy Regulatory Commission regulations thereunder, Code of Federal Regulations, title 18, part 292, shall, unless otherwise provided in this section, apply to all Minnesota electric utilities, including cooperative electric associations and municipal electric utilities.

Sec. 3. Minnesota Statutes 2012, section 216B.164, is amended by adding a subdivision to read:

Subd. 2a. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given them:

(b) "Aggregated meter" means a meter located on the premises of a customer's owned or leased property that is contiguous with property containing the customer's designated meter.

(c) "Capacity" means the number of megawatts AC (alternating current) at the point of interconnection between a distributed generation facility and a utility's electric system.

(d) "Cogeneration" means a combined process whereby electrical and useful thermal energy are produced simultaneously.

(e) "Contiguous property" means property owned or leased by the customer sharing a common border, without regard to interruptions in contiguity caused by easements, public thoroughfares, transportation rights-of-way, or utility rights-of-way.

(f) "Customer" means the person who is named on the utility electric bill for the premises.

(g) "Designated meter" means a meter that is physically attached to the customer's facility that the customer-generator designates as the first meter to which net metered credits are to be applied as the primary meter for billing purposes when the customer is serviced by more than one meter.

(h) "Distributed generation" means a facility that:

(1) has a capacity of ten megawatts or less;

(2) is interconnected with a utility's distribution system, over which the commission has jurisdiction; and

(3) generates electricity from natural gas, renewable fuel, or a similarly clean fuel, and may include waste heat, cogeneration, or fuel cell technology.

(i) "High-efficiency, distributed generation" means a distributed energy facility that has a minimum efficiency of 40 percent, as calculated under section 272.0211.

(j) "Net metered facility" means an electric generation facility with the purpose of offsetting energy use through the use of renewable energy or high-efficiency distributed generation sources.

(k) "Renewable energy" has the meaning given in section 216B.2411, subdivision 2.

Sec. 4. Minnesota Statutes 2012, section 216B.164, subdivision 3, is amended to read:

Subd. 3. **Purchases; small facilities.** (a) This paragraph applies to cooperative electric associations and municipal utilities. For a qualifying facility having less than 40-kilowatt capacity, the customer shall be billed for the net energy supplied by the utility according to the applicable rate schedule for sales to that class of customer. In the case of net input into the utility system by a

qualifying facility having less than 40-kilowatt capacity, compensation to the customer shall be at a per kilowatt-hour rate determined under paragraph ~~(b) or~ (c) or (d).

(b) This paragraph applies to public utilities. For a qualifying facility having less than 1,000-kilowatt capacity, the customer shall be billed for the net energy supplied by the utility according to the applicable rate schedule for sales to that class of customer. In the case of net input into the utility system by a qualifying facility having: (1) more than 40-kilowatt but less than 1,000-kilowatt capacity, compensation to the customer shall be at a per kilowatt-hour rate determined under paragraph (c); or (2) less than 40-kilowatt capacity, compensation to the customer shall be at a per-kilowatt rate determined under paragraph (d). Compensation for net input into the utility system shall be applied as a credit to the customer's energy bill, carried forward and applied to subsequent energy bills for a period of up to 12 months. If any credit remains after a calendar year, the value of the remaining credit must be paid to the customer within 15 days of the next billing date.

(c) In setting rates, the commission shall consider the fixed distribution costs to the utility not otherwise accounted for in the basic monthly charge and shall ensure that the costs charged to the qualifying facility are not discriminatory in relation to the costs charged to other customers of the utility. The commission shall set the rates for net input into the utility system based on avoided costs as defined in the Code of Federal Regulations, title 18, section 292.101, paragraph (b)(6), the factors listed in Code of Federal Regulations, title 18, section 292.304, and all other relevant factors.

~~(c)~ (d) Notwithstanding any provision in this chapter to the contrary, a qualifying facility that began generating electricity before January 1, 2015, having less than 40-kilowatt capacity may elect that the compensation for net input by the qualifying facility into the utility system shall be at the average retail utility energy rate. "Average retail utility energy rate" is defined as the average of the retail energy rates, exclusive of special rates based on income, age, or energy conservation, according to the applicable rate schedule of the utility for sales to that class of customer.

~~(d)~ (e) If the qualifying facility or net metered facility is interconnected with a nongenerating utility which has a sole source contract with a municipal power agency or a generation and transmission utility, the nongenerating utility may elect to treat its purchase of any net input under this subdivision as being made on behalf of its supplier and shall be reimbursed by its supplier for any additional costs incurred in making the purchase. Qualifying facilities or net metered facilities having less than ~~40-kilowatt~ 1,000-kilowatt capacity if interconnected to a public utility, or 40-kilowatt capacity if interconnected to a cooperative electric association or municipal utility may, at the customer's option, elect to be governed by the provisions of subdivision 4.

Sec. 5. Minnesota Statutes 2012, section 216B.164, subdivision 4, is amended to read:

Subd. 4. **Purchases; wheeling; costs.** (a) Except as otherwise provided in paragraph (c), this subdivision shall apply to all qualifying facilities having 40-kilowatt capacity or more as well as qualifying facilities as defined in subdivision 3 and net metered systems under subdivision 4a, if interconnected to a cooperative electric association or municipal utility, or 1,000-kilowatt capacity or more if interconnected to a public utility, which elect to be governed by its provisions.

(b) The utility to which the qualifying facility is interconnected shall purchase all energy and capacity made available by the qualifying facility. The qualifying facility shall be paid the utility's full avoided capacity and energy costs as negotiated by the parties, as set by the commission, or as determined through competitive bidding approved by the commission. The full avoided capacity and

energy costs to be paid a qualifying facility that generates electric power by means of a renewable energy source are the utility's least cost renewable energy facility or the bid of a competing supplier of a least cost renewable energy facility, whichever is lower, unless the commission's resource plan order, under section 216B.2422, subdivision 2, provides that the use of a renewable resource to meet the identified capacity need is not in the public interest.

(c) For all qualifying facilities having 30-kilowatt capacity or more, the utility shall, at the qualifying facility's or the utility's request, provide wheeling or exchange agreements wherever practicable to sell the qualifying facility's output to any other Minnesota utility having generation expansion anticipated or planned for the ensuing ten years. The commission shall establish the methods and procedures to insure that except for reasonable wheeling charges and line losses, the qualifying facility receives the full avoided energy and capacity costs of the utility ultimately receiving the output.

(d) The commission shall set rates for electricity generated by renewable energy.

Sec. 6. Minnesota Statutes 2012, section 216B.164, is amended by adding a subdivision to read:

Subd. 4a. **Net metered facility.** Except for customers receiving a value of solar rate under subdivision 10, a customer with a net metered facility having less than 1,000-kilowatt capacity if interconnected to a public utility or 40-kilowatt capacity if interconnected to a cooperative electric association or municipal utility may elect to be compensated for the customer's net input into the utility system in the form of a kilowatt-hour credit on the customer's energy bill carried forward and applied to subsequent energy bills. Any net input supplied by the customer into the utility system that exceeds energy supplied to the customer by the utility during a calendar year must be compensated at the utility's avoided cost rate under subdivision 3, paragraph (c), or subdivision 4, paragraph (b), as applicable.

Sec. 7. Minnesota Statutes 2012, section 216B.164, is amended by adding a subdivision to read:

Subd. 4b. **Aggregation of meters.** (a) For the purpose of measuring electricity under subdivisions 3 and 4a, a public utility must aggregate for billing purposes a customer's designated meter with one or more aggregated meters if a customer requests that it do so. To qualify for aggregation under this subdivision, a meter must be owned by the customer requesting the aggregation, must be located on contiguous property owned by the customer requesting the aggregation, and the total of all aggregated meters must be subject to the size limitation in this section.

(b) A public utility must comply with a request by a customer-generator to aggregate additional meters within 90 days. The specific meters must be identified at the time of the request. In the event that more than one meter is identified, the customer must designate the rank order for the aggregated meters to which the net metered credits are to be applied. At least 60 days prior to the beginning of the next annual billing period, a customer may amend the rank order of the aggregated meters, subject to this subdivision.

(c) The aggregation of meters applies only to charges that use kilowatt-hours as the billing determinant. All other charges applicable to each meter account shall be billed to the customer.

(d) A public utility will first apply the kilowatt-hour credit to the charges for the designated meter and then to the charges for the aggregated meters in the rank order specified by the customer. If the net metered facility supplies more electricity to the public utility than the energy usage recorded

by the customer-generator's designated and aggregated meters during a monthly billing period, the public utility shall apply credits to the customer's next monthly bill for the excess kilowatt-hours.

(e) With the commission's prior approval, a public utility may charge the customer-generator requesting to aggregate meters a reasonable fee to cover the administrative costs incurred in implementing the costs of this subdivision, pursuant to a tariff approved by the commission for a public utility.

Sec. 8. Minnesota Statutes 2012, section 216B.164, is amended by adding a subdivision to read:

Subd. 4c. **Limiting cumulative generation prohibited.** The commission is prohibited from limiting the cumulative generation of net metered facilities under subdivision 4a and qualifying facilities under subdivision 3 to less than five percent of a public utility's average annual retail electricity sales over the previous three calendar years. Prior to interconnecting a net metered facility that would result in cumulative net metered facility generation in excess of its limit of five percent, a public utility's obligation to offer net metering to a new customer-generator may be limited by the commission if it determines doing so is in the public interest. The commission may limit net metering obligations under this subdivision only after providing notice and opportunity for public comment. When determining whether limiting net metering obligations under this subdivision is in the public interest, the commission shall consider:

(1) the environmental and other public policy benefits of net metered systems;

(2) the impact of net metered systems on the electricity costs for customers without net metered systems;

(3) the effects of net metering on the reliability of the electric system;

(4) technical advances or technical concerns; and

(5) other statutory obligations imposed on the commission or a utility.

The commission may limit net metering obligations under clauses (2) to (4) only if it finds implementation would cause significant rate impact, require significant measures to address reliability, or raise significant technical issues.

Sec. 9. Minnesota Statutes 2012, section 216B.164, is amended by adding a subdivision to read:

Subd. 4d. **Individual system capacity limits.** Public utilities that provide retail electric service may require customers participating in net metering and net billing to limit the total generation capacity of individual distributed generation systems by either:

(1) for wind generation systems, limiting the total generation system capacity kilowatt alternating current to 120 percent of the customer's on-site maximum electric demand; or

(2) for solar photovoltaic and other distributed generation limiting the total generation system annual energy production kilowatt hours alternating current to 120 percent of the customer's on-site annual electric energy consumption.

Limits under clauses (1) and (2) must be based on standard 15-minute intervals, measured during the previous 12 calendar months, or on a reasonable estimate of the average monthly maximum demand or average annual consumption if the customer has either:

(i) less than 12 calendar months of actual electric usage; or

(ii) no demand metering available.

Sec. 10. Minnesota Statutes 2012, section 216B.164, subdivision 6, is amended to read:

Subd. 6. **Rules and uniform contract.** (a) The commission shall promulgate rules to implement the provisions of this section. The commission shall also establish a uniform statewide form of contract for use between utilities and a net metered or qualifying facility having less than ~~40-kilowatt~~ 1,000-kilowatt capacity if interconnected to a public utility or 40-kilowatt capacity if interconnected to a cooperative electric association or municipal utility.

(b) The commission shall require the qualifying facility to provide the utility with reasonable access to the premises and equipment of the qualifying facility if the particular configuration of the qualifying facility precludes disconnection or testing of the qualifying facility from the utility side of the interconnection with the utility remaining responsible for its personnel.

(c) The uniform statewide form of contract shall be applied to all new and existing interconnections established between a utility and a net metered or qualifying facility having less than 40-kilowatt capacity, except that existing contracts may remain in force until ~~written notice of election that the uniform statewide contract form applies is given by either party to the other, with the notice being of the shortest time period permitted under the existing contract for termination of the existing contract by either party, but not less than ten nor longer than 30 days~~ terminated by mutual agreement between both parties.

(d) A public utility may not apply a standby charge to a net metered facility.

Sec. 11. Minnesota Statutes 2012, section 216B.164, is amended by adding a subdivision to read:

Subd. 10. **Alternative tariff; compensation for resource value.** (a) A public utility may apply for commission approval, or a cooperative electric association or municipal electric utility may apply for approval from its governing body, for an alternative tariff that compensates customers through a bill credit mechanism for the value to the utility, its customers, and society for operating distributed solar photovoltaic resources interconnected to the utility system and operated by customers primarily for meeting their own energy needs. Alternative tariffs approved by the governing body of a cooperative electric association or municipal utility must be filed with the commission.

(b) If approved, the alternative tariff shall apply to customers' interconnections occurring after the date of approval. The alternative tariff is in lieu of the small facility rate or net metering for distributed solar resources under subdivisions 3 and 4a.

(c) The commission or governing body shall after notice and opportunity for public comment approve the alternative tariff provided the utility or association has demonstrated the alternative tariff:

(1) appropriately applies a methodology substantially similar to the methodology established by the department under this subdivision;

(2) includes a mechanism to allow recovery of the cost to serve customers operating distributed solar systems;

(3) charges the customer for all electricity consumed by the customer at the applicable rate schedule for sales to that class of customer;

(4) credits the customer for all electricity generated by the solar photovoltaic device at the value-based credit rate established under this subdivision;

(5) applies the charges and credits in clauses (3) and (4) to a monthly bill that includes a provision so that the unused portion of the credit in any month or billing period shall be carried forward and credited against all charges. In the event that the customer has a positive balance after the 12-month cycle ending on the last day in February, that balance will be eliminated and the credit cycle will restart the following billing period beginning on March 1;

(6) complies with the size limits specified in subdivision 4a;

(7) complies with the interconnection requirements under section 216B.1611; and

(8) is not subject to standby or network charges.

(d) A utility must provide to the customer the meter and any other equipment needed to provide service under the alternative tariff.

(e) The department must establish the distributed solar value methodology in paragraph (c), clause (1), no later than January 31, 2014. The methodology may not be used unless approved by the commission. The department must submit the methodology to the commission for approval. The commission must approve, modify with the consent of the department, or disapprove the methodology within 60 days of its submission. When developing the distributed solar value methodology, the department shall consult stakeholders with experience and expertise in power systems, solar energy, and electric utility ratemaking regarding the proposed methodology, underlying assumptions, and preliminary data.

(f) The distributed solar value methodology established by the department must, at a minimum, account for the value of energy and its delivery, generation capacity, transmission capacity, transmission and distribution line losses, and environmental value. The department may, based on known and measurable evidence of the cost or benefit of solar operation to the utility, incorporate other values into the methodology, including credit for locally manufactured or assembled energy systems, systems installed at high-value locations on the distribution grid, or other factors.

(g) The credit for distributed solar value applied to alternative tariffs approved under this section shall represent the present value of the future revenue streams of the value components identified in paragraph (f).

(h) The utility shall recalculate the alternative tariff on an annual cycle, and shall file the recalculated alternative tariff with the commission or governing body for approval.

(i) Renewable energy credits for solar energy credited under this subdivision belong to the electric utility providing the credit.

Sec. 12. **[216B.1641] COMMUNITY SOLAR GARDEN.**

(a) The public utility subject to section 116C.779 shall file by September 30, 2013, a plan with the commission to operate a community solar garden program. Other public utilities may file an application at their election. The community solar garden program must be designed to offset the energy use of not less than five subscribers in each community solar garden program of which no single subscriber has more than a 40 percent interest. The owner of the community solar garden

may be a public utility or any other entity or organization that contracts to sell the output from the community solar garden to the utility.

(b) A solar garden must have a nameplate capacity of no more than one megawatt. Each subscription shall be sized to represent at least one kilowatt of the community solar garden's generating capacity and to supply, when combined with other distributed generation resources serving the premises, no more than 120 percent of the average annual consumption of electricity by each subscriber at the premises to which the subscription is attributed.

(c) The solar generation facility must be located in the service territory of the public utility filing the plan. Subscribers must be retail customers of the public utility located in the same county or a county contiguous to where the facility is located.

(d) The public utility must purchase from the community solar garden all energy generated by the solar garden. The purchase shall be at the value of solar rate as calculated under section 216B.164, subdivision 10.

(e) The commission may approve, disapprove, or modify a plan based on, among other things, the following factors:

(1) that the plan reasonably allows for the creation of solar gardens;

(2) that the plan establishes a mechanism that allows the utility to recoup interconnection costs for each community solar garden;

(3) that the plan is nondiscriminatory among customers; and

(4) that the plan is consistent with the public interest.

Sec. 13. **[216B.2427] SOLAR ELECTRICITY STANDARD.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Public utility" has the meaning given in section 216B.02, subdivision 4.

(c) "Total retail electric sales" has the meaning given in section 216B.1691, subdivision 1, paragraph (c).

Subd. 2. **Solar electricity standard.** (a) A public utility must generate or procure solar electric generation capacity for its retail customers in Minnesota or the retail customers of a distribution utility to which the public utility provides wholesale electric service. At a minimum, one percent of the public utility's total retail electric sales to retail customers in Minnesota must be generated by solar energy by the end of the year 2025.

(b) For the purposes of calculating the total retail electric sales under this section of a public utility, there shall be excluded retail electric sales to customers that are:

(1) a mineral extraction or mineral processing facility or a paper mill that meets the definition of a "large customer facility" under section 216B.241, subdivision 1, paragraph (i); or

(2) an iron ore mining operation using over ten megawatts connected load and producing iron concentrate.

Those customers may not have included in the rates charged to them by the public utility any costs of satisfying the solar standard specified by this section.

(c) A public utility may not use energy used to satisfy the solar energy standard under this section to satisfy its standard obligation under section 216B.1691, nor may energy used to satisfy the standard under section 216B.1691 be used to satisfy the standard under this section.

Subd. 3. **Use of integrated resource planning process.** Except if inconsistent with this section, the commission may modify or delay implementation of a standard obligation in the same manner as in section 26B.1691, subdivision 2b, as a part of an integrated resource planning proceeding under section 216B.2422, or in other proceedings before the commission. The order to delay or modify shall not be considered advisory with respect to any public utility. This subdivision shall not be construed to limit the commission's authority to modify or delay implementation of a standard obligation in other proceedings before it.

Subd. 4. **Utility plans filed with commission.** Each public utility shall report to the commission on its plans, activities, and progress demonstrating the efforts made towards complying with this section. The report shall be included in its filings under section 216B.2422 or in a separate report submitted to the commission every two years, whichever is more frequent. In its resource plan or separate report, each public utility shall provide a description of:

(1) the status of the utility's solar energy mix relative to the standards;

(2) efforts taken to meet the standards;

(3) any obstacles encountered or anticipated in meeting the standards;

(4) potential solutions to the identified obstacles; and

(5) an estimation of the rate impact related to measures taken by the public utility necessary to comply with this section. The rate impact estimate must be for wholesale rates and, if the public utility makes retail sales, an estimate shall also be completed for the impact on the public utility's retail rates. An estimation of rate impacts must also account for acquisition of energy capacity, distribution, and transmission upgrades avoided as a result of the standards.

Subd. 5. **Renewable energy credits.** In lieu of generating or procuring energy directly to satisfy the solar electricity standard of this section, a public utility may use renewable energy credits that originate from a solar electricity generator to satisfy the standard. In doing so, a public utility must follow protocols established by the commission under section 216B.1691, subdivision 4 for registering, tracking, and retiring credits.

Subd. 6. **Compliance; penalties.** (a) The commission must regularly investigate whether a public utility is in compliance with its standard obligation under subdivision 2.

(b) If the commission finds noncompliance, it may order the public utility to construct solar energy facilities, purchase solar energy, purchase renewable energy credits generated by solar energy, or engage in other activities to achieve compliance. If a public utility fails to comply with an order under this subdivision, the commission may impose a financial penalty on the public utility in an amount not to exceed the estimated cost of the public utility to achieve compliance. The penalty may not exceed the lesser of the cost of constructing facilities or purchasing renewable energy credits necessary for the public utility to achieve compliance. The commission must

deposit financial penalties imposed under this subdivision in the energy and conservation account established in the special revenue fund under section 216B.241, subdivision 2a.

(c) Nothing in this subdivision shall be construed to limit any other authority the commission possesses to enforce this section.

Sec. 14. **STUDY; SOLAR ENERGY AND COOPERATIVE ELECTRIC ASSOCIATIONS AND MUNICIPAL UTILITIES.**

The Legislative Energy Commission must convene a group, including representatives from cooperative electric associations and municipal utilities, to discuss the role of solar energy as a generation resource for associations and municipal utilities. The discussions should be broadly focused on all issues related to solar as a generation resource including, without limitation:

(1) the comparative cost and value of solar and other generation resources;

(2) the need for new generation resources and timing of that need;

(3) the ownership, siting, sizing, pricing, and interconnection of solar generation; and

(4) the integration of solar generation with conservation and other generation resources.

The group must be convened by July 1, 2013, and must report the results of the discussion to the commission by February 1, 2014.

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

ARTICLE 3

MADE IN MINNESOTA

Section 1. **[216C.411] DEFINITIONS.**

For the purposes of sections 216C.411 to 216C.415, the following terms have the meanings given.

(a) "Made in Minnesota" means the manufacture in this state of solar photovoltaic modules:

(1) at a manufacturing facility located in Minnesota that is registered and authorized to manufacture and apply the UL 1703 certification mark to solar photovoltaic modules by Underwriters Laboratory (UL), CSA International, Intertek, or an equivalent UL-approved independent certification agency;

(2) that bear UL 1703 certification marks from UL, CSA International, Intertek, or an equivalent UL-approved independent certification agency, which must be physically applied to the modules at a manufacturing facility described in clause (1); and

(3) that are manufactured in Minnesota:

(i) by manufacturing processes that must include tabbing, stringing, and lamination; or

(ii) by interconnecting low-voltage direct current photovoltaic elements that produce the final useful photovoltaic output of the modules.

A solar photovoltaic module that is manufactured by attaching microinverters, direct current optimizers, or other power electronics to a laminate or solar photovoltaic module that has received UL 1703 certification marks outside Minnesota from UL, CSA International, Intertek, or an equivalent UL-approved independent certification agency is not "Made in Minnesota" under this paragraph.

(b) "Solar photovoltaic module" has the meaning given in section 116C.7791, subdivision 1, paragraph (e).

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

Sec. 2. **[216C.412] "MADE IN MINNESOTA" SOLAR ENERGY PRODUCTION INCENTIVE ACCOUNT.**

Subdivision 1. **Account established; account management.** A "Made in Minnesota" solar energy production incentive account is established as a separate account in the special revenue fund in the state treasury. Earnings, such as interest, dividends, and any other earnings arising from account assets, must be credited to the account. Funds remaining in the account at the end of a fiscal year do not cancel to the general fund but remain in the account. There is annually appropriated from the account to the commissioner of commerce money sufficient to make the incentive payments under section 216C.415 and to administer sections 216C.412 to 216C.415.

Subd. 2. **Payments from public utilities.** (a) Beginning January 1, 2014, and each January 1 thereafter, through 2023, for a total of ten years, each electric public utility subject to section 216B.241 must annually pay to the commissioner of commerce five percent of the minimum amount it is required to spend on energy conservation improvements under section 216B.241, subdivision 1a. Payments made under this paragraph count towards satisfying expenditure obligations of a public utility under section 216B.241, subdivision 1a. The commissioner shall, upon receipt of the funds, deposit them in the account established in subdivision 1. A public utility subject to this paragraph must be credited energy-savings for the purpose of satisfying its energy savings requirement under section 216B.241, subdivision 1c, based on its payment to the commissioner.

(b) Notwithstanding section 116C.779, subdivision 1, paragraph (g), beginning January 1, 2014, and continuing through January 1, 2023, for a total of ten years, the utility that manages the account under section 116C.779 must annually pay from that account to the commissioner an amount that, when added to the total amount paid to the commissioner of commerce under paragraph (a), totals $15,000,000 annually. The commissioner shall, upon receipt of the payment, deposit it in the account established in subdivision 1.

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

Sec. 3. **[216C.413] "MADE IN MINNESOTA" SOLAR ENERGY PRODUCTION INCENTIVE; QUALIFICATION.**

Subdivision 1. **Application.** A manufacturer of solar photovoltaic modules seeking to qualify those modules as eligible to receive the "Made in Minnesota" solar energy production incentive must submit an application to the commissioner of commerce on a form prescribed by the commissioner. The application must contain:

(1) a technical description of the solar photovoltaic module and the processes used to manufacture it, excluding proprietary details;

(2) documentation that the solar photovoltaic module meets all the required applicable parts of the "Made in Minnesota" definition in section 216C.411, including evidence of the UL 1703 right to mark for all solar photovoltaic modules seeking to qualify as "Made in Minnesota";

(3) any additional nonproprietary information requested by the commissioner of commerce; and

(4) certification signed by the chief executive officer of the manufacturing company attesting to the truthfulness of the contents of the application and supporting materials under penalty of perjury.

Subd. 2. **Certification.** If the commissioner determines that a manufacturer's solar photovoltaic module meets the definition of "Made in Minnesota" in section 216C.411, the commissioner shall issue the manufacturer a "Made in Minnesota" certificate containing the name and model numbers of the certified solar photovoltaic modules and the date of certification. The commissioner must issue or deny the issuance of a certificate within 90 days of receipt of a completed application. A copy of the certificate must be provided to each purchaser of the solar photovoltaic module.

Subd. 3. **Revocation of certification.** The commissioner may revoke a certification of a module as "Made in Minnesota" if the commissioner finds that the module no longer meets the requirements to be certified. The revocation does not affect incentive payments awarded prior to the revocation.

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

Sec. 4. **[216C.414] "MADE IN MINNESOTA" SOLAR ENERGY PRODUCTION INCENTIVE.**

Subdivision 1. **Setting incentive.** Within 90 days of a module being certified as "Made in Minnesota" the commissioner of commerce shall set a solar energy production incentive amount for that solar photovoltaic module for the purpose of the incentive payment under section 216C.415. The incentive is a performance-based financial incentive expressed as a per kilowatt-hour amount. The amount shall be used for incentive applications approved in the year to which the incentive amount is applicable for the ten-year duration of the incentive payments. An incentive amount must be calculated for each module for each calendar year, through 2023.

Subd. 2. **Criteria for determining incentive amount.** (a) The commissioner shall set the incentive payment amount by determining the average amount of incentive payment required to allow an average owner of installed solar photovoltaic modules a reasonable return on their investment. In setting the incentive amount the commissioner shall consider:

(1) an estimate of the installed cost per kilowatt-direct current, based on the cost data supplied by the manufacturer in the application submitted under section 216C.413, and an estimate of the average installation cost based on a representative sample of Minnesota solar photovoltaic installed projects;

(2) the average insolation rate in Minnesota;

(3) an estimate of the decline in the generation efficiency of the solar photovoltaic modules over time;

(4) the rate paid by utilities to owners of solar photovoltaic modules under section 216B.164 or other law;

(5) applicable federal tax incentives for installing solar photovoltaic modules; and

(6) the estimated levelized cost per kilowatt-hour generated.

(b) The commissioner shall annually, for incentive applications received in a year, revise each incentive amount based on the factors in paragraph (a), clauses (1) to (6), general market conditions, and the availability of other incentives. In no case shall the "Made in Minnesota" incentive amount result in the "Made in Minnesota" incentives paid exceeding 40 percent, net of average applicable taxes on the ten-year incentive payments, of the average historic installation cost per kilowatt. The commissioner may exceed the 40 percent cap if the commissioner determines it is necessary to fully expend funds available for incentive payments in a particular year.

Subd. 3. **Metering of production.** A utility or association must, at the expense of a customer, provide a meter to measure the production of a solar photovoltaic module system that is approved to receive incentive payments. The utility or association must furnish the commissioner with information sufficient for the commissioner to determine the incentive payment. The information must be provided on a calendar year basis by no later than March 1. The commissioner shall provide an association or utility with forms to use to provide the production information. A customer must attest to the accuracy of the production information.

Subd. 4. **Payment due date.** Payments must be made no later than July 1 following the year of production.

Subd. 5. **Renewable energy credits.** Renewable energy credits associated with energy provided to a utility or association for which an incentive payment is made belong to the utility or association.

Sec. 5. **[216C.415] "MADE IN MINNESOTA" SOLAR ENERGY PRODUCTION INCENTIVE; PAYMENT.**

Subdivision 1. **Incentive payment.** Incentive payments may be made under this section only to an owner of grid-connected solar photovoltaic modules with a total nameplate capacity below 40 kilowatts direct current who:

(1) has submitted to the commissioner, on a form established by the commissioner, an application to receive the incentive that has been approved by the commissioner;

(2) has received a "Made in Minnesota" certificate under section 216C.413 for the module; and

(3) has installed on residential or commercial property solar photovoltaic modules that are generating electricity and has received a "Made in Minnesota" certificate under section 216C.413.

Subd. 2. **Application process.** Applications for an incentive payment must be received by the commissioner between January 1 and February 28. The commissioner shall by a random method approve the number of applications the commissioner reasonably determines will exhaust the funds available for payment for the ten-year period of incentive payments. Applications for residential and commercial installations shall be separately randomly approved.

Subd. 3. **Commissioner approval of incentive application.** The commissioner must approve an application for an incentive for an owner to be eligible for incentive payments. The commissioner must not approve an application in a calendar year if the commissioner determines there will not be sufficient funding available to pay an incentive to the applicant for any portion of the ten-year duration of payment. The commissioner shall annually establish a cap on the cumulative capacity for a program year based on funds available and historic average installation costs. Receipt of an

incentive is not an entitlement and payment need only be made from available funds in the "Made in Minnesota" solar production incentive account.

Subd. 4. **Eligibility window; payment duration.** (a) Payments may be made under this section only for electricity generated from new solar photovoltaic module installations that are commissioned between January 1, 2014, and December 31, 2023.

(b) The payment eligibility window of the incentive begins and runs consecutively from the date the solar system is commissioned.

(c) An owner of solar photovoltaic modules may receive payments under this section for a particular module for a period of ten years provided that sufficient funds are available in the account.

(d) No payment may be made under this section for electricity generated after December 31, 2033.

(e) An owner of solar photovoltaic modules may not first begin to receive payments under this section after December 31, 2024.

Subd. 5. **Allocation of payments.** (a) If there are sufficient applications, approximately 50 percent of the incentive payment shall be for owners of eligible solar photovoltaic modules installed on residential property, and approximately 50 percent shall be for owners of eligible solar photovoltaic modules installed on commercial property.

(b) The commissioner shall endeavor to distribute incentives paid under this section to owners of solar photovoltaic modules installed in a manner so that the amount of payments received in an area of the state reasonably approximates the amount of payments made by a utility serving that area.

(c) For purposes of this subdivision:

(1) "residential property" means residential real estate that is occupied and used as a homestead by its owner or by a renter and includes "multifamily housing development" as defined in section 462C.02, subdivision 5, except that residential property on which solar photovoltaic modules (i) whose capacity exceeds 10 kilowatts is installed; or (ii) connected to a utility's distribution system and whose electricity is purchased by several residents, each of whom own a share of the electricity generated, shall be deemed commercial property; and

(2) "commercial property" means real property on which is located a business, government, or nonprofit establishment.

Subd. 6. **Limitation.** An owner receiving an incentive payment under this section may not receive a rebate under section 116C.7791 for the same solar photovoltaic modules.

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

Sec. 6. **VALUE OF ON-SITE ENERGY STORAGE STUDY.**

(a) The commissioner of commerce shall contract with an independent consultant selected through a request for proposal process to produce a report analyzing the potential costs and benefits of installing utility-managed energy storage modules in residential and commercial buildings in this state. The study must:

(1) estimate the potential value of on-site energy storage modules as a load-management tool to reduce costs for individual customers and for the utility, including, but not limited to, reductions in energy, particularly peaking and capacity costs;

(2) examine the interaction of energy storage modules with on-site solar photovoltaic modules; and

(3) analyze existing barriers to the installation of on-site energy storage modules by utilities, and examine strategies and design potential economic incentives, including using utility funds expended under Minnesota Statutes, section 216B.241, to overcome those barriers.

By January 1, 2014, the commissioner of commerce shall submit the study to the chairs and ranking minority members of the legislative committees with jurisdiction over energy policy and finance.

(b) The commissioner of commerce shall assess an amount, not to exceed $100,000, under Minnesota Statutes, section 216B.241, subdivision 1e, for the purpose of completing the study described in this section.

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

Sec. 7. **VALUE OF SOLAR THERMAL STUDY.**

(a) The commissioner of commerce shall contract with an independent consultant selected through a request for proposal process to produce a report analyzing the potential costs and benefits of expanding the installation of solar thermal projects, as defined in Minnesota Statutes, section 216B.2411, subdivision 2, in residential and commercial buildings in this state. The study must examine the potential for solar thermal projects to reduce heating and cooling costs for individual customers and to reduce utilities' costs. The study must also analyze existing barriers to the installation of solar thermal projects by utilities, and examine strategies and design potential economic incentives, including using utility funds expended under Minnesota Statutes, section 216B.241, to overcome those barriers. By January 1, 2014, the commissioner of commerce shall submit the study to the chairs and ranking minority members of the legislative committees with jurisdiction over energy policy and finance.

(b) The commissioner of commerce shall assess an amount, not to exceed $100,000, under Minnesota Statutes, section 216B.241, subdivision 1e, for the purpose of completing the study described in this section.

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

ARTICLE 4

TRANSMISSION COST RECOVERY

Section 1. Minnesota Statutes 2012, section 216B.16, subdivision 7b, is amended to read:

Subd. 7b. **Transmission cost adjustment.** (a) Notwithstanding any other provision of this chapter, the commission may approve a tariff mechanism for the automatic annual adjustment of charges for the Minnesota jurisdictional costs net of associated revenues of:

(i) new transmission facilities that have been separately filed and reviewed and approved by the commission under section 216B.243 or are certified as a priority project or deemed to be a priority transmission project under section 216B.2425; ~~and~~

(ii) new transmission facilities approved by the regulatory commission of the state in which the new transmission facilities are to be constructed, to the extent approval is required by the laws of that state, and determined by the Midwest Independent Transmission System Operator to benefit the utility or integrated transmission system; and

(iii) charges incurred by a utility under a federally approved tariff that accrue from other transmission owners' regionally planned transmission projects that have been determined by the Midwest Independent Transmission System Operator to benefit the utility~~, as provided for under a federally approved tariff~~ or integrated transmission system.

(b) Upon filing by a public utility or utilities providing transmission service, the commission may approve, reject, or modify, after notice and comment, a tariff that:

(1) allows the utility to recover on a timely basis the costs net of revenues of facilities approved under section 216B.243 or certified or deemed to be certified under section 216B.2425 or exempt from the requirements of section 216B.243;

(2) allows the utility to recover charges incurred ~~by a utility~~ under a federally approved tariff that accrue from other transmission owners' regionally planned transmission projects that have been determined by the Midwest Independent Transmission System Operator to benefit the utility~~, as provided for under a federally approved tariff~~ or integrated transmission system. These charges must be reduced or offset by revenues received by the utility and by amounts the utility charges to other regional transmission owners, to the extent those revenues and charges have not been otherwise offset;

(3) allows the utility to recover on a timely basis the costs net of revenues of facilities approved by the regulatory commission of the state in which the new transmission facilities are to be constructed and determined by the Midwest Independent Transmission System Operator to benefit the utility or integrated transmission system;

(4) allows a return on investment at the level approved in the utility's last general rate case, unless a different return is found to be consistent with the public interest;

~~(4)~~ (5) provides a current return on construction work in progress, provided that recovery from Minnesota retail customers for the allowance for funds used during construction is not sought through any other mechanism;

~~(5)~~ (6) allows for recovery of other expenses if shown to promote a least-cost project option or is otherwise in the public interest;

~~(6)~~ (7) allocates project costs appropriately between wholesale and retail customers;

~~(7)~~ (8) provides a mechanism for recovery above cost, if necessary to improve the overall economics of the project or projects or is otherwise in the public interest; and

~~(8)~~ (9) terminates recovery once costs have been fully recovered or have otherwise been reflected in the utility's general rates.

(c) A public utility may file annual rate adjustments to be applied to customer bills paid under the tariff approved in paragraph (b). In its filing, the public utility shall provide:

(1) a description of and context for the facilities included for recovery;

(2) a schedule for implementation of applicable projects;

(3) the utility's costs for these projects;

(4) a description of the utility's efforts to ensure the lowest costs to ratepayers for the project; and

(5) calculations to establish that the rate adjustment is consistent with the terms of the tariff established in paragraph (b).

(d) Upon receiving a filing for a rate adjustment pursuant to the tariff established in paragraph (b), the commission shall approve the annual rate adjustments provided that, after notice and comment, the costs included for recovery through the tariff were or are expected to be prudently incurred and achieve transmission system improvements at the lowest feasible and prudent cost to ratepayers.

ARTICLE 5

CERTS FUNDING

Section 1. Minnesota Statutes 2012, section 216B.241, subdivision 1e, is amended to read:

Subd. 1e. **Applied research and development grants.** (a) The commissioner may, by order, approve and make grants for applied research and development projects of general applicability that identify new technologies or strategies to maximize energy savings, improve the effectiveness of energy conservation programs, or document the carbon dioxide reductions from energy conservation programs. When approving projects, the commissioner shall consider proposals and comments from utilities and other interested parties. The commissioner may assess up to $3,600,000 annually for the purposes of this subdivision. The assessments must be deposited in the state treasury and credited to the energy and conservation account created under subdivision 2a. An assessment made under this subdivision is not subject to the cap on assessments provided by section 216B.62, or any other law.

(b) The commissioner, as part of the assessment authorized under paragraph (a), shall annually assess and grant up to $500,000 for the purpose of subdivision 9.

(c) The commissioner, as part of the assessment authorized under paragraph (a), each state fiscal year shall assess $500,000 for a grant to the partnership created by section 216C.385, subdivision 2. The grant must be used to exercise the powers and perform the duties specified in section 216C.385, subdivision 3.

(d) By February 15 annually, the commissioner shall report to the chairs and ranking minority members of the committees of the legislature with primary jurisdiction over energy policy and energy finance on the assessments made under this subdivision for the previous calendar year and the use of the assessment. The report must clearly describe the activities supported by the assessment and the parties that engaged in those activities.

EFFECTIVE DATE. Paragraph (c) is effective for assessments for state fiscal years commencing on or after July 1, 2013.

ARTICLE 6

ENERGY POLICY AMENDMENT

Section 1. Minnesota Statutes 2012, section 216B.2401, is amended to read:

216B.2401 ENERGY ~~CONSERVATION~~ SAVINGS POLICY GOAL.

The legislature finds that energy savings are an energy resource, and that cost-effective energy savings are preferred over all other energy resources. The legislature further finds that cost-effective energy savings should be procured systematically and aggressively in order to reduce utility costs for businesses and residents, improve the competitiveness and profitability of businesses, create more energy-related jobs, reduce the economic burden of fuel imports, and reduce pollution and emissions that cause climate change. Therefore, it is the energy policy of the state of Minnesota to achieve annual energy savings equal to at least 1.5 percent of annual retail energy sales of electricity and natural gas ~~directly~~ through cost-effective energy conservation improvement programs and rate design, ~~and indirectly through~~ energy efficiency achieved by energy consumers without direct utility involvement, energy codes and appliance standards, programs designed to transform the market or change consumer behavior, energy savings resulting from efficiency improvements to the utility infrastructure and system, and other efforts to promote energy efficiency and energy conservation.

Sec. 2. Minnesota Statutes 2012, section 216C.05, is amended to read:

216C.05 FINDINGS AND PURPOSE.

Subdivision 1. **Energy planning.** The legislature finds and declares that continued growth in demand for energy will cause severe social and economic dislocations, and that the state has a vital interest in providing for: increased efficiency in energy consumption, the development and use of renewable energy resources wherever possible, and the creation of an effective energy forecasting, planning, and education program.

The legislature further finds and declares that the protection of life, safety, and financial security for citizens during an energy crisis is of paramount importance.

Therefore, the legislature finds that it is in the public interest to review, analyze, and encourage those energy programs that will minimize the need for annual increases in fossil fuel consumption by 1990 and the need for additional electrical generating plants, and provide for an optimum combination of energy sources and energy conservation consistent with environmental protection and the protection of citizens.

The legislature intends to monitor, through energy policy planning and implementation, the transition from historic growth in energy demand to a period when demand for traditional fuels becomes stable and the supply of renewable energy resources is readily available and adequately utilized.

The legislature further finds that for economic growth, environmental improvement, and protection of citizens, it is in the public interest to encourage those energy programs that will provide an optimum combination of energy resources, including energy savings.

Therefore, the legislature, through its committees, must monitor and evaluate progress towards greater reliance on cost-effective energy efficiency and renewable energy and lesser dependence on fossil fuels in order to reduce the economic burden of fuel imports, diversify utility-owned

and consumer-owned energy resources, reduce utility costs for businesses and residents, improve the competitiveness and profitability of Minnesota businesses, create more energy-related jobs that contribute to the Minnesota economy, and reduce pollution and emissions that cause climate change.

Subd. 2. **Energy policy goals.** It is the energy policy of the state of Minnesota that:

(1) annual energy savings equal to at least 1.5 percent of annual retail energy sales of electricity and natural gas be achieved through cost-effective energy efficiency;

~~(1)~~ (2) the per capita use of fossil fuel as an energy input be reduced by 15 percent by the year 2015, through increased reliance on energy efficiency and renewable energy alternatives; and

~~(2)~~ (3) 25 percent of the total energy used in the state be derived from renewable energy resources by the year 2025.

Sec. 3. **DEPARTMENT OF COMMERCE; DIVISION OF ENERGY RESOURCES; STUDY.**

The Division of Energy Resources of the Department of Commerce must conduct public meetings with stakeholders and members of the public and shall produce a report on findings and legislative recommendations to accomplish the following purposes:

(1) clarify statewide energy-savings policies and utility energy-savings goals;

(2) maximize long-term cost-effective energy savings and minimize energy waste;

(3) maximize carbon reductions and economic benefits by increasing the efficiency of all sectors of the state's energy system;

(4) minimize total utility costs and rate impacts for ratepayers in all sectors;

(5) determine appropriate funding sources for nonconservation projects and programs, cogeneration, and combined heat and power projects;

(6) determine the appropriate consideration in the integrated resource planning and certificate of need processes of the requirements to meet the state's energy conservation and renewable energy goals; and

(7) provide the utility the appropriate incentives to meet the state's energy conservation and renewable energy goals.

The report must be submitted by January 15, 2014, to the chairs and ranking minority members of the committees of the legislature with primary jurisdiction over energy policy.

The division must provide public notice of the meetings.

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

ARTICLE 7

EMISSION REDUCTION COST RECOVERY

Section 1. Minnesota Statutes 2012, section 216B.1692, subdivision 1, is amended to read:

Subdivision 1. **Qualifying projects.** (a) Projects that may be approved for the emissions reduction-rate rider allowed in this section must:

(1) be installed on existing large electric generating power plants, as defined in section 216B.2421, subdivision 2, clause (1), that are located in the state and that are currently not subject to emissions limitations for new power plants under the federal Clean Air Act, United States Code, title 42, section 7401 et seq.;

(2) not increase the capacity of the existing electric generating power plant more than ten percent or more than 100 megawatts, whichever is greater; and

(3) result in the existing plant either:

(i) complying with applicable new source review standards under the federal Clean Air Act; or

(ii) emitting air contaminants at levels substantially lower than allowed for new facilities by the applicable new source performance standards under the federal Clean Air Act; or

(iii) reducing emissions from current levels at a unit to the lowest cost-effective level when, due to the age or condition of the generating unit, the public utility demonstrates that it would not be cost-effective to reduce emissions to the levels in item (i) or (ii).

(b) Notwithstanding paragraph (a), a project may be approved for the emission reduction rate rider allowed in this section if the project is to be installed on existing large electric generating power plants, as defined in section 216B.2421, subdivision 2, clause (1), that are located outside the state and are needed to comply with state or federal air quality standards, but only if the project has received an advance determination of prudence from the commission under section 216B.1695.

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

Sec. 2. Minnesota Statutes 2012, section 216B.1692, is amended by adding a subdivision to read:

Subd. 1a. **Exemption.** Subdivisions 2, 4, and 5, paragraph (c), clause (1), do not apply to projects qualifying under subdivision 1, paragraph (b).

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

Sec. 3. Minnesota Statutes 2012, section 216B.1692, subdivision 8, is amended to read:

Subd. 8. **Sunset.** This section is effective until December 31, ~~2015~~ 2020, and applies to plans, projects, and riders approved before that date and modifications made to them after that date.

Sec. 4. Minnesota Statutes 2012, section 216B.1695, subdivision 5, is amended to read:

Subd. 5. **Cost recovery.** The utility may begin recovery of costs that have been incurred by the utility in connection with implementation of the project in the next rate case following an advance determination of prudence or in a rider approved under section 216B.1692. The commission shall review the costs incurred by the utility for the project. The utility must show that the project costs are reasonable and necessary, and demonstrate its efforts to ensure the lowest reasonable project costs. Notwithstanding the commission's prior determination of prudence, it may accept, modify, or reject any of the project costs. The commission may determine whether to require an allowance for funds used during construction offset.

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

Sec. 5. Minnesota Statutes 2012, section 216B.1695, is amended by adding a subdivision to read:

Subd. 5a. **Rate of return.** The return on investment in the rider shall be at the level approved by the commission in the public utility's last general rate case, unless the commission determines that a different rate of return is in the public interest.

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

ARTICLE 8

STATE BUILDINGS GUARANTEED ENERGY SAVINGS PROGRAM

Section 1. Minnesota Statutes 2012, section 16C.144, subdivision 2, is amended to read:

Subd. 2. **Guaranteed energy-savings agreement.** The commissioner may enter into a guaranteed energy-savings agreement with a qualified provider if:

(1) the qualified provider is selected through a competitive process in accordance with the guaranteed energy-savings program guidelines within the Department of Administration;

(2) the qualified provider agrees to submit an engineering report prior to the execution of the guaranteed energy-savings agreement. The cost of the engineering report may be considered as part of the implementation costs if the commissioner enters into a guaranteed energy-savings agreement with the provider;

(3) the term of the guaranteed energy-savings agreement shall not exceed ~~15~~ 25 years from the date of final installation;

(4) the commissioner finds that the amount it would spend on the utility cost-savings measures recommended in the engineering report will not exceed the amount to be saved in utility operation and maintenance costs over ~~15~~ 25 years from the date of implementation of utility cost-savings measures;

(5) the qualified provider provides a written guarantee that the annual utility, operation, and maintenance cost savings during the term of the guaranteed energy-savings agreement will meet or exceed the annual payments due under a lease purchase agreement. The qualified provider shall reimburse the state for any shortfall of guaranteed utility, operation, and maintenance cost savings; and

(6) the qualified provider gives a sufficient bond in accordance with section 574.26 to the commissioner for the faithful implementation and installation of the utility cost-savings measures.

ARTICLE 9

INTEGRATED RESOURCE PLANNING

Section 1. Minnesota Statutes 2012, section 216B.2422, subdivision 4, is amended to read:

Subd. 4. **Preference for renewable energy facility.** The commission shall not approve a new or refurbished nonrenewable energy facility in an integrated resource plan or a certificate of need, pursuant to section 216B.243, nor shall the commission allow rate recovery pursuant to section 216B.16 for such a nonrenewable energy facility, unless the utility has demonstrated that a renewable energy facility is not in the public interest. The public interest determination must include whether the resource plan helps the utility achieve the greenhouse gas reduction goals under section 216H.02,

the renewable energy standard under section 216B.1691, or the solar energy standard under section 216B.2427.

ARTICLE 10

RENEWABLE INTEGRATION STUDY

Section 1. **RENEWABLE INTEGRATION STUDY.**

The commission shall order all Minnesota electric utilities, as defined in Minnesota Statutes, section 216B.1691, subdivision 1, paragraph (b), to study and develop plans for the transmission network enhancements necessary to support increasing the renewable energy standard established in Minnesota Statutes, section 216B.1691, subdivision 2a, to 40 percent by 2030, while maintaining system reliability.

The Minnesota electric utilities must complete the study work under the direction of the commissioner of commerce. Prior to the start of the study, the commissioner shall appoint a technical review committee consisting of up to 15 individuals with experience and expertise in electric transmission system engineering, electric power systems operations, and renewable energy generation technology to review the study's proposed methods and assumptions, ongoing work, and preliminary results.

As part of the planning process, the Minnesota electric utilities must incorporate and build upon the analyses that have previously been done or that are in progress including but not limited to the 2006 Minnesota Wind Integration Study and ongoing work to address geographically dispersed development plans, the 2007 Minnesota Transmission for Renewable Energy Standard Study, the 2008 and 2009 Statewide Studies of Dispersed Renewable Generation, the 2009 Minnesota RES Update, Corridor, and Capacity Validation Studies, the 2010 Regional Generation Outlet Study, the 2011 Multi Value Project Portfolio Study, and recent and ongoing Midwest Independent System Operator transmission expansion planning work. The utilities shall collaborate with the Midwest Independent System Operator to optimize and integrate, to the extent possible, Minnesota's transmission plans with other regional considerations and to encourage the Midwest Independent System Operator to incorporate Minnesota's planning work into its transmission expansion future planning.

The study must be completed and submitted to the Minnesota Public Utilities Commission by December 1, 2013. The report shall include a description of the analyses that have been conducted and the results, including:

(1) a conceptual plan for transmission necessary for generation interconnection and delivery and for access to regional geographic diversity and regional supply and demand side flexibility; and

(2) identification and development of potential solutions to any critical issues encountered to support increasing the renewable energy standard to 40 percent by 2030 while maintaining system reliability, as well as potential impacts and barriers of increasing the renewable energy standard to 45 percent and 50 percent.

ARTICLE 11

GAS UTILITY INFRASTRUCTURE COSTS

Section 1. Minnesota Statutes 2012, section 216B.1635, is amended to read:

216B.1635 RECOVERY OF GAS UTILITY INFRASTRUCTURE COSTS.

Subdivision 1. **Definitions.** (a) "Gas utility" means a public utility as defined in section 216B.02, subdivision 4, that furnishes natural gas service to retail customers.

(b) "Gas utility infrastructure costs" or "GUIC" means costs incurred in gas utility projects that:

(1) do not serve to increase revenues by directly connecting the infrastructure replacement to new customers;

(2) are in service but were not included in the gas utility's rate base in its most recent general rate case~~; and~~, or are planned to be in service during the period covered by the report submitted under subdivision 2, but in no case longer than the one year forecast period in the report; and

(3) ~~replace or modify existing infrastructure if the replacement or modification does not constitute a betterment, unless the betterment is required by a political subdivision, as evidenced by specific documentation from the government entity requiring the replacement or modification of infrastructure~~ do not constitute a betterment, unless the betterment is based on requirements by a political subdivision or a federal or state agency, as evidenced by specific documentation, an order, or other similar requirement from the government entity requiring the replacement or modification of infrastructure.

(c) "Gas utility projects" means ~~relocation and~~:

(1) replacement of natural gas facilities located in the public right-of-way required by the construction or improvement of a highway, road, street, public building, or other public work by or on behalf of the United States, the state of Minnesota, or a political subdivision~~.~~; and

(2) replacement or modification of existing natural gas facilities, including surveys, assessments, reassessment, and other work necessary to determine the need for replacement or modification of existing infrastructure that is required by a federal or state agency.

Subd. 2. **Gas infrastructure filing.** ~~(a) The commission may approve a gas utility's petition for a rate schedule~~ A public utility submitting a petition to recover ~~GUIC~~ gas infrastructure costs under this section~~. A gas utility may~~ must submit to the commission, the department, and interested parties a gas infrastructure project plan report and a petition ~~the commission to recover a rate of return, income taxes on the rate of return, incremental property taxes, plus incremental depreciation expense associated with GUIC~~ for rate recovery of only incremental costs associated with projects under subdivision 1, paragraph (c), clause (2). The report and petition must be made at least 150 days in advance of implementation of the rate schedule, provided that the rate schedule will not be implemented until the petition is approved by the commission pursuant to subdivision 6. The report must be for a forecast period of one year.

~~(b) The filing is subject to the following:~~

~~(1) A gas utility may submit a filing under this section no more than once per year.~~

~~(2) A gas utility must file sufficient information to satisfy the commission regarding the proposed GUIC or be subject to denial by the commission. The information includes, but is not limited to:~~

~~(i) the government entity ordering the gas utility project and the purpose for which the project is undertaken;~~

~~(ii) the location, description, and costs associated with the project;~~

~~(iii) a description of the costs, and salvage value, if any, associated with the existing infrastructure replaced or modified as a result of the project;~~

~~(iv) the proposed rate design and an explanation of why the proposed rate design is in the public interest;~~

~~(v) the magnitude and timing of any known future gas utility projects that the utility may seek to recover under this section;~~

~~(vi) the magnitude of GUIC in relation to the gas utility's base revenue as approved by the commission in the gas utility's most recent general rate case, exclusive of gas purchase costs and transportation charges;~~

~~(vii) the magnitude of GUIC in relation to the gas utility's capital expenditures since its most recent general rate case;~~

~~(viii) the amount of time since the utility last filed a general rate case and the utility's reasons for seeking recovery outside of a general rate case; and~~

~~(ix) documentation supporting the calculation of the GUIC.~~

Subd. 3. **Gas infrastructure project plan report.** The gas infrastructure project plan report required to be filed under subdivision 2 shall include all pertinent information and supporting data on each proposed project including, but not limited to, project description and scope, estimated project costs, and project in-service date.

Subd. 4. **Cost recovery petition for utility's facilities.** Notwithstanding any other provision of this chapter, the commission may approve a rate schedule for the automatic annual adjustment of charges for gas utility infrastructure costs net of revenues under this section, including a rate of return, income taxes on the rate of return, incremental property taxes, incremental depreciation expense, and any incremental operation and maintenance costs. A gas utility's petition for approval of a rate schedule to recover gas utility infrastructure costs outside of a general rate case under section 216B.16, is subject to the following:

(1) a gas utility may submit a filing under this section no more than once per year; and

(2) a gas utility must file sufficient information to satisfy the commission regarding the proposed GUIC. The information includes, but is not limited to:

(i) the information required to be included in the gas infrastructure project plan report under subdivision 3;

(ii) the government entity ordering or requiring the gas utility project and the purpose for which the project is undertaken;

(iii) a description of the estimated costs and salvage value, if any, associated with the existing infrastructure replaced or modified as a result of the project;

(iv) a comparison of the utility's estimated costs included in the gas infrastructure project plan and the actual costs incurred, including a description of the utility's efforts to ensure the costs of the facilities are reasonable and prudently incurred;

(v) calculations to establish that the rate adjustment is consistent with the terms of the rate schedule, including the proposed rate design and an explanation of why the proposed rate design is in the public interest;

(vi) the magnitude and timing of any known future gas utility projects that the utility may seek to recover under this section;

(vii) the magnitude of GUIC in relation to the gas utility's base revenue as approved by the commission in the gas utility's most recent general rate case, exclusive of gas purchase costs and transportation charges;

(viii) the magnitude of GUIC in relation to the gas utility's capital expenditures since its most recent general rate case; and

(ix) the amount of time since the utility last filed a general rate case and the utility's reasons for seeking recovery outside of a general rate case.

Subd. 5. **Commission action.** Upon receiving a gas utility report and petition for cost recovery under subdivision 2 and assessment and verification under subdivision 4, the commission may approve the annual GUIC rate adjustments provided that, after notice and comment, the costs included for recovery through the rate schedule are prudently incurred and achieve gas facility improvements at the lowest reasonable and prudent cost to ratepayers.

Subd. 5a. **Rate of return.** The return on investment for the rate adjustment shall be at the level approved by the commission in the public utility's last general rate case, unless the commission determines that a different rate of return is in the public interest.

Subd. ~~3~~ 6. **Commission authority; rules.** The commission may issue orders and adopt rules necessary to implement and administer this section.

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

Sec. 2. Laws 2005, chapter 97, article 10, section 3, is amended to read:

Sec. 3. **SUNSET.**

Sections 1 and 2 shall expire on June 30, ~~2015~~ 2023.

Sec. 3. **REPEALER.**

Minnesota Statutes 2012, section 216B.1637, is repealed.

ARTICLE 12

PACE

Section 1. Minnesota Statutes 2012, section 216C.435, is amended by adding a subdivision to read:

Subd. 3a. **Cost-effective energy improvements.** "Cost-effective energy improvements" mean energy improvements that have been identified in an energy audit or renewable energy system feasibility study as repaying their purchase and installation costs in 20 years or less, based on the amount of future energy saved and estimated future energy prices.

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

Sec. 2. Minnesota Statutes 2012, section 216C.435, subdivision 8, is amended to read:

Subd. 8. **Qualifying real property.** "Qualifying real property" means a single-family or multifamily residential dwelling, or a commercial or industrial building, that the implementing entity has determined, after review of an energy audit or renewable energy system feasibility study, can be benefited by installation of cost-effective energy improvements.

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

Sec. 3. Minnesota Statutes 2012, section 216C.436, subdivision 2, is amended to read:

Subd. 2. **Program requirements.** A financing program must:

(1) impose requirements and conditions on financing arrangements to ensure timely repayment;

(2) require an energy audit or renewable energy system feasibility study to be conducted on the qualifying real property and reviewed by the implementing entity prior to approval of the financing;

(3) require the inspection of all installations and a performance verification of at least ten percent of the energy improvements financed by the program;

(4) not prohibit the financing of all cost-effective energy improvements not otherwise prohibited by this section;

(5) require that all cost-effective energy improvements be made to a qualifying real property prior to, or in conjunction with, an applicant's repayment of financing for energy improvements for that property;

~~(5)~~ (6) have energy improvements financed by the program performed by licensed contractors as required by chapter 326B or other law or ordinance;

~~(6)~~ (7) require disclosures to borrowers by the implementing entity of the risks involved in borrowing, including the risk of foreclosure if a tax delinquency results from a default;

~~(7)~~ (8) provide financing only to those who demonstrate an ability to repay;

~~(8)~~ (9) not provide financing for a qualifying real property in which the owner is not current on mortgage or real property tax payments;

~~(9)~~ (10) require a petition to the implementing entity by all owners of the qualifying real property requesting collections of repayments as a special assessment under section 429.101;

~~(10)~~ (11) provide that payments and assessments are not accelerated due to a default and that a tax delinquency exists only for assessments not paid when due; and

~~(11)~~ (12) require that liability for special assessments related to the financing runs with the qualifying real property.

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

Sec. 4. Minnesota Statutes 2012, section 216C.436, subdivision 7, is amended to read:

Subd. 7. **Repayment.** An implementing entity that finances an energy improvement under this section must:

(1) secure payment with a lien against the ~~benefited~~ qualifying real property; and

(2) collect repayments as a special assessment as provided for in section 429.101 or by charter, provided that special assessments may be made payable in up to 20 equal annual installments.

If the implementing entity is an authority, the local government that authorized the authority to act as implementing entity shall impose and collect special assessments necessary to pay debt service on bonds issued by the implementing entity under subdivision 8, and shall transfer all collections of the assessments upon receipt to the authority.

Sec. 5. Minnesota Statutes 2012, section 216C.436, subdivision 8, is amended to read:

Subd. 8. **Bond issuance; repayment.** (a) An implementing entity may issue revenue bonds as provided in chapter 475 for the purposes of this section, provided the revenue bond must not be payable more than 20 years from the date of issuance.

(b) The bonds must be payable as to both principal and interest solely from the revenues from the assessments established in subdivision 7.

(c) No holder of bonds issued under this subdivision may compel any exercise of the taxing power of the implementing entity that issued the bonds to pay principal or interest on the bonds, and if the implementing entity is an authority, no holder of the bonds may compel any exercise of the taxing power of the local government. Bonds issued under this subdivision are not a debt or obligation of the issuer or any local government that issued them, nor is the payment of the bonds enforceable out of any money other than the revenue pledged to the payment of the bonds.

Sec. 6. Minnesota Statutes 2012, section 429.101, subdivision 2, is amended to read:

Subd. 2. **Procedure for assessment.** Any special assessment levied under subdivision 1 shall be payable in a single installment, or by up to ten equal annual installments as the council may provide, except that a special assessment made under an energy improvements financing program under subdivision 1, paragraph (c), may be repayable in up to 20 equal installments. With ~~this exception~~ these exceptions, sections 429.061, 429.071, and 429.081 shall apply to assessments made under this section.

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

ARTICLE 13

WASTE HEAT RECOVERY

Section 1. Minnesota Statutes 2012, section 216B.241, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section and section 216B.16, subdivision 6b, the terms defined in this subdivision have the meanings given them.

(a) "Commission" means the Public Utilities Commission.

(b) "Commissioner" means the commissioner of commerce.

(c) "Department" means the Department of Commerce.

(d) "Energy conservation" means demand-side management of energy supplies resulting in a net reduction in energy use. Load management that reduces overall energy use is energy conservation.

(e) "Energy conservation improvement" means a project that results in energy efficiency or energy conservation. Energy conservation improvement may include waste heat ~~recovery~~ that is recovered and converted into electricity, but does not include electric utility infrastructure projects approved by the commission under section 216B.1636. Energy conservation improvement also includes waste heat recovered and used as thermal energy.

(f) "Energy efficiency" means measures or programs, including energy conservation measures or programs, that target consumer behavior, equipment, processes, or devices designed to produce either an absolute decrease in consumption of electric energy or natural gas or a decrease in consumption of electric energy or natural gas on a per unit of production basis without a reduction in the quality or level of service provided to the energy consumer.

(g) "Gross annual retail energy sales" means annual electric sales to all retail customers in a utility's or association's Minnesota service territory or natural gas throughput to all retail customers, including natural gas transportation customers, on a utility's distribution system in Minnesota. For purposes of this section, gross annual retail energy sales exclude:

(1) gas sales to:

(i) a large energy facility;

(ii) a large customer facility whose natural gas utility has been exempted by the commissioner under subdivision 1a, paragraph (b), with respect to natural gas sales made to the large customer facility; and

(iii) a commercial gas customer facility whose natural gas utility has been exempted by the commissioner under subdivision 1a, paragraph (c), with respect to natural gas sales made to the commercial gas customer facility; and

(2) electric sales to a large customer facility whose electric utility has been exempted by the commissioner under subdivision 1a, paragraph (b), with respect to electric sales made to the large customer facility.

(h) "Investments and expenses of a public utility" includes the investments and expenses incurred by a public utility in connection with an energy conservation improvement, including but not limited to:

(1) the differential in interest cost between the market rate and the rate charged on a no-interest or below-market interest loan made by a public utility to a customer for the purchase or installation of an energy conservation improvement;

(2) the difference between the utility's cost of purchase or installation of energy conservation improvements and any price charged by a public utility to a customer for such improvements.

(i) "Large customer facility" means all buildings, structures, equipment, and installations at a single site that collectively (1) impose a peak electrical demand on an electric utility's system of not

less than 20,000 kilowatts, measured in the same way as the utility that serves the customer facility measures electrical demand for billing purposes or (2) consume not less than 500 million cubic feet of natural gas annually. In calculating peak electrical demand, a large customer facility may include demand offset by on-site cogeneration facilities and, if engaged in mineral extraction, may aggregate peak energy demand from the large customer facility's mining and processing operations.

(j) "Large energy facility" has the meaning given it in section 216B.2421, subdivision 2, clause (1).

(k) "Load management" means an activity, service, or technology to change the timing or the efficiency of a customer's use of energy that allows a utility or a customer to respond to wholesale market fluctuations or to reduce peak demand for energy or capacity.

(l) "Low-income programs" means energy conservation improvement programs that directly serve the needs of low-income persons, including low-income renters.

(m) "Qualifying utility" means a utility that supplies the energy to a customer that enables the customer to qualify as a large customer facility.

(n) "Waste heat recovered and used as thermal energy" means capturing heat energy that would otherwise be exhausted or dissipated to the environment from machinery, buildings, or industrial processes and productively using such recovered thermal energy where it was captured or distributing it as thermal energy to other locations where it is used to reduce demand side consumption of natural gas, electric energy, or both.

~~(n)~~ (o) "Waste heat recovery converted into electricity" means an energy recovery process that converts otherwise lost energy from the heat of exhaust stacks or pipes used for engines or manufacturing or industrial processes, or the reduction of high pressure in water or gas pipelines.

Sec. 2. Minnesota Statutes 2012, section 216B.241, is amended by adding a subdivision to read:

Subd. 10. **Waste heat recovery; thermal energy distribution.** Demand side natural gas or electric energy displaced by use of waste heat recovered and used as thermal energy, including the recovered thermal energy from a cogeneration or combined heat and power facility, is eligible to be counted towards a utility's natural gas or electric energy savings goals, subject to department approval.

ARTICLE 14

SOLAR ENERGY INCENTIVE PROGRAM

Section 1. **[116C.7792] SOLAR ENERGY INCENTIVE PROGRAM.**

The utility subject to section 116C.779 shall operate a program to provide solar energy production incentives for solar energy systems of no more than a total nameplate capacity of 20 kilowatts direct current. The program shall be operated for five consecutive calendar years commencing in 2014. The lesser of $10,000,000 or as much as is available in the account shall be allocated for each of the five years from the renewable development account established in section 116C.779 to a separate account for the purpose of the solar production incentive program. The solar system must be sized to less than 120 percent of the customer's on-site annual energy consumption. The production incentive must be paid for ten years commencing with the commissioning of the

system. The utility must file a plan to operate the program with the commissioner of commerce. The utility may not operate the program until it is approved by the commissioner.

ARTICLE 15

STUDY OF INDUSTRIAL ENERGY EFFICIENCY

Section 1. **STUDY.**

The Legislative Energy Commission may study and report to the chairs and ranking minority members of the legislative committees and divisions with primary jurisdiction over energy policy on how best to increase the competitiveness of the paper, pulp, mining, foundry, and steel industries in the state through additional cost-effective energy efficiency, including the potential use of renewable energy systems, work process initiatives, or best practices. In addition, the study must examine ways to use industrial energy efficiency to assist in creating markets for new energy efficiency products and services, and assess the impact of industrial energy efficiency in moderating electricity, water, and waste prices by reducing demand. The commission may include legislative recommendations in its report. The commission shall seek input from interested stakeholders, including entities with recognized expertise with industrial efficiency and work processes with these industries. The commission may contract for all or part of the activities related to preparation of the report.

ARTICLE 16

APPROPRIATIONS

Section 1. **APPROPRIATIONS.**

(a) $364,000 in fiscal year 2014 and $100,000 in fiscal year 2015 are appropriated from the general fund to the commissioner of commerce for the purpose of carrying out the activities required in this act. It is assumed that an amount equal to this appropriation will be assessed by the commissioner of commerce under Minnesota Statutes, section 216B.62, and deposited in the general fund. The base for this appropriation is $22,000 in fiscal year 2016 and $23,000 in fiscal year 2017.

(b) $279,000 in fiscal year 2014 and $263,000 in fiscal year 2015 are appropriated from the general fund from the assessments on utilities to the Public Utilities Commission for the purpose of carrying out the activities required in this act. It is assumed that an amount equal to this appropriation will be assessed by the commission under Minnesota Statutes, section 216B.62, and deposited in the general fund. The base for this appropriation is $63,000 in fiscal year 2016 and $27,000 in fiscal year 2017."

Amend the title as follows:

Page 1, line 7, delete everything after the semicolon and insert "appropriating money;"

Page 1, line 8, delete everything before "amending"

Amend the title numbers accordingly

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

Senator Cohen from the Committee on Finance, to which was re-referred

S.F. No. 266: A bill for an act relating to human services; requiring the development of a program to certify certain behavioral health aides; amending Minnesota Statutes 2012, section 256B.0943, subdivision 7, by adding a subdivision.

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

Page 2, line 19, after "with" insert "children's mental health providers and"

Page 2, line 20, delete "of not fewer than 11 credits"

Page 2, line 21, delete everything after the period

Page 2, delete lines 22 to 24

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

Senator Cohen from the Committee on Finance, to which was referred

H.F. No. 1069: A bill for an act relating to state government; ratifying labor agreements and compensation plans.

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

Page 2, after line 7, insert:

"Subd. 7. **Minnesota state college faculty.** The collective bargaining agreement between the state of Minnesota and the Minnesota state college faculty, recommended for approval by the Legislative Coordinating Commission Subcommittee on Employee Relations on May 1, 2013, is ratified.

Subd. 8. **MnSCU administrators.** The personnel plan for Minnesota State Colleges and Universities administrators, recommended for approval by the Legislative Coordinating Commission Subcommittee on Employee Relations on May 1, 2013, is ratified.

Subd. 9. **Minnesota Insurance Marketplace.** The personnel plan for managers for the Minnesota Insurance Marketplace, recommended for approval by the Legislative Coordinating Commission Subcommittee on Employee Relations on May 1, 2013, is ratified."

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

SECOND READING OF SENATE BILLS

S.F. Nos. 925, 901 and 266 were read the second time.

SECOND READING OF HOUSE BILLS

H.F. Nos. 779 and 1069 were read the second time.

MOTIONS AND RESOLUTIONS - CONTINUED

SPECIAL ORDERS

Pursuant to Rule 26, Senator Bakk, Chair of the Committee on Rules and Administration, designated the following bills a Special Orders Calendar to be heard immediately:

H.F. Nos. 760, 791, 195, 1120 and S.F. No. 1006.

SPECIAL ORDER

H.F. No. 760: A bill for an act relating to human services; updating outdated terminology; amending Minnesota Statutes 2012, sections 15.44; 124D.57; 127A.45, subdivision 12; 144.651, subdivision 4; 145.88; 146A.11, subdivision 1; 148.512, subdivisions 12, 13; 150A.13, subdivision 6; 174.255, subdivision 1; 202A.13; 202A.155; 202A.156; 237.036; 237.16, subdivision 9; 240A.04; 240A.06, subdivisions 1, 2; 256.01, subdivision 2; 256C.24, subdivision 3; 256C.29; 299C.06; 326B.106, subdivisions 9, 11; 473.608, subdivision 22; 589.35, subdivision 1; 595.02, subdivision 1; 609.06, subdivision 1; 609.749, subdivision 2; 626.8455, subdivision 1.

Senator Wiklund moved to amend H.F. No. 760, as amended pursuant to Rule 45, adopted by the Senate April 24, 2013, as follows:

(The text of the amended House File is identical to S.F. No. 655.)

Page 28, line 6, strike "is mentally ill" and insert "has a mental illness"

Page 28, line 7, delete "developmentally disabled" and insert "a developmental disability"

Page 29, line 8, delete "disabilities" and insert "limitations"

The motion prevailed. So the amendment was adopted.

H.F. No. 760 was read the third time, as amended, and placed on its final passage.

The question was taken on the passage of the bill, as amended.

The roll was called, and there were yeas 63 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Eaton	Johnson	Ortman	Sieben
Bakk	Eken	Kent	Osmek	Skoe
Benson	Fischbach	Kiffmeyer	Pappas	Sparks
Brown	Franzen	Koenen	Pederson, J.	Stumpf
Carlson	Gazelka	Latz	Pratt	Thompson
Chamberlain	Goodwin	Limmer	Reinert	Tomassoni
Champion	Hall	Lourey	Rest	Torres Ray
Clausen	Hann	Marty	Rosen	Weber
Cohen	Hawj	Metzen	Saxhaug	Westrom
Dahle	Hayden	Miller	Scalze	Wiger
Dahms	Hoffman	Nelson	Schmit	Wiklund
Dibble	Ingebrigtsen	Newman	Senjem	
Dziedzic	Jensen	Nienow	Sheran	

So the bill, as amended, was passed and its title was agreed to.

SPECIAL ORDER

H.F. No. 791: A bill for an act relating to insurance; regulating annuity products; enacting and modifying a model regulation adopted by the National Association of Insurance Commissioners relating to suitability in annuity transactions; proposing coding for new law in Minnesota Statutes, chapter 72A.

Senator Eaton moved to amend H.F. No. 791, as amended pursuant to Rule 45, adopted by the Senate April 25, 2013, as follows:

(The text of the amended House File is identical to S.F. No. 574.)

Page 7, delete subdivision 8 and insert:

"Subd. 8. **FINRA compliance.** (a) Sales of annuities made by broker-dealers satisfy the requirements under sections 72A.203 to 72A.2036, as to the broker-dealer so long as:

(1) those sales comply with FINRA requirements pertaining to suitability and supervision of annuity transactions; and

(2) a registered principal reviews and approves the transaction based on review criteria that include consideration of the customer's age, income, liquidity needs, and financial situation.

(b) The insurer remains responsible for the suitability of every transaction and must take reasonably appropriate corrective action for any consumer harmed by violation of law and is subject to the penalty provisions described in section 72A.2034, subdivision 1.

(c) For paragraph (a) to apply, an insurer shall:

(1) monitor the FINRA member broker-dealer using information collected in the normal course of the insurer's business; and

(2) provide to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

(d) Nothing in this subdivision limits or changes:

(1) the insurer's responsibilities and duties pursuant to sections 72A.302 to 72A.2036 including, but not limited to, the insurer's obligation to establish and use a supervision system under section 72A.2032, subdivision 6, and otherwise independently review and determine the suitability of the annuity for each particular consumer before issuing the annuity;

(2) the responsibilities of the insurer to monitor the broker-dealer as provided in this subdivision; and

(3) the commissioner of commerce's ability to enforce the provisions of sections 72A.203 to 72A.2036 with respect to sales made in compliance with FINRA requirements and federal law."

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 13 and nays 50, as follows:

Those who voted in the affirmative were:

Carlson	Dahle	Dziedzic	Goodwin	Kent
Cohen	Dibble	Eaton	Hawj	Latz

Marty	Scalze	Torres Ray

Those who voted in the negative were:

Anderson	Franzen	Koenen	Pappas	Sieben
Bakk	Gazelka	Limmer	Pederson, J.	Skoe
Benson	Hall	Lourey	Pratt	Sparks
Brown	Hann	Metzen	Reinert	Stumpf
Chamberlain	Hayden	Miller	Rest	Thompson
Champion	Hoffman	Nelson	Rosen	Tomassoni
Clausen	Ingebrigtsen	Newman	Saxhaug	Weber
Dahms	Jensen	Nienow	Schmit	Westrom
Eken	Johnson	Ortman	Senjem	Wiger
Fischbach	Kiffmeyer	Osmek	Sheran	Wiklund

The motion did not prevail. So the amendment was not adopted.

Senator Reinert moved that the amendment made to H.F. No. 791 by the Committee on Rules and Administration in the report adopted April 25, 2013, pursuant to Rule 45, be stricken. The motion prevailed. So the amendment was stricken.

H.F. No. 791 was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 55 and nays 8, as follows:

Those who voted in the affirmative were:

Anderson	Dziedzic	Johnson	Ortman	Sheran
Bakk	Eken	Kent	Osmek	Sieben
Benson	Fischbach	Kiffmeyer	Pappas	Skoe
Brown	Franzen	Koenen	Pederson, J.	Sparks
Chamberlain	Gazelka	Limmer	Pratt	Stumpf
Champion	Hall	Lourey	Reinert	Thompson
Clausen	Hann	Metzen	Rest	Tomassoni
Cohen	Hayden	Miller	Rosen	Weber
Dahle	Hoffman	Nelson	Saxhaug	Westrom
Dahms	Ingebrigtsen	Newman	Schmit	Wiger
Dibble	Jensen	Nienow	Senjem	Wiklund

Those who voted in the negative were:

Carlson	Goodwin	Latz	Scalze
Eaton	Hawj	Marty	Torres Ray

So the bill passed and its title was agreed to.

SPECIAL ORDER

H.F. No. 195: A bill for an act relating to health; allowing a licensed dietitian or licensed nutritionist to adhere to a practice guideline or protocol for a legend drug prescribed by a physician; amending Minnesota Statutes 2012, section 151.37, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 148.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 61 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Eken	Kent	Osmek	Sparks
Benson	Fischbach	Kiffmeyer	Pederson, J.	Stumpf
Brown	Franzen	Koenen	Pratt	Thompson
Carlson	Gazelka	Latz	Reinert	Tomassoni
Chamberlain	Goodwin	Limmer	Rest	Torres Ray
Champion	Hall	Lourey	Rosen	Weber
Clausen	Hann	Marty	Saxhaug	Westrom
Cohen	Hawj	Metzen	Scalze	Wiger
Dahle	Hayden	Miller	Schmit	Wiklund
Dahms	Hoffman	Nelson	Senjem	
Dibble	Ingebrigtsen	Newman	Sheran	
Dziedzic	Jensen	Nienow	Sieben	
Eaton	Johnson	Ortman	Skoe	

So the bill passed and its title was agreed to.

SPECIAL ORDER

H.F. No. 1120: A bill for an act relating to state government; requiring service on all parties for judicial review of contested case; amending Minnesota Statutes 2012, section 14.63.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 62 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Eken	Kent	Osmek	Skoe
Benson	Fischbach	Kiffmeyer	Pappas	Sparks
Brown	Franzen	Koenen	Pederson, J.	Stumpf
Carlson	Gazelka	Latz	Pratt	Thompson
Chamberlain	Goodwin	Limmer	Reinert	Tomassoni
Champion	Hall	Lourey	Rest	Torres Ray
Clausen	Hann	Marty	Rosen	Weber
Cohen	Hawj	Metzen	Saxhaug	Westrom
Dahle	Hayden	Miller	Scalze	Wiger
Dahms	Hoffman	Nelson	Schmit	Wiklund
Dibble	Ingebrigtsen	Newman	Senjem	
Dziedzic	Jensen	Nienow	Sheran	
Eaton	Johnson	Ortman	Sieben	

So the bill passed and its title was agreed to.

SPECIAL ORDER

S.F. No. 1006: A bill for an act relating to lawful gambling; modifying account, record keeping, and other regulatory provisions; amending Minnesota Statutes 2012, sections 297E.06, subdivision 4; 349.1635, subdivision 3; 349.165, subdivision 5; 349.19, subdivisions 2, 10.

Senator Pappas moved to amend S.F. No. 1006 as follows:

Page 3, line 11, strike everything after "(d)"

Page 3, line 12, strike "electronic bingo games,"

The motion prevailed. So the amendment was adopted.

Senator Pappas moved to amend S.F. No. 1006 as follows:

Page 4, line 14, after "commissioner" insert "of revenue"

The motion prevailed. So the amendment was adopted.

S.F. No. 1006 was read the third time, as amended, and placed on its final passage.

The question was taken on the passage of the bill, as amended.

The roll was called, and there were yeas 60 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Dziedzic	Jensen	Nienow	Senjem
Bakk	Eaton	Johnson	Ortman	Sheran
Benson	Eken	Kent	Osmek	Skoe
Brown	Fischbach	Kiffmeyer	Pappas	Sparks
Carlson	Franzen	Koenen	Pederson, J.	Stumpf
Chamberlain	Gazelka	Latz	Pratt	Thompson
Champion	Goodwin	Limmer	Reinert	Tomassoni
Clausen	Hall	Lourey	Rest	Torres Ray
Cohen	Hann	Marty	Rosen	Weber
Dahle	Hawj	Miller	Saxhaug	Westrom
Dahms	Hoffman	Nelson	Scalze	Wiger
Dibble	Ingebrigtsen	Newman	Schmit	Wiklund

So the bill, as amended, was passed and its title was agreed to.

MOTIONS AND RESOLUTIONS - CONTINUED

Without objection, remaining on the Order of Business of Motions and Resolutions, the Senate reverted to the Orders of Business of Messages From the House and First Reading of House Bills.

MESSAGES FROM THE HOUSE

Madam President:

I have the honor to announce the passage by the House of the following House Files, herewith transmitted: H.F. Nos. 80 and 740.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted May 7, 2013

FIRST READING OF HOUSE BILLS

The following bills were read the first time.

H.F. No. 80: A bill for an act relating to judgments; regulating assigned consumer debt default judgments; proposing coding for new law in Minnesota Statutes, chapter 548.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 33, now on General Orders.

H.F. No. 740: A bill for an act relating to state lands; modifying landowners' bill of rights; modifying land acquisition account; providing for school forests; providing for sale of certain tax-forfeited land within Fond du Lac Indian Reservation; adding to and deleting from state parks and forests; authorizing certain exchanges and sales of state lands; amending Minnesota Statutes

2012, sections 84.0274, subdivision 6; 89.41; 94.165; 282.01, subdivisions 1a, 1d; Laws 1989, chapter 136, section 1.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 886, now on General Orders.

MEMBERS EXCUSED

Senators Bonoff, Housley and Ruud were excused from the Session of today. Senator Petersen, B. was excused from the Session of today at 4:20 p.m. Senator Pappas was excused from the Session of today from 5:15 to 5:30 p.m. Senator Bakk was excused from the Session of today from 5:15 to 5:35 p.m. Senator Metzen was excused from the Session of today at 5:30 p.m. Senator Sieben was excused from the Session of today from 5:30 to 5:40 p.m.

ADJOURNMENT

Senator Bakk moved that the Senate do now adjourn until 11:00 a.m., Wednesday, May 8, 2013. The motion prevailed.

JoAnne M. Zoff, Secretary of the Senate