CHAPTER 62C

NONPROFIT HEALTH SERVICE PLAN CORPORATIONS ACT

62C.01 NONPROFIT HEALTH SERVICE PLAN CORPORATIONS ACT. Subdivision 1. **Citation.** Sections 62C.01 to 62C.23 may be cited as the "nonprofit health service plan corporations act."

Subd. 2. **Purpose.** It is the purpose and intent of Laws 1971, Chapter 568 to promote a wider, more economical and timely availability of hospital, medical-surgical, dental, and other health services for the people of Minnesota, through nonprofit, prepaid health service plans, and thereby advance public health and the art and science of medical and health care within the state, while reasonably regulating the formation, continuation, operation, and termination of such service plans by establishment and enforcement of reasonable and practical standards of administration, investments, surplus and reserves.

Subd. 3. **Scope.** Every foreign or domestic nonprofit corporation organized for the purpose of establishing or operating a health service plan in Minnesota whereby health services are provided to subscribers to the plan under a contract with the corporation shall be subject to and governed by Laws 1971, Chapter 568, and shall not be subject to the laws of this state relating to insurance, except as otherwise specifically provided. Laws 1971, Chapter 568 shall apply to all health service plan corporations incorporated after August 1, 1971, and to all existing health service plan corporations, except as otherwise provided. Nothing in sections 62C.01 to 62C.23 shall apply to prepaid group practice plans. A prepaid group practice plan is any plan or arrangement other than a service plan, whereby health services are rendered to certain patients by providers who devote their professional effort primarily to members or patients of the plan, and whereby the recipients of health services pay for the services on a regular, periodic basis, not on a fee for service basis.

[*1971 c 568 s 1*]

62C.02 DEFINITIONS. Subdivision 1. For the purposes of sections 62C.01 to 62C.23 the terms defined in this section have the meanings given them.

Subd. 2. "Commissioner" means the commissioner of insurance or a person duly designated to act in his place.

Subd. 3. "Health service" means any service or class of services, supply, drug, or equipment provided to an individual for diagnosis, relief, or treatment of an injury, ailment, or bodily condition.

Subd. 4. "Subscriber" means a person covered under a subscriber contract for health services to the extent therein described.

Subd. 5. "Provider" means an institution, organization, or person that furnishes health services either directly or pursuant to a prescription or directive from a person licensed by the state to make such a prescription or directive.

Subd. 6. "Service plan corporation" means a foreign or domestic nonprofit corporation which contracts for health service or payment therefor for subscribers pursuant to a service plan, in exchange for periodic prepayments by or on behalf of subscribers. An "existing corporation" means a service plan association or corporation legally in existence on August 1, 1971, and authorized to do business in this state on that date.

Subd. 7. "Service plan" means any program or other method whereby a service plan corporation, for a consideration, contracts for provision of health service to subscribers by providers who have entered service agreements with the service plan corporation or which provides for reimbursement to the subscriber for health service provided by providers who have not entered service agreements with the service plan corporation.

Subd. 8. "Service agreement" means an agreement, contract or other arrangement between a service plan corporation and a provider under which the provider agrees that when he provides health services for a subscriber he shall not make a direct charge against the subscriber for those services or parts of services which are covered by the subscriber's contract, but shall look to the service plan corporation for the payment for covered services, to the extent they are covered.

Subd. 9. "Subscriber contract" means a contract, agreement, or other arrangement between a service plan corporation and its subscriber under the terms and conditions of which health service or reimbursement therefor is provided to the subscriber.

Subd. 10. "Participating provider" means a provider who is party to a service agreement with a service plan corporation.

[*1971 c 568 s 2*]

62C.03 SERVICE PLAN CORPORATIONS AUTHORIZED. Subdivision 1. A service plan corporation may be organized to establish, maintain and operate a service plan providing health services in their entirety or in part, according to the subscriber contract. No subscriber's contract shall provide for payment of cash indemnification by the corporation to the subscriber or his estate for death, illness, or other injury, except as provided by Laws 1971, Chapter 568 as it relates to nonparticipating providers. In the event that the subscriber compensates the provider for services received he is subrogated to the provider's right against the service plan.

Subd. 2. A service plan corporation may enter other contracts, arrangements, or agreements as provided in Laws 1971, Chapter 568, to carry out the intent and purpose of Laws 1971, Chapter 568.

Subd. 3. A service plan corporation may provide for health services by nonparticipating providers in cases of emergency or expediency, or when selected in accordance with the subscriber's contract. When health service is provided out of state, the provider must be duly licensed, registered, and authorized to provide the service where provided.

[*1971 c 568 s 3*]

62C.04 ORGANIZATION. Subdivision 1. Except as otherwise expressly provided, a service plan corporation organized after August 1, 1971 shall be incorporated under and subject to chapter 317, as it may be amended, and in addition shall have, to the extent provided in its articles of incorporation, all powers and duties provided by Laws 1971, Chapter 568 for service plan corporations. A service plan corporation may be incorporated by not less than three legal residents of this state.

Subd. 2. An existing corporation shall be deemed a service plan corporation under Laws 1971, Chapter 568, subject to all of its terms and conditions, shall receive a certificate of authority from the commissioner, and shall not be required to obtain new licenses for its agents and representatives. However, any existing service plan corporation shall, within 30 days after the first annual meeting of the corporation following August 1, 1971, amend its articles and bylaws to the extent necessary to conform to and be governed by Laws 1971, Chapter 568 and chapter 317 and file said articles and bylaws for approval and filing in accordance with Laws 1971, Chapter 568. If any service plan corporation fails to meet these requirements the commissioner may suspend without a hearing its certificate of authority until the requirements of Laws 1971, Chapter 568 have been fully met.

Subd. 3. No service plan corporation shall include within its name the words "insurance", "casualty", "surety", "mutual", "indemnity", or any other words descriptive of the insurance, casualty, or surety business. No service plan corporation shall have a name, mark or symbol which is the same as, or deceptively similar to, the name of any other domestic corporation.

Subd. 4. A service plan corporation may be organized to provide for a combination of health services and an existing corporation may so provide by amendment of its articles of incorporation, or by merger, consolidation, or joint operating arrangements with another service plan corporation. All such actions taken shall be subject to the provisions of chapter 317, and to the approval of the commissioner for protection of the public and subscribers. If the commissioner denies approval an appeal may be made to the Ramsey county district court for review de novo of all matters relevant to the proposed combination.

[*1971 c 568 s 4*]

62C.05 ARTICLES OF INCORPORATION; BYLAWS. Subdivision 1. The articles of incorporation and bylaws of any service plan corporation and any amendments thereto shall conform to the requirements of Laws 1971, Chapter 568 and chapter 317.

Subd. 2. In addition to meeting the requirements of chapter 317, the articles of incorporation of a service plan corporation shall clearly state its purposes in strict conformity with Laws 1971, Chapter 568 and that subscribers' contracts shall not restrict the subscribers' freedom in selecting a provider in a particular class of providers.

[*1971 c 568 s 5*]

62C.06 APPROVAL OF ARTICLES AND BYLAWS. Subdivision 1. Proposed articles, bylaws or amendments thereto must be approved by the commissioner. The proposed articles, bylaws or amendments shall be submitted to the commissioner in triplicate. One copy shall be promptly returned endorsed by the commissioner to show the date of receipt. Failure of the commissioner to approve or disapprove by an order transmitted to the corporation within 30 days of receipt and stating the reasons for any disapproval, shall be deemed approval.

Subd. 2. Upon approval, the corporation shall file the articles or amendment with the secretary of state, together with a copy of the order or an affidavit of an officer of the corporation that no order has been issued and that more than 30 days have expired since submission of the proposed articles or amendment. When the filing fees and charges have been paid as required by law, and the secretary of state determines that the articles or amendments are in acceptable form, he shall record them and take any other action provided for by chapter 317.

Subd. 3. The existence of a service plan corporation hereafter organized shall begin upon issuance of a certificate of incorporation by the secretary of state. Within 14 days after issuance of the certificate, the corporation shall cause to be published once in a qualified newspaper in the county in which it has its registered office, a notice stating the name of the corporation, the date of incorporation, the general nature of its business, the address of its registered office, and the names and addresses of the incorporators and directors. Proof of publication shall be filed with the secretary of state within ten days after publication. If a corporation fails to comply with this subdivision, it shall forfeit $50 to the state.

Subd. 4. The secretary of state shall file a certified copy of the articles of incorporation with the county recorder of the county in which the registered office of the corporation is situated and with the commissioner, and shall collect from the corporation the necessary fees therefor.

[*1971 c 568 s 6; 1976 c 181 s 2*]

62C.07 DIRECTORS; MANAGEMENT. Subdivision 1. The articles of incorporation or the bylaws of a service plan corporation shall provide that the authority and responsibility for election of officers and proper and lawful operation of the corporation shall be in a board of not less than 12 directors with powers and authority as necessary for or instrumental to complete execution of the purposes of the corporation as provided by law, its articles and bylaws. The number of directors shall be fixed by the articles or bylaws.

Subd. 2. The directors shall be selected in accordance with the bylaws and at least one-third shall be individuals who are not practicing or engaged in providing health services, and who before their retirement did not practice or engage in providing health services, are not spouses of such persons, and are not employed by or directors of a provider.

[*1971 c 568 s 7*]

62C.08 CERTIFICATE OF AUTHORITY. Subdivision 1. No service plan corporation shall enter into subscriber contracts or solicit applications therefor, until it has secured a certificate of authority from the commissioner. Application for a certificate of authority shall be made upon forms prescribed by the commissioner.

Subd. 2. The commissioner may grant a certificate of authority after he has determined that the applicant is in compliance with Laws 1971, Chapter 568 with regard to the applicant's stated purpose, its articles and bylaws and its financial condition, that it has met the filing requirements of Laws 1971, Chapter 568 relating to subscribers' contracts and service agreements and that the service plan corporation has knowledgeable, responsible management.

Subd. 3. A foreign service plan corporation applying for a certificate of authority in this state shall be deemed to be a corporation which is organized under Laws 1971, Chapter 568, and such foreign corporation shall be required to meet the same requirements as an existing domestic corporation provided that no foreign corporation shall be denied a certificate of authority because its corporate powers exceed those which are permitted by the laws of this state, although its activities in this state may not exceed the powers of a domestic service plan corporation.

Subd. 4. No certificate of authority shall be required for a foreign service plan corporation whose activities in this state are limited to servicing members of covered groups whose contracts have been issued in another state, or for a foreign service plan corporation whose activities in this state are conducted pursuant to a contract or agreement with a licensed domestic service plan corporation if such contract or agreement is authorized by section 62C.13.

[*1971 c 568 s 8*]

62C.09 FINANCIAL REQUIREMENTS. Subdivision 1. The commissioner shall not issue a certificate of authority to any service plan corporation hereafter organized unless the corporation has met all legal requirements and, if organized on a capital stock basis unless the corporation has paid up capital stock of not less than $200,000 and an initial surplus of not less than $200,000, or, if organized on a membership basis, unless the corporation has an initial surplus of not less than $400,000.

Subd. 2. A service plan corporation in existence on August 1, 1971, or hereafter formed shall establish and maintain reserves for claims in process, incomplete and unreported claims, retroactive cost adjustments to providers, allowances for subscription charges received from subscribers but not yet earned and all other accrued liabilities in accordance with section 60A.12 as it relates to accident and health insurance companies.

Subd. 3. If organized on a capital stock basis, a service plan corporation shall never reduce its capital, and both capital stock and membership corporations shall maintain a surplus, in addition to all reserves established, of not less than the greater of the initial surplus reduced by $100,000 or 16 2/3 percent of the sum of all health service claims incurred, and administrative expenses in connection therewith, during the most recent calendar year. Corporations whose service plans are limited to the provision of dental services or vision care service only and all of whose service plan contracts have limits for specified benefits and limits for average maximum benefits of not greater than $1,000 per year per insured, shall maintain a surplus, in addition to all reserves established, of not less than the greater of the initial surplus reduced by $100,000 or ten percent of the sum of all health service claims incurred, and administrative expenses in connection therewith, during the previous calendar year; but the minimum shall not be required to exceed the financial requirements for surplus required for insurance companies operating upon the stock plan under section 60A.07, subdivision 5a as to those companies described in section 60A.06, subdivision 1, clause 5 (a). The surplus shall not exceed 33 1/3 percent of the sum of all health service claims incurred, and administrative expenses in connection therewith, during the most current calendar year unless such amount is less than the initial surplus reduced by $100,000. The percentage amounts shall be determined from a financial statement and certified audit filed annually and subject to verification of an examination by the commissioner.

Subd. 4. If the surplus is less than the required minimum or more than the required maximum, or if a service plan corporation does not have the required reserves or its reserves are not properly computed, operations shall be adjusted to correct the condition, according to a written plan proposed by the corporation and approved by

the commissioner. If a service plan corporation does not propose measures to correct its reserve or surplus within a reasonable time, if a corporation violates the plan which has been approved, or if there is evidence that an improper reserve or surplus status cannot be corrected within a reasonable time, the commissioner may take action against such corporation under chapter 60B, or under the suspension and penalty provisions of Laws 1971, Chapter 568.

[*1971 c 568 s 9; 1977 c 261 s 1; 1977 c 405 s 1*]

62C.10 INVESTMENT. Funds of a corporation subject to Laws 1971, Chapter 568 shall be invested only in securities and property designated by law for investment by domestic life insurance companies.

[*1971 c 568 s 10*]

62C.11 FINANCIAL STATEMENTS AND EXAMINATIONS. Subdivision 1. A service plan corporation shall annually on or before the last day of March, file with the commissioner a financial statement, in such form as the commissioner shall prescribe, verified by not less than two of its principal officers, showing the financial condition of the corporation as of December 31 of the preceding year. The statement shall include an audit report certified by an independent certified public accountant and reconciled and adjusted to conform to the financial statement.

Subd. 2. The commissioner shall examine a service plan corporation to ascertain its financial condition, its ability to fulfill its obligations, and its compliance with Laws 1971, Chapter 568, as often as he deems expedient for protection of the public, but not less than once each three years. He shall have access at all reasonable times to all books and records of the corporation, and may summon the officers and employees and examine them under oath as to any matter pertinent to Laws 1971, Chapter 568.

Subd. 3. The commissioner shall visit and examine any service plan corporation formed after August 1, 1971 within the first six months after it begins doing business, and thereafter once during each of the next three years. Thereafter he shall visit and examine the corporation at least once every three years.

Subd. 4. Any examination or audit conducted by or at the request of the commissioner shall be at the expense of the service plan corporation.

Subd. 5. The commissioner shall notify the governor whenever examinations required by this section have not been made and inform the governor of the reasons therefor.

[*1971 c 568 s 11*]

62C.12 SUSPENSION. A service plan corporation shall be subject to section 60A.051, relating to the denial, suspension or revocation of a certificate of authority, and to chapter 60B. The commissioner also may suspend or revoke a certificate for any violation or noncompliance with Laws 1971, Chapter 568 following a hearing under procedures established by rules and regulations of the commissioner. The commissioner may suspend or revoke the certificate of authority of a foreign service plan corporation for the same reasons for which a domestic corporation's certificate may be suspended or revoked, and further, he may revoke or suspend the certificate of a foreign service plan corporation if its activities outside the state of Minnesota impair its solvency or its ability to meet its obligations in this state.

[*1971 c 568 s 12*]

62C.13 AUTHORIZED CONTRACTS AND AGREEMENTS. Subdivision 1. A service plan corporation may act for, or as agent of, a provider and may contract with subscribers and others to render or provide health services for the benefit of subscribers. It may enter into service agreements. A subscriber contract may provide for payment to, or reimbursement of, a subscriber for expenses incurred for health services when rendered or furnished by nonparticipating providers.

Subd. 2. A service plan corporation may contract or make other arrangements with any agency, instrumentality or political subdivision of the United States, or this state, and may accept and administer funds, directly or indirectly, made available thereby provided such agency, instrumentality or political subdivision is authorized by law to make such contracts or arrangements. It may subcontract with any organization which has contracted with any such agency, instrumentality or political subdivision for the administration or furnishing of health services or any publicly supported health service plan.

Subd. 3. A service plan corporation may enter into contracts or other arrangements with similar organizations or corporations domiciled in this or any other state or country, for transfer of subscribers, reciprocal or joint benefits, or for other joint undertakings approved by its board and not inconsistent with the purposes of Laws 1971, Chapter 568, provided, however, that in no event shall a service plan corporation enter into any such contract, arrangement or undertaking which would have the effect of relieving such corporation of its duties and obligations to any subscribers unless the corporation has received the prior written consent of the affected subscribers, or a qualified agent or representative of such subscribers.

Subd. 4. A service plan corporation may enter into contracts or other arrangements with providers or with any agency, instrumentality or political subdivision of the United States or any state or country or any other organization for administrative, accounting, record keeping, data processing, or planning, facility or service related to rendering or furnishing health services.

Subd. 5. Laws 1971, Chapter 568 shall not be construed to require a service plan corporation to contract or arrange to remain under contract or arrangement with any provider, subscriber or group of subscribers.

[*1971 c 568 s 13*]

62C.14 SUBSCRIBER CONTRACTS. Subdivision 1. A service plan corporation shall deliver to every subscriber, except those covered as a spouse or dependent of another subscriber, a copy of the subscriber's contract or a certificate evidencing that the subscriber is covered by a group subscriber's contract.

Subd. 2. The subscriber's contract shall state in a clear and understandable manner all health services to be provided, in whole or in part, to the subscriber and all terms, conditions, limitations and exceptions under which the services shall be provided or paid for, including any provisions for coordination of benefits or subrogation, and including any provisions or conditions under which services from participating providers are not covered.

Subd. 3. Nothing in a subscriber's contract shall deny him free choice of the provider within a particular class of providers who is to treat the subscriber, and there shall be no interference with a provider-subscriber relationship.

Subd. 4. Except for group contracts or certificates, a subscriber's contract or other writing furnished to him with the contract, shall state the periodic subscription charge, the effective date, the expiration date or period of renewal, and the terms upon which the contract may be terminated, cancelled, continued, or renewed.

Subd. 5. 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 age 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 mental retardation or physical handicap, 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 age, and subsequently as required by the corporation, but not more frequently than annually after a two year period following attainment of the age.

Subd. 5a. Any group subscriber's contract delivered or issued for delivery or renewed in this state after August 1, 1973 shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If a subscriber is a parent or an acknowledged or adjudicated parent of a dependent illegitimate child, each group subscriber's contract delivered or issued for delivery or renewed after July 1, 1976, shall, if the subscriber chooses family coverage, provide the same coverage for that child as that provided for the child of any other subscriber choosing dependent family coverage. Any group contracting for a group subscriber's contract may request that the coverage required by this section be omitted.

An individual subscriber's contract delivered or issued for delivery in this state shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If the subscriber is a parent or the acknowledged or adjudicated parent of a dependent illegitimate child, each subscriber's individual contract delivered or issued for delivery or renewed after July 1, 1975, shall, if the subscriber chooses dependent family coverage, provide the same

coverage for that child as that provided for the child of any other subscriber choosing dependent family coverage.

Subd. 5b. The provisions of subdivision 5a shall apply to all health maintenance organizations regulated under any health maintenance organization enabling act enacted in 1973.

Subd. 6. A subscriber's contract or certificate shall state that it and all riders and endorsements, together with any application if signed by the subscriber, identification issued to him, and the applicable benefit schedules on file at the home office of the corporation and with the commissioner, shall constitute the entire contract between the corporation and the subscriber.

Subd. 7. No subscriber's contract shall provide for the payment of any cash or other material benefit to the subscriber or his estate on account of death, illness or injury, provided that a subscriber's contract may provide for the payment for services rendered by a nonparticipating provider to the extent such services are covered by the contract. In the event that the subscriber compensates the provider for services received he is subrogated to the provider's right against the service plan.

Subd. 8. Every subscriber's contract or certificate shall provide in substance that the subscriber has no personal liability to the participating provider rendering health services, except for those services or parts of service not covered by the subscriber's contract.

Subd. 9. No service plan corporation shall deliver or issue for delivery in this state any subscriber contract, endorsement, rider, amendment or application until a copy of the form thereof has been filed with the commissioner, subject to disapproval by the commissioner. Any such form issued or in use on August 1, 1971, if filed with the commissioner within 60 days after August 1, 1971, shall be deemed filed upon receipt by the commissioner. The commissioner also may by regulation exempt from filing those subscriber contracts issued to a group of not less than 300 subscribers, or to other groups upon such reasonable conditions and restrictions as he may require.

Subd. 10. Except as otherwise provided in subdivision 9, all forms received by the commissioner shall be deemed filed 30 days after received unless disapproved by order transmitted to the corporation stating that the form used in a specified respect is contrary to law, contains a provision or provisions which are unfair, inequitable, misleading, inconsistent or ambiguous, or is in part illegible. It shall be unlawful to issue or use a document disapproved by the commissioner.

Subd. 11. An order of disapproval shall state that a hearing will be granted within 20 days upon written request. The commissioner shall conduct the hearing within 20 days after receipt of the request and shall give not less than ten days' written notice of the time and place and matters to be considered. Within 15 days after the hearing, the commissioner shall affirm, reverse, or modify his previous action in writing, specifying his reasons therefor. Pending the hearing and decision thereon, the commissioner may postpone the effective date of his previous action.

Subd. 12. An order or decision of the commissioner under this section shall be subject to review by writ of certiorari at the instance of any party in interest. In the case of disapproval of a form previously in use, the court shall determine whether the petition for the writ shall stay the order or decision. The court may modify, affirm, or reverse the order or decision of the commissioner in whole or in part.

Subd. 13. All subscriber's contracts covering subscribers in this state shall be deemed to have been made in this state and shall be construed pursuant to Minnesota law when the position or rights of a Minnesota subscriber or covered group member are at issue. It shall be unlawful for any service plan corporation to solicit or make any subscriber contract in violation of the provisions of Laws 1971, Chapter 568.

Subd. 14. No subscriber's individual contract or any group contract which provides for coverage of family members or other dependents of a subscriber or of an employee or other group member of a group subscriber, shall be renewed, delivered, or issued for delivery in this state unless such contract includes as covered family members or dependents any newborn infants immediately from the moment of birth and thereafter which insurance shall provide coverage for illness, injury, congenital malformation or premature birth.

Subd. 15. No subscriber's individual contract or any group contract which provides for coverage of family members or dependents of a subscriber or of an employee or other group member of a group subscriber, entered into, issued, amended, renewed

or delivered in this state on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit under the service plan by the amount of, or in proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, as amended subsequent to the date of commencement of such benefit.

[*1971 c 568 s 14; 1973 c 303 s 3; 1973 c 494 s 5; 1973 c 651 s 2,3; 1975 c 323 s 3; 1976 c 121 s 4*]

62C.141 PAYMENTS TO WELFARE RECIPIENTS. After August 1, 1975, no service plan corporation shall deliver, issue for delivery, or renew any subscriber's contract which contains any provision denying or reducing benefits because services are rendered to a subscriber or dependent who is eligible for or receiving medical assistance pursuant to chapter 256B.

[*1975 c 247 s 2*]

62C.142 CONVERSION PRIVILEGE FOR FORMER SPOUSE. Subdivision 1. No subscriber contract of a nonprofit health service plan corporation which in addition to covering the subscriber, also covers the subscriber's spouse shall contain a provision for termination of coverage for a spouse covered under the subscriber contract solely as a result of a break in the marital relationship except by reason of an entry of a valid decree of dissolution of marriage between the parties.

Subd. 2. 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 to the effect that upon the entry of a valid decree of dissolution of marriage between the covered parties the spouse shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the corporation within 30 days following the entry of the decree and upon the payment of the appropriate fee, an individual subscriber contract. The contract shall provide the coverage then being issued by the corporation which is most nearly similar to, but not greater than, the terminated coverage. Any probationary or waiting period set forth in the conversion contract shall be considered as being met to the extent coverage was in force under the prior contract.

Subd. 3. This section applies to every subscriber contract which is delivered, issued for delivery, renewed or amended on or after the effective date of this section.

[*1977 c 186 s 2*]

62C.15 SUBSCRIPTION CHARGES. Subdivision 1. A service plan corporation shall establish and adjust from time to time subscription charges to be paid by or on behalf of its subscribers. The charges shall be reasonable, and not unfairly discriminatory, in relation to the benefits, considering actuarial projection of the cost of providing or paying for the health services, considering costs of administration, and in relation to reserves and surplus required by law.

Subd. 2. No service plan corporation shall deliver, issue for delivery, extend, continue, or renew any form of nongroup subscriber contract until schedules of charges applicable thereto, including any endorsement, rider, amendment or application which is a part thereof, have been filed with the commissioner; nor shall the corporation deliver, issue for delivery, extend, continue or renew any form of group subscriber contract until a schedule of the rating structures and formulae applicable thereto, including any endorsement, rider, amendment or application which is a part thereof, has been filed with the commissioner. The filing for a nongroup subscriber contract shall include the actuarial data needed to justify any increase in subscriber charges. The commissioner may disapprove the schedule of charges for any group or nongroup subscriber contract if:

(a) The unencumbered reserve or surplus is less than the required minimum or more than the required maximum; or

(b) The schedule charges meet the criteria specified in section 62A.02, subdivision 3.

Subd. 3. If subscription charges become subject to disapproval, the commissioner shall within 30 days of filing render an order either disapproving the charges or extending time for review to a specified date, or the charges shall be deemed approved. An order disapproving a charge shall state the reasons therefor and shall be

subject to the notice, hearing, and appeal provisions of section 62C.14. The burden of proving and actuarially demonstrating that the charges are not inadequate or excessive shall be on the corporation.

Subd. 4. It shall be unlawful for a service plan corporation to deliver or issue a subscriber's contract with charges which have been disapproved by the commissioner.

[*1971 c 568 s 15; 1976 c 296 art 2 s 12*]

62C.16 SERVICE AGREEMENTS. Subdivision 1. Service plan corporations, as agents for providers, may enter into service agreements only with providers authorized to practice their profession or conduct their business in this state or the state or foreign country in which the provider is located.

Subd. 2. A service plan corporation shall enforce its service agreements, including agreements of providers to accept payment from the corporation as compensation for health service rendered or provided to subscribers who have prepaid for the health service. Provisions for review, by participating providers, of claims shall be a part of each service agreement.

Subd. 3. Each type of service agreement shall be filed with the commissioner, prior to its use and those in effect on August 1, 1971, shall be filed within 60 days thereof.

[*1971 c 568 s 16*]

62C.17 LICENSE FOR SOLICITOR OR AGENT. Subdivision 1. No person shall act as a solicitor or agent for solicitation of subscribers on behalf of a service plan corporation, except an officer of the corporation, until he obtains a license from the commissioner. The license shall be granted to qualified persons only upon request of the service plan corporation. The commissioner may establish by rule reasonable standards of qualification.

Subd. 2. Applications for license shall be submitted to the commissioner on forms provided by him. Except as provided in subdivision 3, the applicant shall pass a written examination reasonably designed to determine whether he is qualified to be licensed as an agent or solicitor. The examination shall be pertinent to the contracts and coverage furnished by the corporation and shall be comparable to the examination required for a health and accident insurance agent's license. Prior to examination or re-examination, and prior to issuance or renewal of a license, the applicant shall pay to the commissioner the fees required for examination or re-examination for, and issuance or renewal of, an insurance agent's license for one line of insurance. The license shall expire May 31 of each year unless renewed by written request with payment of the renewal fee. The license shall not authorize a person to act as an insurance agent or solicitor.

Subd. 3. The commissioner shall issue and renew licenses without examination for a person who holds a valid health and accident insurance agent's license of this state or who as of October 1, 1971 has been employed as a solicitor or agent for solicitation of subscribers for not less than two years for the corporation to which the license would apply, is a full time employee of the corporation, and has never had an insurance agent's license of this state denied, revoked, or suspended.

Subd. 4. The commissioner may at any time after a hearing pursuant to the contested case provisions of chapter 15, revoke or suspend a license if satisfied that the licensee is not qualified. An application for a new license or for reinstatement may be entertained one year after revocation or suspension, upon filing of a bond in the amount of $5,000 approved by the commissioner for protection of the public for a period of five years, or a lesser amount and period as the commissioner may prescribe. The commissioner shall revoke or suspend a license upon written request by the corporation or agent for which the licensee is licensed to act. Such a request shall include a statement of the specific facts constituting cause for termination. Any such information shall be deemed a confidential and privileged communication, and shall not be admissible, in whole or in part, in any action or proceeding without the corporation's or agent's written consent.

Subd. 5. A person shall not be qualified for a license if upon examination or re-examination it is determined that he is incompetent to act as an agent or solicitor, if he has acted in any manner which would disqualify a person to hold a license as an insurance agent or solicitor under section 60A.17, subdivision 6, or if he fails to produce documents subpoenaed by the commissioner, or fails to appear at a hearing to

which he is a party or has been subpoenaed, if the production of documents or appearance is lawfully required.

[*1971 c 568 s 17*]

62C.18 NO PERSONAL LIABILITY. Subdivision 1. No participating provider shall have any right of action against a subscriber for compensation for health services which such provider has rendered, except to the extent that the subscriber's contract does not provide coverage for the services or part of the services rendered.

Subd. 2. Nothing herein shall affect the rights of a nonparticipating provider who gives the subscriber written notice prior to rendering service that he will bill the subscriber directly for his service, provided that such notice shall not be required if (1) the nonparticipating provider is not informed by the subscriber and does not otherwise have knowledge that such subscriber has a subscriber contract covering such services, or (2) under the existing circumstances it is impossible or impractical for the nonparticipating provider to give such notice, or (3) the services are not provided in this state.

Subd. 3. A nonparticipating provider who fails to give the notice required in subdivision 2 shall not be entitled to recover compensation from a subscriber for health services rendered to such subscriber in an amount in excess of the aggregate of (1) the amount actually received by the subscriber from the service plan corporation as reimbursement for the costs of such service, and (2) the amount by which such nonparticipating provider's fee or charges for such service exceeds the coverage provided for such service in the subscriber's contract.

[*1971 c 568 s 18*]

62C.19 UNFAIR TRADE PRACTICES. Service plan corporations are subject to sections 72A.17 to 72A.30, regarding regulation of trade practices, and to all regulations promulgated by the commissioner regarding advertisements for and marketing of accident and health insurance.

[*1971 c 568 s 19*]

62C.20 PRACTICE NOT AUTHORIZED. Nothing in Laws 1971, Chapter 568 shall authorize any person, association or corporation to engage, in any manner, in the practice of a profession required by this state to be licensed.

[*1971 c 568 s 20*]

62C.21 PENALTIES. If a service plan corporation violates Laws 1971, Chapter 568 or other applicable law, the commissioner may suspend or revoke its certificate of authority, and impose a penalty not to exceed $5,000 for each offense. Such action shall be by order and subject to the notice, hearing and appeal provided as to an order disapproving a subscriber's contract.

[*1971 c 568 s 21*]

62C.22 VIOLATIONS. Any person who violates Laws 1971, Chapter 568, or who makes a material false statement with respect to a written report or statement required by Laws 1971, Chapter 568, shall be punishable, for the first offense, by payment of a fine of not more than $300 or imprisonment for not more than 90 days or both and for the second and each subsequent offense by payment of a fine of not more than $1000 or imprisonment for not more than one year or both.

[*1971 c 568 s 22*]

62C.23 RULES AND REGULATIONS. For the purpose of implementing and enforcing Laws 1971, Chapter 568, the commissioner may adopt rules and regulations pursuant to chapter 15.

[*1971 c 568 s 23*]