CHAPTER 62C

NONPROFIT HEALTH SERVICE PLAN CORPORATIONS

62C.001 MS 2006 [Renumbered 15.001]

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 the gross premiums tax provisions contained in chapter 297I and 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.

History: *1971 c 568 s 1; 1992 c 549 art 9 s 3; 2000 c 394 art 2 s 13*

62C.02 DEFINITIONS.

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

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of commerce or a person duly designated to act in the commissioner's place.

Subd. 3. **Health service.** "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.** "Subscriber" means a person covered under a subscriber contract for health services to the extent therein described.

Subd. 5. **Provider.** "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.** "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.** "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.** "Service agreement" means an agreement, contract or other arrangement between a service plan corporation and a provider under which the provider agrees that when health services are provided for a subscriber the provider 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.** "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.** "Participating provider" means a provider who is party to a service agreement with a service plan corporation.

History: *1971 c 568 s 2; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 444*

62C.03 SERVICE PLAN CORPORATIONS AUTHORIZED.

Subdivision 1. **General authority.** 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 the subscriber's 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 the subscriber is subrogated to the provider's right against the service plan.

Subd. 2. **Contracting authority.** 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. **Health services by nonparticipating providers.** 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.

History: *1971 c 568 s 3; 1986 c 444*

62C.04 ORGANIZATION.

Subdivision 1. **Incorporated as nonprofit.** Except as otherwise expressly provided, a service plan corporation organized after August 1, 1971 shall be incorporated under and subject to chapter 317A, 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. **Existing corporations.** 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 317A 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. **Regulation of name.** 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. **Combination of health services.** 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 317A, 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.

History: *1971 c 568 s 4; 1989 c 304 s 137*

62C.05 ARTICLES OF INCORPORATION; BYLAWS.

Subdivision 1. **Required conformance.** 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 317A.

Subd. 2. **Specified statements in articles.** In addition to meeting the requirements of chapter 317A, 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.

History: *1971 c 568 s 5; 1989 c 304 s 137*

62C.06 APPROVAL OF ARTICLES AND BYLAWS.

Subdivision 1. **Commissioner's review and approval.** 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. **Filing.** 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, the secretary of state shall record them and take any other action provided for by chapter 317A.

Subd. 3. **Certificate of incorporation.** 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. [Repealed, 1984 c 618 s 61]

History: *1971 c 568 s 6; 1976 c 181 s 2; 1986 c 444; 1989 c 304 s 137*

62C.07 DIRECTORS; MANAGEMENT.

Subdivision 1. **Authority and composition.** 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. **Selection.** 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.

History: *1971 c 568 s 7*

62C.08 CERTIFICATE OF AUTHORITY.

Subdivision 1. **Requirement.** 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. **Granting.** The commissioner may grant a certificate of authority after determining 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. **Foreign service plan corporation.** 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. **Exception.** 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.

History: *1971 c 568 s 8; 1986 c 444*

62C.09 FINANCIAL REQUIREMENTS.

Subdivision 1. **Generally.** 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. **Reserve requirements.** 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. [Repealed, 2004 c 285 art 3 s 11]

Subd. 4. [Repealed, 2004 c 285 art 3 s 11]

Subd. 5. **Risk-based capital requirement.** A service plan corporation is subject to regulation of its financial solvency under sections 60A.50 to 60A.592.

History: *1971 c 568 s 9; 1977 c 261 s 1; 1977 c 405 s 1; 2004 c 285 art 3 s 2*

62C.10 INVESTMENT.

Funds of a corporation subject to this chapter shall be invested only in securities and property designated by law for investment by domestic life insurance companies. Notwithstanding any limitations set forth in chapter 61A, an organization which has received a certificate of authority from the commissioner to operate under this chapter may invest up to 20 percent of its admitted assets in corporations whose business is the arrangement for, management of, or provision of health care services, including dental and related managed care and administrative services. Any amounts so invested shall, for purposes of section 62C.09, be added to the minimum and maximum reserve requirements as calculated for a service plan corporation.

History: *1971 c 568 s 10; 1993 c 70 s 1; 1994 c 425 s 12*

62C.11 FINANCIAL STATEMENTS AND EXAMINATIONS.

Subdivision 1. **Annual filing.** 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.

Subd. 2. **Periodic examinations.** 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 the commissioner deems expedient for protection of the public, but not less than once each three years. The commissioner 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. **Initial examinations.** 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 the commissioner shall visit and examine the corporation at least once every three years.

Subd. 4. **Examination and audit expenses.** 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. **Failure to examine; notification to governor.** The commissioner shall notify the governor whenever examinations required by this section have not been made and inform the governor of the reasons therefor.

History: *1971 c 568 s 11; 1986 c 444; 2000 c 483 s 12*

62C.12 SUSPENSION.

A service plan corporation shall be subject to section 60A.052, 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 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, 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.

History: *1971 c 568 s 12; 1985 c 248 s 70; 1986 c 444; 1993 c 13 art 2 s 1*

62C.13 AUTHORIZED CONTRACTS AND AGREEMENTS.

Subdivision 1. **General powers.** 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. **Government units or agencies.** 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. **Similar organizations.** 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. **Administrative services.** 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. **Construction of section.** 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.

History: *1971 c 568 s 13*

62C.14 SUBSCRIBER CONTRACTS.

Subdivision 1. **Copy to subscriber.** 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. **General contents.** 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. **Free choice preserved.** Nothing in a subscriber's contract shall deny the subscriber 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. **Contents of group contracts.** Except for group contracts or certificates, a subscriber's contract or other writing furnished 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, canceled, continued, or renewed.

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.

Subd. 5a. **Maternity benefits.** 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 an unmarried subscriber is a parent of a dependent 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 an unmarried subscriber is a parent of a dependent 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. **Application of maternity benefits provision.** 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. **Required statement.** 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, 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. **Limitation on payment of death, illness, or injury benefits.** No subscriber's contract shall provide for the payment of any cash or other material benefit to the subscriber or the subscriber's 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 the subscriber is subrogated to the provider's right against the service plan.

Subd. 8. **Limitation on subscriber contract liability.** 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. **Required filing.** 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. When an insurer, service plan corporation, or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission. 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 the commissioner may require.

Subd. 10. **Filing or disapproval.** Except as otherwise provided in subdivision 9, all forms received by the commissioner shall be deemed filed 60 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. When an insurer, service plan corporation, or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission.

Subd. 11. **Hearing.** 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 the previous action in writing, specifying the reasons therefor. Pending the hearing and decision thereon, the commissioner may postpone the effective date of previous action.

Subd. 12. **Appeal.** An order or decision of the commissioner under this section shall be subject to appeal in accordance with chapter 14.

Subd. 13. **Construction.** 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. **Newborn infant coverage.** 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. The coverage described in this subdivision includes coverage of cleft lip and cleft palate to the same extent provided in section 62A.042, subdivisions 1, paragraph (b); and 2, paragraph (b). For purposes of this paragraph, "newborn infants" includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from

birth. No policy, contract, or agreement covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy, contract, or agreement mandates an additional premium for each dependent, the health carrier shall be entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may withhold payment of any health benefits for the new dependent until it has been compensated with the applicable premium which would have been owed if the health carrier had been informed of the additional dependent immediately.

Subd. 15. **Certain disability benefits offset prohibited.** 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.

History: *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; 1980 c 589 s 26; 1983 c 247 s 32; 1986 c 444; 1986 c 455 s 13; 1995 c 258 s 37,38; 1996 c 446 art 1 s 40; 2003 c 40 s 3; 2004 c 288 art 3 s 4; 2005 c 56 s 1; 2006 c 255 s 17,18; 2013 c 84 art 1 s 32*

62C.141 [Repealed, 1995 c 207 art 10 s 25]

62C.142 CONTINUATION AND CONVERSION PRIVILEGES FOR FORMER SPOUSES AND CHILDREN.

Subdivision 1. **Termination of coverage.** 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. **Conversion privilege.** 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.

Subd. 2a. **Continuation privilege.** Every subscriber contract, other than a contract whose continuance is contingent upon continued employment or membership, shall contain a provision which permits continuation of coverage under the contract for the subscriber's former spouse and children upon entry of a valid decree of dissolution of marriage. The coverage may be continued until the earlier of the following dates:

(a) the subscriber's former spouse becomes covered under any other group health plan; or

(b) the date coverage would otherwise terminate under the subscriber contract.

The contract must require the group contract holder to, upon request, provide the insured 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. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Subd. 3. **Application.** Subdivision 1 applies to every subscriber contract which is delivered, issued for delivery, renewed or amended on or after July 19, 1977.

Subdivisions 2 and 2a apply to every subscriber contract which is delivered, issued for delivery, renewed, or amended on or after March 1, 1983.

History: *1977 c 186 s 2; 1982 c 555 s 9; 1982 c 642 s 15; 1990 c 403 s 9; 1992 c 564 art 4 s 9; 2000 c 483 s 13; 2013 c 84 art 1 s 33*

62C.143 [Repealed, 1995 c 207 art 10 s 25]

62C.15 SUBSCRIPTION CHARGES.

Subdivision 1. **Establishment and adjustment.** 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. **Nongroup contracts; filing of schedule of charges.** 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. **Disapproval.** 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. **Issuance or delivery of disapproved contract.** 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.

History: *1971 c 568 s 15; 1976 c 296 art 2 s 12*

62C.16 SERVICE AGREEMENTS.

Subdivision 1. **Agreements with authorized providers.** 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. **Enforcement.** 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. **Filing.** 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.

Subd. 4. **Retaliatory action prohibited.** No service plan corporation may take retaliatory action against a provider solely on the grounds that the provider disseminated accurate information regarding coverage of benefits or accurate benefit limitations of a subscriber's contract or accurate interpretations of the provider agreement that limit the prescribing, providing, or ordering of care.

History: *1971 c 568 s 16; 1993 c 345 art 5 s 5*

62C.17 LICENSE FOR SOLICITOR OR AGENT.

Subdivision 1. **Requirement.** 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 that person 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. **Application.** Applications for license shall be submitted to the commissioner on forms provided by the commissioner. Except as provided in subdivision 3, the applicant shall pass a written examination reasonably designed to determine whether the applicant 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 reexamination, and prior to issuance or renewal of a license, the applicant shall pay to the commissioner the fees required for examination or reexamination 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. **Examination exception; health and accident insurance agent.** 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. **Revocation or suspension; reinstatement.** The commissioner may at any time after a hearing pursuant to the contested case provisions of chapter 14, 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. **Nonqualification.** A person shall not be qualified for a license if upon examination or reexamination it is determined that the person is incompetent to act as a producer, if the person has acted in any manner which would disqualify a person to hold a license as an insurance producer under sections 60K.30 to 60K.56, or if the person fails to produce documents subpoenaed by the commissioner, or fails to appear at a hearing to which the person is a party or has been subpoenaed, if the production of documents or appearance is lawfully required.

History: *1971 c 568 s 17; 1982 c 424 s 130; 1986 c 444; 1992 c 564 art 3 s 22; 2001 c 117 art 2 s 8*

62C.18 PERSONAL LIABILITY.

Subdivision 1. **Limitation.** 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. **Rights of nonparticipating providers; notice.** Nothing herein shall affect the rights of a nonparticipating provider who gives the subscriber written notice prior to rendering service that the provider will bill the subscriber directly for 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. **Failure of nonparticipating provider to give notice.** 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.

History: *1971 c 568 s 18; 1986 c 444*

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 rules promulgated by the commissioner regarding advertisements for and marketing of accident and health insurance.

History: *1971 c 568 s 19; 1985 c 248 s 70*

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.

History: *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.

History: *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 $1,000 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 $3,000 or imprisonment for not more than one year or both.

History: *1971 c 568 s 22; 1984 c 628 art 3 s 11; 2004 c 228 art 1 s 72*

62C.23 RULES.

For the purpose of implementing and enforcing Laws 1971, chapter 568, the commissioner may adopt rules pursuant to chapter 14.

History: *1971 c 568 s 23; 1982 c 424 s 130; 1985 c 248 s 70*