dent person at a fair and reasonable price, or in a bona fide relationship in which an independent person has made a significant investment subject to loss in the dealership and can reasonably expect to acquire full ownership of the dealership on reasonable terms and conditions; ~~or~~

(j) To prevent a new motor vehicle dealer from receiving fair and reasonable compensation for the value of the new motor vehicle dealership. There shall be no transfer, assignment of the franchise, or major change in the executive management of the dealership, except as is otherwise provided in sections 80E.01 to 80E.17, without consent of the manufacturer, which shall not be unreasonably withheld. Denial of the request must be in writing and delivered to the new motor vehicle dealer within 60 days after the manufacturer receives the information necessary to evaluate the proposed transfer. If a denial is not sent within this period, the manufacturer shall be deemed to have given its consent to the proposed transfer or change; or

(k) To threaten to modify or replace or modify or replace a franchise with a succeeding franchise that would adversely alter the rights or obligations of a new motor vehicle dealer under an existing franchise or that substantially impairs the sales or service obligations or investments of the motor vehicle dealer.

Sec. 9. **[80E.135] WAIVERS AND MODIFICATIONS PROHIBITED.**

No manufacturer, distributor, or factory branch shall, before entering into a franchise with a new motor vehicle dealer or during the franchise term, use any written instrument, agreement, or waiver, to attempt to nullify or modify any provision of this chapter, or prevent a new motor vehicle dealer from bringing an action in a particular forum otherwise available under law. These instruments, agreements, and waivers are null and void.

Sec. 10. **LEGISLATIVE INTENT.**

Sections 4 to 7 are a restatement and clarification of the legislative intent of Laws 1987, chapter 150, section 3, and shall not be construed as a modification of existing law.

Approved April 24, 1988

CHAPTER 612—H.F.No. 2127

An act relating to health maintenance organizations; requiring insolvency insurance policies to be filed; requiring a deposit; creating a net worth requirement; defining admitted assets; imposing investment restrictions; requiring quarterly reports; providing for the inclusion of certain items in provider contracts; regulating rehabilitation and liquidations; providing for alternative coverage for enrollees of an insolvent health maintenance organization; requiring health maintenance organizations to maintain liabilities for unpaid claims; impos-

ing residency requirements for Minnesota comprehensive health association coverage; requiring a report; amending Minnesota Statutes 1986, sections 62D.02, by adding subdivisions; 62D.03, subdivision 4; 62D.041, subdivisions 1, 2, 3, 4, 7, and by adding subdivisions; 62D.05, subdivision 3; 62D.08, by adding a subdivision; 62D.12, subdivision 5, and by adding a subdivision; 62D.14, subdivision 1; 62D.18; 62D.19; 62E.02, subdivision 13; and 62E.14, subdivision 1; Minnesota Statutes 1987 Supplement, sections 62D.04, subdivision 1; and 62E.10, subdivision 9; Laws 1988, chapter 434, sections 14 and 21; proposing coding for new law in Minnesota Statutes, chapter 62D; repealing Minnesota Statutes 1986, section 62D.041, subdivisions 5, 6, and 8.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1986, section 62D.02, is amended by adding a subdivision to read:

Subd. 15. "Net worth" means admitted assets, as defined in section 15, minus liabilities.

Sec. 2. Minnesota Statutes 1986, section 62D.02, is amended by adding a subdivision to read:

Subd. 16. "Affiliate" means a person or entity controlling, controlled by, or under common control with the person or entity.

Sec. 3. Minnesota Statutes 1986, section 62D.03, subdivision 4, is amended to read:

Subd. 4. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, and shall be in a form prescribed by the commissioner of health. Each application shall include the following:

(a) a copy of the basic organizational document, if any, of the applicant and of each major participating entity; such as the articles of incorporation, or other applicable documents, and all amendments thereto;

(b) a copy of the bylaws, rules and regulations, or similar document, if any, and all amendments thereto which regulate the conduct of the affairs of the applicant and of each major participating entity;

(c) a list of the names, addresses, and official positions of the following:

(1) all members of the board of directors, or governing body of the local government unit, and the principal officers and shareholders of the applicant organization; and

(2) all members of the board of directors, or governing body of the local government unit, and the principal officers of the major participating entity and each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

The commissioner may by rule identify persons included in the term "principal officers";

(d) a full disclosure of the extent and nature of any contract or financial arrangements between the following:

(1) the health maintenance organization and the persons listed in clause (c)(1);

(2) the health maintenance organization and the persons listed in clause (c)(2);

(3) each major participating entity and the persons listed in clause (c)(1) concerning any financial relationship with the health maintenance organization; and

(4) each major participating entity and the persons listed in clause (c)(2) concerning any financial relationship with the health maintenance organization;

(e) the name and address of each participating entity and the agreed upon duration of each contract or agreement;

(f) a copy of the form of each contract binding the participating entities and the health maintenance organization. Contractual provisions shall be consistent with the purposes of sections 62D.01 to 62D.29, in regard to the services to be performed under the contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health maintenance organization, the nature and extent of risk sharing permissible, and contractual termination provisions;

(g) a copy of each contract binding major participating entities and the health maintenance organization. Contract information filed with the commissioner shall be confidential and subject to the provisions of section 13.37, subdivision 1, clause (b), upon the request of the health maintenance organization.

Upon initial filing of each contract, the health maintenance organization shall file a separate document detailing the projected annual expenses to the major participating entity in performing the contract and the projected annual revenues received by the entity from the health maintenance organization for such performance. The commissioner shall disapprove any contract with a major participating entity if the contract will result in an unreasonable expense under section 62D.19. The commissioner shall approve or disapprove a contract within 30 days of filing.

Within 120 days of the anniversary of the implementation of each contract, the health maintenance organization shall file a document detailing the actual expenses incurred and reported by the major participating entity in performing the contract in the proceeding year and the actual revenues received from the health maintenance organization by the entity in payment for the performance.

Contracts implemented prior to April 25, 1984, shall be filed within 90 days of April 25, 1984. These contracts are subject to the provisions of section 62D.19, but are not subject to the prospective review prescribed by this clause, unless or until the terms of the contract are modified. Commencing with the next anniversary of the implementation of each of these contracts immediately following filing, the health maintenance organization shall, as otherwise required by this subdivision, file annual actual expenses and revenues.

(h) a statement generally describing the health maintenance organization, its health maintenance contracts and separate health service contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide enrollees with comprehensive health maintenance services and separate health services;

(i) a copy of the form of each evidence of coverage to be issued to the enrollees;

(j) a copy of the form of each individual or group health maintenance contract and each separate health service contract which is to be issued to enrollees or their representatives;

(k) financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement may be deemed to satisfy this requirement;

(l) a description of the proposed method of marketing the plan, a schedule of proposed charges, and a financial plan which includes a three year projection of the expenses and income and other sources of future capital;

(m) a statement reasonably describing the geographic area or areas to be served and the type or types of enrollees to be served;

(n) a description of the complaint procedures to be utilized as required under section 62D.11;

(o) a description of the procedures and programs to be implemented to meet the requirements of section 62D.04, subdivision 1, clauses (b) and (c) and to monitor the quality of health care provided to enrollees;

(p) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section 62D.06;

(q) a copy of any agreement between the health maintenance organization and an insurer or nonprofit health service corporation regarding reinsurance, stop-loss coverage, insolvency coverage, or any other type of coverage for potential costs of health services, as authorized in ~~section~~ sections 62D.04, subdivision 1, clause (f), 62D.05, subdivision 3, and ~~section~~ 62D.13; and

(r) other information as the commissioner of health may reasonably require to be provided.

Sec. 4. Minnesota Statutes 1987 Supplement, section 62D.04, subdivision 1, is amended to read:

Subdivision 1. Upon receipt of an application for a certificate of authority, the commissioner of health shall determine whether the applicant for a certificate of authority has:

(a) demonstrated the willingness and potential ability to assure that health care services will be provided in such a manner as to enhance and assure both the availability and accessibility of adequate personnel and facilities;

(b) arrangements for an ongoing evaluation of the quality of health care;

(c) a procedure to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the quality, availability and accessibility of its services, and such other matters as may be reasonably required by regulation of the commissioner of health;

(d) reasonable provisions for emergency and out of area health care services;

(e) demonstrated that it is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner of health ~~may~~ shall require the amounts of net worth and working capital required in section 14, the deposit required in section 62D.041, and in addition shall consider:

(1) the financial soundness of its arrangements for health care services and the proposed schedule of charges used in connection therewith;

(2) ~~the adequacy of its working capital;~~

~~(3)~~ arrangements which will guarantee for a reasonable period of time the continued availability or payment of the cost of health care services in the event of discontinuance of the health maintenance organization; and

~~(4)~~ (3) agreements with providers for the provision of health care services; ~~and~~

~~(5) any deposit of cash or securities submitted in accordance with section 62D.041;~~

(f) demonstrated that it will assume full financial risk on a prospective basis for the provision of comprehensive health maintenance services, including hospital care; provided, however, that the requirement in this paragraph shall not prohibit the following:

(1) a health maintenance organization from obtaining insurance or making other arrangements (i) for the cost of providing to any enrollee comprehensive

health maintenance services, the aggregate value of which exceeds $5,000 in any year, (ii) for the cost of providing comprehensive health care services to its members on a nonelective emergency basis, or while they are outside the area served by the organization, or (iii) for not more than 95 percent of the amount by which the health maintenance organization's costs for any of its fiscal years exceed 105 percent of its income for such fiscal years; and

(2) a health maintenance organization from having a provision in a group health maintenance contract allowing an adjustment of premiums paid based upon the actual health services utilization of the enrollees covered under the contract, except that at no time during the life of the contract shall the contract holder fully self-insure the financial risk of health care services delivered under the contract. Risk sharing arrangements shall be subject to the requirements of sections 62D.01 to 62D.30;

(g) otherwise met the requirements of sections 62D.01 to 62D.29.

Sec. 5. Minnesota Statutes 1986, section 62D.041, subdivision 1, is amended to read:

62D.041 **PROTECTION ~~AGAINST~~ IN THE EVENT OF INSOLVENCY.**

Subdivision 1. **DEFINITION.** For the purposes of this section, the term "uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization for which an enrollee would also be liable in the event of the organization's insolvency, ~~including out-of-area services, referral services, and any other expenditures for health care services for which the health maintenance organization is at risk~~ and that are not guaranteed, insured, or assumed by a person other than the health maintenance organization.

Sec. 6. Minnesota Statutes 1986, section 62D.041, subdivision 2, is amended to read:

Subd. 2. **REQUIRED DEPOSIT.** ~~Unless otherwise provided in this section,~~ Each health maintenance organization shall deposit with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, the cash~~, freely alienable securities, or any combination of these or other measures that is acceptable to the commissioner in the~~ amount ~~set forth~~ required in this section. ~~If a health maintenance organization 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 health maintenance organization and approved by the commissioner. If a health maintenance organization does not propose measures to correct its reserves 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 of commerce may take action against the corporation under chapter 60B~~ The commissioner may allow a health maintenance organization's deposit require-

New language is indicated by underline, deletions by ~~strikeout~~.

ment to be met by a guaranteeing organization, as defined in section 14, subdivision 1, based on the criteria set out in section 14, subdivision 5.

Sec. 7. Minnesota Statutes 1986, section 62D.041, subdivision 3, is amended to read:

Subd. 3. **AMOUNT FOR BEGINNING ORGANIZATIONS.** ~~The amount for an organization that is beginning operation shall be the greater of: (a) five percent of its estimated expenditures for health care services for its first year of operation; (b) twice its estimated average monthly uncovered expenditures for its first year of operation; or (c) $100,000.~~

~~At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the organization or trustee, cash, freely alienable securities, or any combination of these or other measures acceptable to the commissioner in an amount equal to four percent of its estimated annual uncovered expenditures for that year.~~ (a) Organizations that obtain a certificate of authority after the effective date of this subdivision shall deposit, before receiving a certificate of authority, $500,000. The health maintenance organization shall provide the commissioner with evidence of the deposit before receiving a certificate of authority.

(b) By April 1 of the year following the organization's first 12 months of operation under a certificate of authority, an organization shall deposit an amount equal to the difference between the initial deposit and 33 percent of its uncovered expenditures in its first 12 months of operation.

(c) By April 1 of subsequent years, an organization shall deposit an amount equal to the difference between the amount on deposit and 33 percent of its uncovered expenditures in the preceding calendar year.

Sec. 8. Minnesota Statutes 1986, section 62D.041, subdivision 4, is amended to read:

Subd. 4. **AMOUNT FOR EXISTING ORGANIZATIONS.** ~~Unless not applicable,~~ By December 31, 1989, an organization that ~~is in operation on August 1, 1984,~~ has received a certificate of authority on or before the effective date of this subdivision shall ~~make a~~ have on deposit an amount equal to the larger of:

(a) ~~one percent of the preceding 12 months' uncovered expenditures~~ 33 percent of its uncovered expenditures in the preceding calendar year; or

(b) ~~$100,000 on the first day of the fiscal year beginning six months or more after August 1, 1984~~ $500,000.

~~In the second fiscal year, if applicable, the amount of the additional deposit shall be equal to two percent of its estimated annual uncovered expenditures. In the third year, if applicable, the additional deposit shall be equal to three percent of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and subsequent years, if applicable, the additional deposit shall be equal to four percent of its estimated annual uncovered expenditures for~~

~~each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.~~

By April 1 of each subsequent year, an organization shall deposit an amount equal to the difference between the amount on deposit and 33 percent of its uncovered expenditures in the preceding calendar year.

Sec. 9. Minnesota Statutes 1986, section 62D.041, is amended by adding a subdivision to read:

Subd. 5a. **WAIVER OF ADDITIONAL DEPOSIT.** In any year when the amount determined according to this section is zero or less than zero, the commissioner shall not require the organization to make any additional deposit.

Sec. 10. Minnesota Statutes 1986, section 62D.041, is amended by adding a subdivision to read:

Subd. 6a. **WITHDRAWAL OF DEPOSIT.** If the amount previously deposited by the organization under this section exceeds the amount required under this section by more than $50,000 for a continuous 12-month period, the commissioner shall allow the organization to withdraw the portion of the deposit that exceeds by more than $50,000 the amount required to be on deposit for the organization, unless the commissioner determines that release of a portion of the deposit could be hazardous to enrollees, creditors, or the general public. An organization shall not apply for the withdrawal more than once in each calendar year.

Sec. 11. Minnesota Statutes 1986, section 62D.041, is amended by adding a subdivision to read:

Subd. 6b. **EVIDENCE OF DEPOSIT.** An organization shall provide the commissioner with evidence of every deposit made on or before the date of the deposit.

Sec. 12. Minnesota Statutes 1986, section 62D.041, subdivision 7, is amended to read:

Subd. 7. **CONTROL OF OVER DEPOSITS.** All income from deposits shall belong to the depositing organizations and shall be paid to it as it becomes available. ~~A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, freely alienable securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being substituted.~~

Sec. 13. Minnesota Statutes 1986, section 62D.041, is amended by adding a subdivision to read:

Subd. 9. **LETTER OF CREDIT.** A health maintenance organization may satisfy one-half of its deposit requirement through use of a letter of credit issued by a bank authorized to do business in this state, provided that:

(1) nothing more than a demand for payment is necessary for payment;

(2) the letter of credit is irrevocable;

(3) according to its terms, the letter of credit cannot expire without due notice from the issuer and the notice must occur at least 60 days before the expiration date and be in the form of a written notice to the commissioner;

(4) the letter of credit is issued or confirmed by a bank which is a member of the federal reserve system;

(5) the letter of credit is unconditional, is not contingent upon reimbursement to the bank or the bank's ability to perfect any lien or security interest, and does not contain references to any other agreements, documents, or entities;

(6) the letter of credit designates the commissioner as beneficiary; and

(7) the letter of credit may be drawn upon after insolvency of the health maintenance organization.

Sec. 14. **[62D.042] NET WORTH AND WORKING CAPITAL REQUIREMENTS.**

Subdivision 1. **DEFINITIONS.** (a) For purposes of this section, "guaranteeing organization" means an organization that has agreed to make necessary contributions or advancements to the health maintenance organization to maintain the health maintenance organization's statutorily required net worth.

(b) For this section, "working capital" means current assets minus current liabilities.

Subd. 2. **BEGINNING ORGANIZATIONS.** (a) Beginning organizations shall maintain net worth of at least 8-1/3 percent of the sum of all expenses expected to be incurred in the 12 months following the date the certificate of authority is granted, or $1,500,000, whichever is greater.

(b) After the first full calendar year of operation, organizations shall maintain net worth of at least 8-1/3 percent of the sum of all expenses incurred during the most recent calendar year, or $1,000,000, whichever is greater.

Subd. 3. **PHASE-IN FOR EXISTING ORGANIZATIONS.** (a) Organizations that obtained a certificate of authority on or before the effective date of this subdivision have until December 31, 1993, to establish a net worth of at least 8-1/3 percent of the sum of all expenses incurred during the previous calendar year, or $1,000,000, whichever is greater.

(b) By December 31, 1989, organizations shall have a net worth of at least one-fifth of 8-1/3 percent of the sum of all expenses incurred during the previous calendar year, or $1,000,000, whichever is greater.

(c) By December 31, 1990, organizations shall have a net worth of at least

two-fifths of 8-1/3 percent of the sum of all expenses incurred during the previous calendar year, or $1,000,000, whichever is greater.

(d) By December 31, 1991, organizations shall have a net worth of at least three-fifths of 8-1/3 percent of the sum of all expenses incurred during the previous calendar year, or $1,000,000, whichever is greater.

(e) By December 31, 1992, organizations shall have a net worth of at least four-fifths of 8-1/3 percent of the sum of all expenses incurred during the previous calendar year, or $1,000,000, whichever is greater.

Subd. 4. **REDUCTION FOR REINSURANCE.** In calculating expenses for purposes of the net worth requirement, a health maintenance organization may subtract 90 percent of the cost of premiums it pays for insurance coverage specified in section 62D.04, subdivision 1, clause (f).

Subd. 5. **GUARANTEEING ORGANIZATION.** (a) The commissioner may determine that it is in the best interests of an organization's enrollees and the public to allow an organization's net worth requirement to be satisfied by a guaranteeing organization. The commissioner shall consider the net worth of a guaranteeing organization, the number of organizations it guarantees, whether it is a governmental entity with power to tax, and other factors the commissioner considers relevant. If the commissioner allows a guaranteeing organization to satisfy the net worth requirement of more than one health maintenance organization, the guaranteeing organization must maintain the required net worth of the guaranteed health maintenance organizations on an aggregate basis.

(b) A health maintenance organization that requests the commissioner to allow a guaranteeing organization to satisfy its net worth or deposit requirement shall provide the commissioner with the guaranteeing organization's financial records and other relevant information when the request is made and annually by April 1, and must continue to do so upon request by the commissioner.

(c) No provider may be compelled to serve as a guaranteeing organization.

Subd. 6. **WORKING CAPITAL.** A health maintenance organization must maintain a positive working capital.

Subd. 7. **PLANS OF CORRECTION.** If the working capital or net worth is less than the required minimum, operations must be adjusted to correct the net worth or working capital, according to a written plan proposed by the organization and approved by the commissioner. The commissioner may take action against the organization under chapter 60B or under the suspension and penalty provisions of sections 62D.15, 62D.16, and 62D.17 if:

(1) an organization does not propose a plan to correct its working capital or net worth within a reasonable time;

(2) an organization violates a plan that has been approved;

(3) the commissioner determines that an improper working capital or net worth status cannot be corrected within a reasonable time; or

(4) the commissioner determines that the organization is in such financial condition that the transaction of further business would be hazardous to its enrollees, its creditors, or the public.

Sec. 15. **[62D.044] ADMITTED ASSETS.**

"Admitted assets" includes only the investments allowed by section 16 and the following:

(1) petty cash and other cash funds in the organization's principal or official branch office that are under the organization's control;

(2) immediately withdrawable funds on deposit in demand accounts, in a bank or trust company organized and regularly examined under the laws of the United States or any state, and insured by an agency of the United States government, or like funds actually in the principal or official branch office at statement date, and, in transit to a bank or trust company with authentic deposit credit given before the close of business on the fifth bank working day following the statement date;

(3) the amount fairly estimated as recoverable on cash deposited in a closed bank or trust company, if the assets qualified under this section before the suspension of the bank or trust company;

(4) bills and accounts receivable that are collateralized by securities in which the organization is authorized to invest;

(5) premiums due from groups or individuals that are not more than 90 days past due;

(6) amounts due under reinsurance arrangements from insurance companies authorized to do business in this state;

(7) tax refunds due from the United States or this state;

(8) interest accrued on mortgage loans not exceeding in aggregate one year's total due and accrued interest on an individual loan;

(9) the rents due to the organization on real and personal property, directly or beneficially owned, not exceeding the amount of one year's total due and accrued rent on each individual property;

(10) interest or rents accrued on conditional sales agreements, security interests, chattel mortgages, and real or personal property under lease to other corporations that do not exceed the amount of one year's total due and accrued interest or rent on an individual investment;

(11) the fixed required interest due and accrued on bonds and other evidences of indebtedness that are not in default;

(12) dividends receivable on shares of stock, provided that the market price for valuation purposes does not include the value of the dividend;

(13) the interest on dividends due and payable, but not credited, on deposits in banks and trust companies or on accounts with savings and loan associations;

(14) interest accrued on secured loans that do not exceed the amount of one year's interest on any loan;

(15) interest accrued on tax anticipation warrants;

(16) the amortized value of electronic computer or data processing machines or systems purchased for use in the business of the organization, including software purchased and developed specifically for the organization's use;

(17) the cost of furniture, equipment, and medical equipment, less accumulated depreciation thereon, and medical and pharmaceutical supplies that are used to deliver health care and are under the organization's control, provided the assets do not exceed 30 percent of admitted assets;

(18) amounts currently due from an affiliate that has liquid assets with which to pay the balance and maintain its accounts on a current basis. Any amount outstanding more than three months is not current;

(19) amounts on deposit under section 62D.041; and

(20) accounts receivable from participating health care providers that are not more than 60 days past due.

Sec. 16. **[62D.045] INVESTMENT RESTRICTIONS.**

Subdivision 1. **RESTRICTIONS.** Funds of a health maintenance organization shall be invested only in securities and property designated by law for investment by domestic life insurance companies, except that money may be used to purchase real estate, including leasehold estates and leasehold improvements, for the convenient accommodation of the organization's business operations, including the home office, branch offices, medical facilities, and field office operations, on the following conditions:

(1) a parcel of real estate acquired under this subdivision may include excess space for rent to others if it is reasonably anticipated that the excess will be required by the organization for expansion or if the excess is reasonably required in order to have one or more buildings that will function as an economic unit;

(2) the real estate may be subject to a mortgage; and

(3) the purchase price of the asset, including capitalized permanent improvements, less depreciation spread evenly over the life of the property or less depreciation computed on any basis permitted under the Internal Revenue Code and its regulations, or the organization's equity, plus all encumbrances on the real estate owned by a company under this subdivision, whichever is greater, does not exceed 20 percent of its admitted assets, except if permitted by the commissioner upon a finding that the percentage of the health maintenance

organization's admitted assets is insufficient to provide convenient accommodation for the organization's business. However, a health maintenance organization that directly provides medical services may invest an additional 20 percent of its admitted assets in real estate, not requiring the permission of the commissioner.

Subd. 2. **AUTHORIZATION REQUIRED.** A health maintenance organization shall not make or engage in a loan or investment unless the loan or investment has been authorized or ratified by the board of directors or by a committee supervising investments and loans.

Subd. 3. **LIMITS ON COMMISSIONS.** A health maintenance organization shall not pay a commission or brokerage for the purchase or sale of real or personal property that exceeds usual and customary commissions or brokerage at the time and place of the purchases or sales. Information regarding payments of commissions and brokerage must be maintained by the health maintenance organization.

Subd. 4. **OFFICER'S CONFLICT OF INTEREST.** A health maintenance organization shall not knowingly, directly or indirectly, invest in or loan upon any real or personal property, in which any principal officer or director of the organization has a financial interest. An organization shall not make a loan to a principal officer or director of the organization.

Subd. 5. **EXEMPTION.** This section shall not apply to a health maintenance organization which has a city or county as a guaranteeing organization.

Sec. 17. Minnesota Statutes 1986, section 62D.05, subdivision 3, is amended to read:

Subd. 3. A health maintenance organization may contract with providers of health care services to render the services the health maintenance organization has promised to provide under the terms of its health maintenance contracts, may, subject to section 62D.12, subdivision 11, enter into separate prepaid dental contracts, or other separate health service contracts, may, subject to the limitations of section 62D.04, subdivision 1, clause (f), contract with insurance companies and nonprofit health service plan corporations for insurance, indemnity or reimbursement of its cost of providing health care services for enrollees or against the risks incurred by the health maintenance organization, may contract with insurance companies and nonprofit health service plan corporations for insolvency insurance coverage, and may contract with insurance companies and nonprofit health service plan corporations to insure or cover the enrollees' costs and expenses in the health maintenance organization, including the customary prepayment amount and any copayment obligations.

Sec. 18. Minnesota Statutes 1986, section 62D.08, is amended by adding a subdivision to read:

Subd. 6. A health maintenance organization shall submit to the commissioner unaudited financial statements of the organization on a quarterly basis on

forms prescribed by the commissioner. The statements are due 30 days after the end of each quarter and shall be maintained as nonpublic data, as defined by section 13.02, subdivision 9.

Sec. 19. Minnesota Statutes 1986, section 62D.12, subdivision 5, is amended to read:

Subd. 5. The providers under agreement with a health maintenance organization to provide health care services ~~and the health maintenance organization~~ shall not have recourse against enrollees or persons acting on their behalf for amounts above those specified in the evidence of coverage as copayments for health care services. The health maintenance organization shall not have recourse against enrollees or persons acting on their behalf for amounts above those specified in the evidence of coverage as the periodic prepayment, or copayment, for health care services. This subdivision applies but is not limited to the following events:

(1) nonpayment by the health maintenance organization;

(2) insolvency of the health maintenance organization; and

(3) breach of the agreement between the health maintenance organization and the provider.

This subdivision does not limit a provider's ability to seek payment from any person other than the enrollee, the enrollee's guardian or conservator, the enrollee's immediate family members, or the enrollee's legal representative in the event of nonpayment by the health maintenance organization.

Sec. 20. Minnesota Statutes 1986, section 62D.12, is amended by adding a subdivision to read:

Subd. 9b. A health maintenance organization shall not enter into an agreement with a hospital in which the hospital agrees to assume the financial risk for services provided by other facilities or providers not owned, operated, or otherwise subject to the control of the hospital assuming the financial risk.

Sec. 21. **[62D.123] PROVIDER CONTRACTS.**

Subdivision 1. **PROVIDER AGREEMENT.** Except for an employment agreement between a provider and health maintenance organization, an agreement to provide health care services between a provider and a health maintenance organization entered into or renewed after the effective date of this section must contain the following provision:

PROVIDER AGREES NOT TO BILL, CHARGE, COLLECT A DEPOSIT FROM, SEEK REMUNERATION FROM, OR HAVE ANY RECOURSE AGAINST AN ENROLLEE OR PERSONS ACTING ON THEIR BEHALF FOR SERVICES PROVIDED UNDER THIS AGREEMENT. THIS PROVISION APPLIES TO BUT IS NOT LIMITED TO THE FOLLOWING EVENTS: (1) NONPAYMENT BY THE HEALTH MAINTENANCE ORGANIZATION OR (2) BREACH OF THIS AGREEMENT. THIS PROVISION DOES NOT

PROHIBIT THE PROVIDER FROM COLLECTING COPAYMENTS OR FEES FOR UNCOVERED SERVICES.

THIS PROVISION SURVIVES THE TERMINATION OF THIS AGREEMENT FOR AUTHORIZED SERVICES PROVIDED BEFORE THIS AGREEMENT TERMINATES, REGARDLESS OF THE REASON FOR TERMINATION. THIS PROVISION IS FOR THE BENEFIT OF THE HEALTH MAINTENANCE ORGANIZATION ENROLLEES. THIS PROVISION DOES NOT APPLY TO SERVICES PROVIDED AFTER THIS AGREEMENT TERMINATES.

THIS PROVISION SUPERSEDES ANY CONTRARY ORAL OR WRITTEN AGREEMENT EXISTING NOW OR ENTERED INTO IN THE FUTURE BETWEEN THE PROVIDER AND THE ENROLLEE OR PERSONS ACTING ON THEIR BEHALF REGARDING LIABILITY FOR PAYMENT FOR SERVICES PROVIDED UNDER THIS AGREEMENT.

Subd. 2. **COOPERATION REQUIRED.** An agreement to provide health care services between a provider and a health maintenance organization must require the provider to cooperate with and participate in the health maintenance organization's quality assurance program, dispute resolution procedure, and utilization review program.

Subd. 3. **NOTICE OF TERMINATION.** An agreement to provide health care services between a provider and a health maintenance organization must require that if the provider terminates the agreement, without cause, the provider shall give the organization 120 days' advance notice of termination.

Subd. 4. **LATE PAYMENTS.** If a health maintenance organization's payments to a provider are delayed beyond the payment date in the contract, the provider may notify the commissioner who shall consider that information in assessing the financial solvency of the health maintenance organization.

Sec. 22. Minnesota Statutes 1986, section 62D.14, subdivision 1, is amended to read:

Subdivision 1. The commissioner of health may make an examination of the affairs of any health maintenance organization and its contracts, agreements, or other arrangements with any participating entity as often as the commissioner of health deems necessary for the protection of the interests of the people of this state, but not less frequently than once every three years~~, provided that~~. Examinations of participating entities pursuant to this subdivision shall be limited to their dealings with the health maintenance organization and its enrollees, except that examinations of major participating entities may include inspection of the entity's financial statements kept in the ordinary course of business. The commissioner may require major participating entities to submit the financial statements directly to the commissioner. Financial statements of major participating entities are subject to the provisions of section 13.37, subdivision 1, clause (b), upon request of the major participating entity or the health maintenance organization with which it contracts.

Sec. 23. Minnesota Statutes 1986, section 62D.18, is amended to read:

62D.18 **REHABILITATION, OR LIQUIDATION, ~~OR CONSERVATION~~ OF HEALTH MAINTENANCE ORGANIZATION.**

Subdivision 1. **COMMISSIONER OF HEALTH; ORDER.** The commissioner of ~~commerce~~ health may independently, ~~or shall at the request of the commissioner of health,~~ order the rehabilitation, or liquidation ~~or conservation~~ of health maintenance organizations. The rehabilitation, or liquidation ~~or conservation~~ of a health maintenance organization shall be ~~deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be~~ conducted under the supervision of the commissioner ~~of commerce and pursuant to~~ under the procedures in chapter 60B, except to the extent that the nature of health maintenance organizations ~~render such law~~ renders the procedures clearly inappropriate and as provided in subdivisions 2 to 7.

Subd. 2. **INSOLVENCY; GROUNDS FOR REHABILITATION; LIQUIDATION.** Insolvency, as grounds for rehabilitation or liquidation of a health maintenance organization, exists when a health maintenance organization cannot be expected to satisfy its financial obligations when the obligations become due or when the health maintenance organization has failed to correct within the time required by the commissioner deficiencies due to net worth or working capital below the required amount.

Subd. 3. **PRIORITY OF CLAIMS.** To determine the priority of distribution of general assets, claims of enrollees have the same priority as claimants under policies or contracts of coverage for losses established under section 60B.44, subdivision 4. If an enrollee is liable to any provider for covered services provided under the health plan, that liability has the status of an enrollee claim for distribution of general assets, whether the enrollee or the provider files the claim. Claims of providers under agreement with the health maintenance organization for services rendered have priority after enrollee claims under section 60B.44, subdivision 4.

Subd. 4. **POWERS OF REHABILITATOR.** The powers of the rehabilitator include, subject to the approval of the court the power to change premium rates, without the notice requirements of section 62D.07, and the power to amend the terms of provider contracts, and of contracts with participating entities for the provision of administrative, financial, or management services, relating to reimbursement and termination, considering the interests of providers and other contracting participating entities and the continued viability of the health plan.

If the court approves a contract amendment that diminishes the compensation of a provider or of a participating entity providing administrative, financial, or management services to the health maintenance organization, the amendment may not be effective for more than 60 days and shall not be renewed or extended.

Subd. 5. **POWERS OF LIQUIDATOR.** The power to transfer coverage obligations under section 60B.25, clause (8), includes the power to transfer coverage obligations to a solvent health maintenance organization and to assign the provider contracts of the insolvent health maintenance organization to an assuming health maintenance organization.

Subd. 6. **SPECIAL EXAMINER.** The commissioner as rehabilitator shall make every reasonable effort to employ a senior executive from a successful health maintenance organization to serve as special examiner to rehabilitate the health maintenance organization, provided that the individual does not have a conflict of interest. The special examiner shall have all the powers of the rehabilitator granted under this section and section 60B.17.

Subd. 7. **EXAMINATION ACCOUNT.** The commissioner of health shall assess against a health maintenance organization not yet in rehabilitation or liquidation a fee sufficient to cover the costs of a special examination. The fee must be deposited in an examination account. Money in the account is appropriated to the commissioner of health to pay for the examinations. If the money in the account is insufficient to pay the initial costs of examinations, the commissioner may use other money appropriated to the commissioner, provided the other appropriation is reimbursed from the examination account when it contains sufficient money. Money from the examination account must be used to pay per diem salaries and expenses of special examiners, including meals, lodging, laundry, transportation, and mileage. The salary of regular employees of the health department must not be paid out of the account.

Sec. 24. **[62D.181] INSOLVENCY; MCHA ALTERNATIVE COVERAGE.**

Subdivision 1. **DEFINITION.** "Association" means the Minnesota comprehensive health association created in section 62E.10.

Subd. 2. **ELIGIBLE INDIVIDUALS.** An individual is eligible for alternative coverage under this section if:

(1) the individual had individual health coverage through a health maintenance organization, the coverage is no longer available due to the insolvency of the health maintenance organization, and the individual has not obtained alternative coverage; or

(2) the individual had group health coverage through a health maintenance organization, the coverage is no longer available due to the insolvency of the health maintenance organization and the individual has not obtained alternative coverage.

Subd. 3. **APPLICATION AND ISSUANCE.** If a health maintenance organization will be liquidated, individuals eligible for alternative coverage under subdivision 2 may apply to the association to obtain alternative coverage. Upon receiving an application and evidence that the applicant was enrolled in the health maintenance organization at the time of an order for liquidation, the association shall issue policies to eligible individuals, without the limitation on preexisting conditions described in section 62E.14, subdivision 3.

Subd. 4. **COVERAGE.** Alternative coverage issued under this section must be at least a number two qualified plan, as described in section 62E.06, subdivision 2, or for individuals over age 65, a medicare supplement 2 plan, as described in section 62A.34.

Subd. 5. **PREMIUM.** The premium for alternative coverage issued under this section must not exceed 80 percent of the premium for the comparable coverage offered by the association.

Subd. 6. **DURATION.** The duration of alternative coverage issued under this section is:

(1) for individuals eligible under subdivision 2, clause (1), 90 days; and

(2) for individuals eligible under subdivision 2, clause (2), 90 days or the length of time remaining in the group contract with the insolvent health maintenance organization, whichever is greater.

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

Subd. 8. **CLAIMS EXPENSES EXCEEDING PREMIUMS.** Claims expenses resulting from the operation of this section which exceed premiums received shall be borne by contributing members of the association in accordance with section 62E.11, subdivision 5.

Subd. 9. **COORDINATION OF POLICIES.** If an insolvent health maintenance organization has insolvency insurance coverage at the time of an order for liquidation, the association may coordinate the benefits of the policy issued under this section with those of the insolvency insurance policy available to the enrollees. The premium level for the combined association policy and the insolvency insurance policy may not exceed those described in subdivision 5 of this section.

Sec. 25. **[62D.182] LIABILITIES.**

Every health maintenance organization shall maintain liabilities estimated in the aggregate to be sufficient to pay all reported or unreported claims incurred that are unpaid and for which the organization is liable. Liabilities are computed under rules adopted by the commissioner.

Sec. 26. Minnesota Statutes 1986, section 62D.19, is amended to read:

62D.19 **UNREASONABLE EXPENSES.**

No health maintenance organization shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or

goods provided. The commissioner of health shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of sections 62D.01 to 62D.29; in order to safeguard the underlying nonprofit status of health maintenance organizations; and to ensure that the payment of health maintenance organization money to major participating entities results in a corresponding benefit to the health maintenance organization and its enrollees, when determining whether an organization has incurred an unreasonable expense in relation to a major participating entity, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the health maintenance organization have acted with good faith and in the best interests of the health maintenance organization in entering into, and performing under, a contract under which the health maintenance organization has incurred an expense. The commissioner has standing to sue, on behalf of a health maintenance organization, officers or trustees of the health maintenance organization who have breached their fiduciary duty in entering into and performing such contracts.

Sec. 27. Minnesota Statutes 1986, section 62E.02, subdivision 13, is amended to read:

Subd. 13. "Eligible person" means an individual who is currently and has been a resident of Minnesota for the six months immediately preceding the date of receipt by the association or its writing carrier of a completed certificate of eligibility and who meets the enrollment requirements of section 62E.14.

Sec. 28. Minnesota Statutes 1987 Supplement, section 62E.10, subdivision 9, is amended to read:

Subd. 9. **EXPERIMENTAL DELIVERY METHOD.** The association may petition the commissioner of commerce for a waiver to allow the experimental use of alternative means of health care delivery. The commissioner may approve the use of the alternative means the commissioner considers appropriate. The commissioner may waive any of the requirements of this chapter and chapters 60A, 62A, and 62D in granting the waiver. The commissioner may also grant to the association any additional powers as are necessary to facilitate the specific waiver, including the power to implement a provider payment schedule.

This subdivision is effective until August 1, ~~1989~~ 1990.

The commissioner of commerce in consultation with the governor's commission on health plan regulatory reform shall study and report to the legislature by January 15, 1989, on the current means utilized to finance the annual operating deficits incurred under the association. In conducting the study, the commissioner shall analyze any negative financial impacts which the current deficits are having on the contributing members of the association and recommend alternative sources of funding or other approaches which could be utilized to finance the operating deficit. The study shall also address the current association funding inequities between employers which self-insure for employee health benefit coverage and those employers which have health coverage subject to state regulation.

Sec. 29. Minnesota Statutes 1986, section 62E.14, subdivision 1, is amended to read:

Subdivision 1. **CERTIFICATE, CONTENTS.** The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person shall enroll by submission of a certificate of eligibility to the writing carrier. The certificate shall provide the following:

(a) Name, address, age, list of residences for the immediately preceding six months and length of time at current residence of the applicant;

(b) Name, address, and age of spouse and children if any, if they are to be insured;

(c) Evidence of rejection, a requirement of restrictive riders, a rate up, or a preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least one association members within six months of the date of the certificate, or other eligibility requirements adopted by rule by the commissioner which are not inconsistent with this chapter and which evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk;

(d) Evidence that the applicant meets the eligibility requirements of section 62E.081, subdivision 1; and

(e) A designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan. Upon ceasing to be a resident of Minnesota a person is no longer eligible to purchase or renew coverage under the state plan.

Sec. 30. Laws 1988, chapter 434, section 14, is amended to read:

Sec. 14. **[62D.122] MEDIATION.**

When current parties to a health maintenance organization contract between providers of health care services and the health maintenance organization believe they will be unable to reach agreement on the terms of renewal or maintenance of the agreement, either party may request the commissioner of health to order that the dispute be submitted to mediation. The parties to the dispute shall enter mediation upon the order of the commissioner of health. Whether or not a request for mediation from one of the parties has been received, the commissioner shall order mediation if failure to reach agreement would significantly impair access to health care services on the part of current enrollees of that health maintenance organization. The commissioner shall be a participant in the mediation. In determining whether access to health care services for current enrollees will be significantly impaired, the commissioner shall consider:

(1) the number of enrollees affected,

(2) the ability of the plan to make alternate arrangements with other participating providers for the provision of health care services to the affected enrollees,

(3) the availability of nonparticipating providers who may become participating providers for those with whom the health maintenance organization is in dispute,

(4) the time remaining until termination of the provider contract, and

(5) whether failure to resolve the dispute may establish a precedent for similar disputes in other parts of the state or might impede competition among health plans.

During the period in which the dispute is in mediation, no action to terminate provider or enrollee contracts may be taken by either party. Participation in mediation shall be required of all parties for a period of not more than 30 days. Notice of termination of provider agreements, as required under section 5, shall take effect no earlier than 31 days after the first day of mediation under this section.

When mediation is ordered by the commissioner, arrangements for mediation shall be made through either the office of dispute resolution in the state planning agency, or the office of administrative hearings.

Costs of the mediation shall be borne equally by the health maintenance organization and the health care providers unless otherwise agreed to by the parties. The office of administrative hearings shall establish rates for mediation services comparable to those charged by mediators listed with the office of dispute resolution.

The mediator shall not have authority to impose a settlement or otherwise bind a participant to a nonvoluntary resolution of the dispute; however, any agreement reached as a result of the mediation shall be enforceable.

Except as otherwise provided under chapter 13 and sections 62D.03 and 62D.14, the commissioner shall make public the results of any mediation agreement.

Sec. 31. Laws 1988, chapter 434, section 21, is amended to read:

Sec. 21. Minnesota Statutes 1986, section 62E.14, is amended by adding a subdivision to read:

Subd. 6. A Minnesota resident who holds an individual health maintenance contract, individual nonprofit health service corporation contract, or an individual insurance policy previously approved by the commissioners of health or commerce, may enroll in the comprehensive health insurance plan with a waiver of the preexisting condition as described in subdivision 3, without interruption in coverage, provided (1) no replacement coverage that meets the require-

ments of section 13 was offered by the contributing member, and (2) the policy or contract has been terminated for reasons other than (a) nonpayment of premium; (b) failure to make copayments required by the health care plan; (c) moving out of the area served; or (d) a materially false statement or misrepresentation by the enrollee in the application for membership; and, provided further, that the option to enroll in the plan is exercised within 30 days of termination of the existing policy or contract.

Coverage allowed under this section is effective ~~on the date of termination,~~ when the contract or policy is terminated and the enrollee has completed the proper application and paid the required premium or fee.

Expenses incurred from the preexisting conditions of individuals enrolled in the state plan under this subdivision must be paid by the contributing member canceling coverage as set forth in section 62E.11, subdivision 10.

The application must include evidence of termination of the existing policy or certificate as required in subdivision 1.

Sec. 32. **REPEALER.**

Minnesota Statutes 1986, section 62D.041, subdivisions 5, 6, and 8, are repealed.

Sec. 33. **EFFECTIVE DATE.**

Sections 1 to 15 and 17 to 32 are effective the day following final enactment. Section 16 is effective January 1, 1990.

Approved April 24, 1988

CHAPTER 613—H.F.No. 2291

An act relating to state agencies; amending, enacting, and repealing certain laws administered by the department of administration; requiring the commissioner of administration to consider the provision of child care facilities in new state office space; requiring state agencies to adopt policies regulating smoking in space under their control; increasing the powers of the state board for community colleges; changing the criteria for board membership; amending Minnesota Statutes 1986, sections 15.0591, subdivision 2; 16A.41, subdivision 1; 16B.07, subdivisions 2 and 3; 16B.08, subdivision 4; 16B.09, subdivision 3; 16B.24, by adding subdivisions; 16B.28; 16B.42, subdivision 1; 16B.48, subdivision 2; 16B.55, subdivisions 3 and 6; 16B.65, subdivision 3; 16B.85; 94.12; 136.61, subdivision 1; 136.622; 136.67, subdivision 2; 214.07, subdivision 1; and 382.153; Minnesota Statutes 1987 Supplement, sections 16B.09, subdivision 1; 16B.67; 115A.15, subdivision 6; and 168.012, subdivision 1; Laws 1987, chapter 365, section 24; proposing coding for new law in Minnesota Statutes, chapters 16B; and 136.

New language is indicated by underline, deletions by ~~strikeout~~.