CHAPTER 538—S.F.No. 1940

An act relating to health; establishing requirements for rehabilitating or liquidating a health maintenance organization; specifying requirements for a health maintenance organization application for a certificate; establishing protections against conflicts of interest; establishing requirements for a guaranteeing organization; including certain investments as admitted assets; requiring an expedited resolution of disputes about coverage of immediately and urgently needed service; allowing replacement coverage by other health maintenance organizations; allowing appointment of a special examiner; amending Minnesota Statutes 1988, sections 60B.03, subdivision 2; 60B.15; 60B.17, subdivision 2, and by adding a subdivision; 60B.20; 60B.25; 61A.284, by adding a subdivision; 62D.02, subdivisions 3 and 15; 62D.03, subdivision 4; 62D.04, subdivision 1; 62D.041, subdivision 2; 62D.044; 62D.08, subdivisions 1, 2, and 6; 62D.11, subdivisions 1a, 4, and by adding a subdivision; 62D.121, by adding a subdivision; 62D.17, subdivisions 1 and 4; 62D.18, subdivision 1; 62D.211; Minnesota Statutes 1989 Supplement, section 62D.121, subdivision 3; Laws 1988, chapter 434, section 24; proposing coding for new law in Minnesota Statutes, chapters 60B; and 62D; repealing Minnesota Statutes 1988, sections 62D.02, subdivision 2; 62D.12, subdivision 16; 62D.18, subdivisions 2, 3, and 5.

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

Section 1. Minnesota Statutes 1988, section 60B.03, subdivision 2, is amended to read:

Subd. 2. **COMMISSIONER.** "Commissioner" means the commissioner of commerce of the state of Minnesota and, in ~~the~~ that commissioner's absence or disability, a deputy or other person duly designated to act in ~~the~~ that commissioner's place. In the context of rehabilitation or liquidation of a health maintenance organization, "commissioner" means the commissioner of health of the state of Minnesota and, in that commissioner's absence or disability, a deputy or other person duly designated to act in that commissioner's place.

Sec. 2. Minnesota Statutes 1988, section 60B.15, is amended to read:

60B.15 **GROUNDS FOR REHABILITATION.**

The commissioner may apply by verified petition to the district court for Ramsey county or for the county in which the principal office of the insurer is located for an order directing the commissioner to rehabilitate a domestic insurer or an alien insurer domiciled in this state on any one or more of the following grounds:

(1) Any ground on which the commissioner may apply for an order of liquidation under section 60B.20, whenever the commissioner believes that the insurer may be successfully rehabilitated without substantial increase in the risk of loss to creditors of the insurer, its policyholders or to the public;

(2) That the commissioner has reasonable cause to believe that there has

been theft from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer or other illegal conduct in, by or with respect to the insurer, which endanger assets in an amount threatening insolvency of the insurer;

(3) That substantial and unexplained discrepancies exist between the insurer's records and the most recent annual report or other official company reports;

(4) That the insurer, after written demand by the commissioner, has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found by the commissioner after notice and hearing to be dishonest or untrustworthy in a way affecting the insurer's business such as is the basis for action under section 60A.051;

(5) That control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in one or more persons found by the commissioner after notice and hearing to be dishonest or untrustworthy such as is the basis for action under section 60A.051;

(6) That the insurer, after written demand by the commissioner, has failed within a reasonable period of time to terminate the employment and status and all influences on management of any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee or other person if the person has refused to submit to lawful examination under oath by the commissioner concerning the affairs of the insurer, whether in this state or elsewhere;

(7) That after lawful written demand by the commissioner the insurer has failed to submit promptly any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer, to reasonable inspection or examination by the commissioner or an authorized representative. If the insurer is unable to submit the property, books, accounts, documents, or other records of a person having executive authority in the insurer, it shall be excused from doing so if it promptly and effectively terminates the relationship of the person to the insurer;

(8) That without first obtaining the written consent of the commissioner, or if required by law, the written consent of the attorney general, the insurer has transferred, or attempted to transfer, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business of any other person;

(9) That the insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized

under sections 60B.01 to 60B.61, and that such appointment has been made or is imminent, and that such appointment might divest the courts of this state of jurisdiction or prejudice orderly delinquency proceedings under sections 60B.01 to 60B.61;

(10) That within the previous year the insurer has willfully violated its charter or articles of incorporation or its bylaws or any applicable insurance law or regulation of any state, or of the federal government, or any valid order of the commissioner under section 60B.11 in any manner or as to any matter which threatens substantial injury to the insurer, its creditors, it policyholders or the public, or having become aware within the previous year of an unintentional or willful violation has failed to take all reasonable steps to remedy the situation resulting from the violation and to prevent the same violations in the future;

(11) That the directors of the insurer are deadlocked in the management of the insurer's affairs and that the members or shareholders are unable to break the deadlock and that irreparable injury to the insurer, its creditors, its policyholders, or the public is threatened by reason thereof;

(12) That the insurer has failed to pay for 60 days after due date any obligation to this state or any political subdivision thereof or any judgment entered in this state, except that such nonpayment shall not be a ground until 60 days after any good faith effort by the insurer to contest the obligation or judgment has been terminated, whether it is before the commissioner or in the courts;

(13) That the insurer has failed to file its annual report or other report within the time allowed by law, and after written demand by the commissioner has failed to give an adequate explanation immediately;

(14) That two-thirds of the board of directors, or the holders of a majority of the shares entitled to vote, or a majority of members or policyholders of an insurer subject to control by its members or policyholders, consent to rehabilitation under sections 60B.01 to 60B.61;

(15) That the insurer is engaging in a systematic practice of reaching settlements with and obtaining releases from policyholders or third party claimants and then unreasonably delaying payment of or failing to pay the agreed upon settlements;

(16) That the insurer is in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public;

(17) That within the previous 12 months the insurer has systematically attempted to compromise with its creditors on the ground that it is financially unable to pay its claims in full~~.~~;

(18) In the context of a health maintenance organization, "insurer" when used in clauses (1) to (17) means "health maintenance organization." In addition to the grounds in clauses (1) to (17), any one of the following constitutes grounds for rehabilitation of a health maintenance organization:

(a) the health maintenance organization is unable or is expected to be unable to meet its debts as they become due;

(b) grounds exist under section 62D.042, subdivision 7;

(c) the health maintenance organization's liabilities exceed the current value of its assets, exclusive of intangibles and, where the guaranteeing organization's financial condition no longer meets the requirements of sections 62D.041 and 62D.042, exclusive of any deposits, letters of credit, or guarantees provided by any guaranteeing organization under chapter 62D;

(d) in addition to grounds under clause (16), within the last year the health maintenance organization has failed, and the commissioner of health expects such failure to continue in the future, to make comprehensive medical care adequately available and accessible to its enrollees and the health maintenance organization has not successfully implemented a plan of corrective action pursuant to section 62D.121, subdivision 7; and

(e) in addition to grounds under clause (16), within the last year the directors or officers of the health maintenance organization willfully violated the requirements of section 317A.251, or having become aware within the previous year of an unintentional or willful violation of section 317A.251, have failed to take all reasonable steps to remedy the situation resulting from the violation and to prevent the same violation in the future.

Sec. 3. Minnesota Statutes 1988, section 60B.17, subdivision 2, is amended to read:

Subd. 2. **GENERAL POWER.** Subject to court approval, the rehabilitator may take such action as that person deems necessary or expedient to reform and revitalize the insurer. The rehabilitator shall have all the powers of the officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator and shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

The power of the rehabilitator of a health maintenance organization includes the power to transfer coverage obligations to a solvent and voluntary health maintenance organization, insurer, or nonprofit health service plan, and to assign provider contracts of the insolvent health maintenance organization to an assuming health maintenance organization, insurer, or nonprofit health service plan permitted to enter into such agreements. The rehabilitator shall not be required to meet the notice requirements of section 62D.121. Transferees of coverage obligations or provider contracts shall have no liability to creditors or obligees of the health maintenance organization except those liabilities expressly assumed.

Sec. 4. Minnesota Statutes 1988, section 60B.17, is amended by adding a subdivision to read:

Subd. 8. **PLAN OF REHABILITATION FOR A HEALTH MAINTENANCE ORGANIZATION.** (a) The rehabilitator of a health maintenance organization, after consultation with the board of directors of the health maintenance organization, has the sole authority to propose a plan of rehabilitation.

(b) The court shall approve a plan of rehabilitation of a health maintenance organization if it meets the following criteria:

(1) the plan provides for payments to lien claimants equal to the value of each lien claim on the date of approval of the plan and may provide for payment of lien claims beyond the effective date of the plan and beyond the original repayment period for the obligation underlying the claim where the plan provides sufficient protection for the lien claim during the period for such claim under the rehabilitation plan;

(2) the plan provides for payment in full of each prior class of claims before payment of the next class;

(3) the plan provides for payment in full of all claims for taxes of the United States Government, except for claims for interest accruing during the rehabilitation or claims for penalties. The plan may provide for payment of the claims over any period of time up to ten years after the effective date of the plan; and

(4) the plan is fair and equitable as to each class of claims for which the plan does not provide full payment. In determining whether the plan is fair and equitable to these claimants, the court shall consider the feasibility of the plan, the health maintenance organization's ability to generate a significant surplus, the health maintenance organization's need to expend money to change or expand its business, and the injury to enrollees through loss of coverage, if such a plan is not approved.

(c) The plan may provide for transfer of the health maintenance contracts and liquidation of the health maintenance organization.

(d) The court's approval of a plan of rehabilitation discharges the health maintenance organization from all claims except to the extent provided in the plan.

Sec. 5. **[60B.171] USE, SALE, OR TRANSFER OF ASSETS DURING REHABILITATION.**

Subdivision 1. **REHABILITATOR AUTHORITY TO USE, SELL, TRANSFER ASSETS.** In addition to the powers of the rehabilitator provided in this chapter, during rehabilitation of a health maintenance organization, the rehabilitator may use, sell, or transfer assets as provided in this section.

Subd. 2. **ORDINARY COURSE OF BUSINESS.** (a) The rehabilitator may use, sell, or transfer assets in which a person has a lien, which are not cash or cash equivalents, in the ordinary course of business without approval of the court, except that the rehabilitator must provide sufficient protection for that lien unless the lienholder consents.

(b) The rehabilitator may use, sell, or transfer cash or cash equivalents in which any person has a lien in the ordinary course of business only if:

(1) each person who has a lien in the assets consents; or

(2) after notice and a hearing, the court finds that the rehabilitator has or will provide the person who has a lien with sufficient protection for that lien.

Subd. 3. **OUT OF THE ORDINARY COURSE OF BUSINESS.** (a) The rehabilitator may use, sell, or transfer assets in which any person has a lien out of the ordinary course of business with court approval where:

(1) the person that has a lien consents; or

(2) the rehabilitator provides sufficient protection for that lien. Sufficient protection includes, but is not limited to, equivalent substitute collateral or payments in the amount approximately equal to decrease in value or amount of collateral.

(b) Any sale or transfer shall be free and clear of all lien interests, if:

(1) all persons with liens in the assets to be sold or transferred consent to the sale or transfer;

(2) the consideration for the sale or transfer exceeds the total amount of all liens in the assets to be transferred;

(3) the rehabilitator provides sufficient protection for all lien claims in the assets; or

(4) other law permits a sale or transfer free and clear of any lien.

Sec. 6. **[60B.181] NOTICE REGARDING REHABILITATION OR LIQUIDATION PROCEEDING.**

In an insolvency proceeding against a health maintenance organization, at the time the rehabilitator or liquidator gives notice to creditors and enrollees according to section 60B.26, the rehabilitator or liquidator shall also give notice that any interested party may request in writing notice of subsequent actions or hearings in the proceeding. After the initial notice, the rehabilitator or liquidator may give notice only to those with a direct stake in any action or hearing and to those who have requested notice in writing. However, the rehabilitator or liquidator must give all claimants who timely file proofs of claims notice of any plan of rehabilitation or liquidation.

Sec. 7. **[60B.191] CLAIMS REGARDING REHABILITATION AND LIQUIDATION OF HEALTH MAINTENANCE ORGANIZATIONS.**

Subdivision 1. **PRIORITY OF CLAIMS.** The rehabilitator or liquidator of a health maintenance organization shall, in lieu of the classification otherwise provided in this chapter, classify all approved claims into the following classes:

(1) claims for ordinary and necessary expenses of operating and administering the health maintenance organization during rehabilitation or liquidation proceeding. Administrative expenses of a rehabilitation proceeding shall constitute administrative expenses of the liquidation proceeding;

(2) claims of the United States government for unpaid taxes;

(3) claims by persons employed by the health maintenance organization for services rendered within the four months before the initiation of any insolvency proceeding, up to $1,000. Employee claimants shall not be entitled to any lien claim or other claim under chapter 514;

(4) claims by all providers for health care goods and services to the extent covered under a health maintenance contract between enrollees and the health maintenance organization, and claims by enrollees for coverage under a health maintenance contract with the health maintenance organization;

(5) claims which are not secured by any perfected lien or security interest in assets of the health maintenance organization and which are not otherwise classified; or

(6) claims subordinated under this chapter, chapter 62D, or by agreement with the health maintenance organization or the commissioner of health.

Subd. 2. **CLAIMS FOR MALPRACTICE.** As to a health maintenance organization, a claim shall be classified as an unsecured claim if it is made by an enrollee, a parent or guardian of an enrollee, or a person seeking contribution based on injuries to an enrollee, for damages of any type related to death or bodily illness or injury based on improper provisions or failure to provide health care goods or services by a health maintenance organization and its employees, or a provider and its employees to an enrollee of the health maintenance organization. However, a claimant who has secured a judgment or settlement shall receive any insurance proceeds received by the health maintenance organization based on the claims or the medical care provided to the enrollee, other than reinsurance payable because the aggregate value of services to an enrollee exceeds a certain amount, less any expenses, including reasonable attorneys' fees the health maintenance organization incurred in defending the claim or prosecuting its claim against the insurer. This section does not expand the liability of health maintenance organizations on bodily injury to enrollees.

Sec. 8. **[60B.193] LIABILITY OF ENROLLEES.**

Upon any Minnesota state district court's order of rehabilitation or liquidation of a health maintenance organization under this chapter, all providers of health care goods or services to enrollees of the health maintenance organization, regardless of whether they have a written contract with the health maintenance organization, are prohibited from attempting to collect or collecting payment for authorized referrals from any enrollee of the health maintenance organization for goods or services to the extent the health maintenance organization is obligated to cover the goods and services under a health maintenance contract with the enrollee. A provider's only recourse is to file a claim against the health maintenance organization in the insolvency proceeding and to receive payment in the proceeding.

Sec. 9. Minnesota Statutes 1988, section 60B.20, is amended to read:

60B.20 **GROUNDS FOR LIQUIDATION.**

The commissioner may apply by verified petition to the district court for Ramsey county or for the county in which the principal office of the insurer is located for an order to liquidate a domestic insurer or an alien insurer domiciled in this state on any one or more of the following grounds:

(1) Any ground on which the commissioner may apply for an order of rehabilitation under section 60B.15, whenever the commissioner believes that attempts to rehabilitate the insurer would substantially increase the risk of loss to its creditors, its policyholders, or the public, or would be futile, or that rehabilitation would serve no useful purpose;

(2) That the insurer is or is about to become insolvent;

(3) That the insurer has not transacted the business for which it was organized or incorporated during the previous 12 months or has transacted only a token such business during that period, although authorized to do so throughout that period, or that more than 12 months after incorporation it has failed to become authorized to do the business for which it was organized or incorporated;

(4) That the insurer has commenced, or within the previous year has attempted to commence, voluntary dissolution or liquidation otherwise than as provided in section 60B.04, subdivision 3 in the case of a solvent insurer;

(5) That the insurer has concealed records or assets from the commissioner or improperly removed them from the jurisdiction, or the commissioner believes that the insurer is about to do so;

(6) That the insurer does not satisfy the requirements that would be applicable if it were seeking initial authorization in this state to do the business for which it was organized or incorporated, except for:

~~(a)~~ (i) Requirements that are intended to apply only at the time the initial authorization to do business is obtained, and not thereafter; and

~~(b)~~ (ii) Requirements that are expressly made inapplicable by the laws establishing the requirements;

(7) That the holders of two-thirds of the shares entitled to vote, or two-thirds of the members or policyholders entitled to vote in an insurer controlled by its members or policyholders, have consented to a petition~~.~~;

(8) In the context of a health maintenance organization, "insurer" when used in clauses (1) to (7) means "health maintenance organization." In addition to the grounds in clauses (1) to (7), any one of the following constitutes grounds for liquidation of a health maintenance organization:

(i) the health maintenance organization is unable or is expected to be unable to meet its debts as they become due;

(ii) grounds exist under section 62D.042, subdivision 7;

(iii) the health maintenance organization's liabilities exceed the current value of its assets, exclusive of intangibles and, where the guaranteeing organization's financial condition no longer meets the requirements of sections 62D.041 and 62D.042, exclusive of any deposits, letters of credit, or guarantees provided by any guaranteeing organization under chapter 62D;

(iv) within the last year the health maintenance organization has failed, and the commissioner of health expects failure to continue in the future, to make comprehensive medical care adequately available and accessible to its enrollees and the health maintenance organization has not successfully implemented a plan of corrective action pursuant to section 62D.121, subdivision 7; and

(v) within the last year the directors or officers of the health maintenance organization willfully violated the requirements of section 317A.251, or having become aware within the previous year of an unintentional or willful violation of section 317A.251, have failed to take all reasonable steps to remedy the situation resulting from the violation and to prevent the same violation in the future.

Sec. 10. Minnesota Statutes 1988, section 60B.25, is amended to read:

60B.25 **POWERS OF LIQUIDATOR.**

The liquidator shall report to the court monthly, or at other intervals specified by the court, on the progress of the liquidation in whatever detail the court orders. The liquidator shall coordinate having an interest in the liquidation and shall submit a report detailing how coordination will be achieved to the court for its approval within 30 days following appointment, or within the time which the court, in its discretion, may establish. Subject to the court's control, the liquidator may:

(1) Appoint a special deputy to act under sections 60B.01 to 60B.61 and

determine the deputy's compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the liquidator.

(2) Appoint or engage employees and agents, actuaries, accountants, appraisers, consultants, and other personnel deemed necessary to assist in the liquidation without regard to chapter 14.

(3) Fix the compensation of persons under clause (2), subject to the control of the court.

(4) Defray all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. If the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the liquidator may advance the costs so incurred out of the appropriation made to the department of commerce. Any amounts so paid shall be deemed expense of administration and shall be repaid for the credit of the department of commerce out of the first available money of the insurer.

(5) Hold hearings, subpoena witnesses and compel their attendance, administer oaths, examine any person under oath and compel any person to subscribe to testimony after it has been correctly reduced to writing, and in connection therewith require the production of any books, papers, records, or other documents which the liquidator deems relevant to the inquiry.

(6) Collect all debts and moneys due and claims belonging to the insurer, wherever located, and for this purpose institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts; do such other acts as are necessary or expedient to collect, conserve, or protect its assets or property, including sell, compound, compromise, or assign for purposes of collection, upon such terms and conditions as the liquidator deems best, any bad or doubtful debts; and pursue any creditor's remedies available to enforce claims.

(7) Conduct public and private sales of the property of the insurer in a manner prescribed by the court.

(8) Use assets of the estate to transfer coverage obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under section 60B.44.

(9) Acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable, except that no transaction involving property the market value of which exceeds $10,000 shall be concluded without express permission of the court. The liquidator may also execute, acknowledge, and deliver any deeds, assignments, releases, and

other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation. In cases where real property sold by the liquidator is located other than in the county where the liquidation is pending, the liquidator shall cause to be filed with the county recorder for the county in which the property is located a certified copy of the order of appointment.

(10) Borrow money on the security of the insurer's assets or without security and execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation.

(11) Enter into such contracts as are necessary to carry out the order to liquidate, and affirm or disavow any contracts to which the insurer is a party.

(12) Continue to prosecute and institute in the name of the insurer or in the liquidator's own name any suits and other legal proceedings, in this state or elsewhere, and abandon the prosecution of claims the liquidator deems unprofitable to pursue further. If the insurer is dissolved under section 60B.23, the liquidator may apply to any court in this state or elsewhere for leave to be substituted for the insurer as plaintiff.

(13) Prosecute any action which may exist in behalf of the creditors, members, policyholders, or shareholders of the insurer against any officer of the insurer, or any other person.

(14) Remove any records and property of the insurer to the offices of the commissioner or to such other place as is convenient for the purposes of efficient and orderly execution of the liquidation.

(15) Deposit in one or more banks in this state such sums as are required for meeting current administration expenses and dividend distributions.

(16) Deposit with the state board of investment for investment pursuant to section 11A.24, all sums not currently needed, unless the court orders otherwise.

(17) File any necessary documents for record in the office of any county recorder or record office in this state or elsewhere where property of the insurer is located.

(18) Assert all defenses available to the insurer as against third persons, including statutes of limitations, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition for liquidation has been filed shall not bind the liquidator.

(19) Exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be given by law and that is not included within sections 60B.30 and 60B.32.

(20) Intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and act as the receiver or trustee whenever the appointment is offered.

(21) Enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation, or dissolution of an insurer doing business in both states.

(22) Exercise all powers now held or hereafter conferred upon receivers by the laws of this state not inconsistent with sections 60B.01 to 60B.61.

(23) The enumeration in this section of the powers and authority of the liquidator is not a limitation, nor does it exclude the right to do such other acts not herein specifically enumerated or otherwise provided for as are necessary or expedient for the accomplishment of or in aid of the purpose of liquidation.

(24) The power of the liquidator of a health maintenance organization includes the power to transfer coverage obligations to a solvent and voluntary health maintenance organization, insurer, or nonprofit health service plan, and to assign provider contracts of the insolvent health maintenance organization to an assuming health maintenance organization, insurer, or nonprofit health service plan permitted to enter into such agreements. The liquidator is not required to meet the notice requirements of section 62D.121. Transferees of coverage obligations or provider contracts shall have no liability to creditors or obligees of the health maintenance organization except those liabilities expressly assumed.

Sec. 11. Minnesota Statutes 1988, section 61A.284, is amended by adding a subdivision to read:

Subd. 3. **INVESTMENTS IN HEALTH MAINTENANCE ORGANIZATIONS.** An investment in a health maintenance organization may be deemed by a domestic life insurance company to be an investment under this section.

Sec. 12. Minnesota Statutes 1988, section 62D.02, subdivision 3, is amended to read:

Subd. 3. "Commissioner of health" or "commissioner" means the state commissioner of health or a designee.

Sec. 13. Minnesota Statutes 1988, section 62D.02, subdivision 15, is amended to read:

Subd. 15. "Net worth" means admitted assets, as defined in section 62D.044, minus liabilities. Liabilities do not include those obligations that are subordinated in the same manner as preferred ownership claims under section 60B.44, subdivision 10. For purposes of this subdivision, preferred ownership claims under section 60B.44, subdivision 10, include promissory notes subordinated to all other liabilities of the health maintenance organization.

Sec. 14. Minnesota Statutes 1988, 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.30, 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 sections 62D.04, subdivision 1, clause (f), 62D.05, subdivision 3, and 62D.13; ~~and~~

(r) a copy of the conflict of interest policy which applies to all members of the board of directors and the principal officers of the health maintenance organization, as described in section 62D.04, subdivision 1, paragraph (g). All currently licensed health maintenance organizations shall also file a conflict of interest policy with the commissioner within 60 days after the effective date of this provision or at a later date if approved by the commissioner;

(s) a copy of the statement that describes the health maintenance organization's prior authorization administrative procedures;

(t) a copy of the agreement between the guaranteeing organization and the health maintenance organization, as described in section 62D.043, subdivision 6; and

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

Sec. 15. Minnesota Statutes 1988, 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 shall require the amounts of net worth and working capital required in section 62D.042, 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) 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

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

(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) demonstrated that it has made provisions for and adopted a conflict of interest policy applicable to all members of the board of directors and the principal officers of the health maintenance organization. The conflict of interest policy shall include the procedures described in section 317A.255, subdivisions 1 and 2. However, the commissioner is not precluded from finding that a particular transaction is an unreasonable expense as described in section 62D.19 even if the directors follow the required procedures; and

(h) otherwise met the requirements of sections 62D.01 to 62D.30.

Sec. 16. Minnesota Statutes 1988, section 62D.041, subdivision 2, is amended to read:

Subd. 2. **REQUIRED DEPOSIT.** Each health maintenance organization shall deposit with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, bankable funds in the ~~cash~~ amount required in this section. The commissioner may allow a health maintenance organization's deposit requirement to be ~~met~~ funded by a guaranteeing organization, as defined in section ~~62D.042, subdivision 1, based on the criteria set out in section 62D.042, subdivision 5~~ 62D.043.

Sec. 17. **[62D.043] GUARANTEEING ORGANIZATIONS.**

Subdivision 1. **DEFINITION.** (a) For purposes of this section, a "guaranteeing organization" means an organization that has agreed to assume the responsibility for the obligation of the health maintenance organization's net worth requirement.

Subd. 2. **RESPONSIBILITIES OF GUARANTEEING ORGANIZATION.** Upon an order of rehabilitation or liquidation, a guaranteeing organization shall transfer funds to the commissioner in the amount necessary to satisfy the net worth requirement.

Subd. 3. **REQUIREMENTS FOR GUARANTEEING ORGANIZATION.** (a) An organization's net worth requirement may be guaranteed provided that the guaranteeing organization:

(1) transfers into a restricted asset account cash or securities permitted by section 61A.28, subdivisions 2, 5, and 6, in an amount necessary to satisfy the net worth requirement. Restricted asset accounts shall be considered admitted assets for the purpose of determining whether a guaranteeing organization is maintaining sufficient net worth. Permitted securities shall not be transferred to the restricted asset account in excess of the limits applied to the health maintenance organization, unless approved by the commissioner in advance;

(2) designates the restricted asset account specifically for the purpose of funding the health maintenance organization's net worth requirement;

(3) maintains positive working capital subsequent to establishing the restricted asset account, if applicable;

(4) maintains net worth, retained earnings, or surplus in an amount in excess of the amount of the restricted asset account, if applicable, and allows the guaranteeing organization:

(i) to remain a solvent business organization, which shall be evaluated on the basis of the guaranteeing organization's continued ability to meet its maturing obligations without selling substantially all its operating assets and paying debts when due; and

(ii) to be in compliance with any state or federal statutory net worth, surplus, or reserve requirements applicable to that organization or lesser requirements agreed to by the commissioner; and

(5) fulfills requirements of clauses (1) to (4) by April 1 of each year.

(b) The commissioner may require the guaranteeing organization to complete the requirements of paragraph (a) more frequently if the amount necessary to satisfy the net worth requirement increases during the year.

Subd. 4. **EXCEPTIONS TO REQUIREMENTS.** When a guaranteeing organization is a governmental entity, subdivision 3 is not applicable. The commissioner may consider factors which provide evidence that the governmental entity is a financially reliable guaranteeing organization. Similarly, when a guaranteeing organization is a Minnesota-licensed health maintenance organization, health service plan corporation, or insurer, subdivision 3, paragraphs (1) and (2), are not applicable.

Subd. 5. **AMOUNTS NEEDED TO MEET NET WORTH REQUIREMENTS.** The amount necessary for a guaranteeing organization to satisfy the health maintenance organization's net worth requirement shall be the lesser of:

(1) an amount needed to bring the health maintenance organization's net worth to the amount required by section 62D.042; or

(2) an amount agreed to by the guaranteeing organization.

Subd. 6. **CONSOLIDATED CALCULATIONS FOR GUARANTEED HEALTH MAINTENANCE ORGANIZATIONS.** If a guaranteeing organization guarantees one or more health maintenance organizations, the guaranteeing organization may calculate the amount necessary to satisfy the health maintenance organizations' net worth requirements on a consolidated basis. Liabilities of the health maintenance organization to the guaranteeing organization must be subordinated in the same manner as preferred ownership claims under section 60B.44, subdivision 10.

Subd. 7. **AGREEMENT BETWEEN GUARANTEEING ORGANIZATION AND HEALTH MAINTENANCE ORGANIZATION.** A written agreement between the guaranteeing organization and the health maintenance organization must include the commissioner as a party and include the following provisions:

(1) any or all of the funds needed to satisfy the health maintenance organization's net worth requirement shall be transferred, unconditionally and upon demand, according to subdivision 2;

(2) the arrangement shall not terminate for any reason without the commissioner being notified of the termination at least nine months in advance. The arrangement may terminate earlier if net worth requirements will be satisfied under other arrangements, as approved by the commissioner;

(3) the guaranteeing organization shall pay or reimburse the commissioner for all costs and expenses, including reasonable attorney fees and costs, incurred by the commissioner in connection with the protection, defense, or enforcement of the guarantee;

(4) the guaranteeing organization shall waive all defenses and claims it may have or the health maintenance organization may have pertaining to the guarantee including, but not limited to, waiver, release, res judicata, statute of frauds, lack of authority, usury, illegality;

(5) the guaranteeing organization waives present demand for payment, notice of dishonor or nonpayment and protest, and the commissioner shall not be required to first resort for payment to other sources or other means before enforcing the guarantee;

(6) the guarantee may not be waived, modified, amended, terminated, released, or otherwise changed except as provided by the guarantee agreement, and as provided by applicable statutes;

(7) the guaranteeing organization waives its rights under the Federal Bankruptcy Code, United States Code, title 11, section 303, to initiate involuntary proceedings against the health maintenance organization and agrees to submit to the jurisdiction of the commissioner and Minnesota state courts in any rehabilitation or liquidation of the health maintenance organization;

(8) the guarantee shall be governed by and construed and enforced according to the laws of the state of Minnesota; and

(9) the guarantee must be approved by the commissioner.

Subd. 8. **SUBMISSION OF GUARANTEEING ORGANIZATION'S FINANCIAL STATEMENTS.** Health maintenance organizations shall submit to the commissioner the guaranteeing organization's audited financial statements annually by April 1 or at a different date if agreed to by the commissioner. The

health maintenance organization shall also provide other relevant financial information regarding a guaranteeing organization as may be requested by the commissioner.

Subd. 9. **PERFORMANCE AS GUARANTEEING ORGANIZATION VOLUNTARY.** No provider may be compelled to serve as a guaranteeing organization.

Subd. 10. **GUARANTOR STATUS IN REHABILITATION OR LIQUIDATION.** Any or all of the funds in excess of the amounts needed to satisfy the health maintenance organization's obligations as of the date of an order of liquidation or rehabilitation shall be returned to the guaranteeing organization in the same manner as preferred ownership claims under section 60B.44, subdivision 10.

Sec. 18. Minnesota Statutes 1988, section 62D.044, is amended to read:

62D.044 **ADMITTED ASSETS.**

"Admitted assets" includes ~~only the investments allowed by section 62D.045 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; and

(21) investments allowed by section 62D.045, except for investments in securities and properties described under section 61A.284.

Sec. 19. Minnesota Statutes 1988, section 62D.08, subdivision 1, is amended to read:

Subdivision 1. A health maintenance organization shall, unless otherwise provided for by rules adopted by the commissioner of health, file notice with the commissioner of health prior to any modification of the operations or docu-

ments described in the information submitted under clauses (a), (b), (e), (f), (g), (i), (j), (l), (m), (n), (o), (p), (q) ~~and~~, (r), (s), and (t) of section 62D.03, subdivision 4. If the commissioner of health does not disapprove of the filing within ~~30~~ 60 days, it shall be deemed approved and may be implemented by the health maintenance organization.

Sec. 20. Minnesota Statutes 1988, section 62D.08, subdivision 2, is amended to read:

Subd. 2. Every health maintenance organization shall annually, on or before April 1, file a verified report with the commissioner of health ~~and to the commissioner of commerce~~ covering the preceding calendar year. However, utilization data required under subdivision 3, clause (c), shall be filed on or before July 1.

Sec. 21. Minnesota Statutes 1988, section 62D.08, subdivision 6, is amended to read:

Subd. 6. A health maintenance organization shall submit to the commissioner unaudited financial statements of the organization ~~on a quarterly basis~~ for the first three quarters of the year on forms prescribed by the commissioner. The statements are due 30 days after the end of ~~each~~ the quarter and shall be maintained as nonpublic data, as defined by section 13.02, subdivision 9. Unaudited financial statements for the fourth quarter shall be submitted at the request of the commissioner.

Sec. 22. Minnesota Statutes 1988, section 62D.11, subdivision 1a, is amended to read:

Subd. 1a. Where a complaint involves a dispute about a health maintenance organization's coverage of ~~an immediately and urgently needed~~ a service, the commissioner may ~~either~~ ~~(a)~~ review the complaint and any information and testimony necessary in order to make a determination and order the appropriate remedy pursuant to sections 62D.15 to 62D.17~~, or (b) order the health maintenance organization to use an expedited system to process the complaint~~.

Sec. 23. Minnesota Statutes 1988, section 62D.11, is amended by adding a subdivision to read:

Subd. 1b. **EXPEDITED RESOLUTION OF COMPLAINTS ABOUT URGENTLY NEEDED SERVICE.** In addition to any remedy contained in subdivision 1a, when a complaint involves a dispute about a health maintenance organization's coverage of an immediately and urgently needed service, the commissioner may also order the health maintenance organization to use an expedited system to process the complaint.

Sec. 24. Minnesota Statutes 1988, section 62D.11, subdivision 4, is amended to read:

Subd. 4. **COVERAGE OF SERVICE.** A health maintenance organization may not deny or limit coverage of a service which the enrollee has already received:

~~(1)~~ solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained; ~~or~~

~~(2) from a nonparticipating provider, if (i) the service was ordered or recommended by a participating provider; (ii) the service would otherwise be covered, or was part of a discharge plan of a participating provider; and (iii) the enrollee was not given prior written notice stating that this service by a nonparticipating provider would not be covered, and listing the participating providers of this service available in the enrollee's area.~~

Sec. 25. Minnesota Statutes 1988, section 62D.121, is amended by adding a subdivision to read:

Subd. 2a. **REPLACEMENT COVERAGE.** The terminating health maintenance organization may also offer as replacement coverage health maintenance organization coverage issued by another health maintenance organization.

Sec. 26. Minnesota Statutes 1989 Supplement, section 62D.121, subdivision 3, is amended to read:

Subd. 3. If health maintenance organization replacement coverage is not ~~provided~~ offered by the health maintenance organization, as explained under ~~subdivision~~ subdivisions 2 and 2a, the replacement coverage shall provide, for enrollees covered by title XVIII of the Social Security Act, coverage at least equivalent to a basic Medicare supplement plan as defined in section 62A.316, except that the replacement coverage shall also cover the liability for any Medicare part A and part B deductible as defined under title XVIII of the Social Security Act. After satisfaction of the Medicare part B deductible, the replacement coverage shall be ~~based on 120 percent of the~~ at least 80 percent of usual and customary eligible medical expenses and supplies not covered by Medicare part B eligible expenses ~~less the Medicare part B payment amount~~. This does not include outpatient prescription drugs. The fee or premium of the replacement coverage shall not exceed the premium charged by the state comprehensive health plan as established under section 62E.08, for a qualified Medicare supplement plan. All enrollees not covered by Medicare shall be given the option of a number three qualified plan or a number two qualified plan as defined in section 62E.06, subdivisions 1 and 2, for replacement coverage. The fee or premium for a number three qualified plan shall not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number three qualified plan of insurance in force in Minnesota. The fee or premium for a number two qualified plan shall not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two qualified plan of insurance in force in Minnesota.

Subd. 3a. If the replacement coverage is health maintenance organization coverage, as explained in subdivisions 2 and 2a, the fee shall not exceed 125 percent of the cost of the average fee charged by health maintenance organizations for a similar health plan. The commissioner of health will determine the average cost of the plan on the basis of information provided annually by the health maintenance organizations concerning the rates charged by the health maintenance organizations for the plans offered. Fees or premiums charged under this section must be actuarially justified.

Sec. 27. Minnesota Statutes 1988, section 62D.17, subdivision 1, is amended to read:

Subdivision 1. The commissioner of health may, for any violation of statute or rule applicable to a health maintenance organization, or in lieu of suspension or revocation of a certificate of authority under section 62D.15, levy an administrative penalty in an amount up to ~~$10,000~~ $25,000 for each violation. In the case of contracts or agreements made pursuant to section 62D.05, subdivisions 2 to 4, each contract or agreement entered into or implemented in a manner which violates sections 62D.01 to 62D.30 shall be considered a separate violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of enrollees affected by the violation;

(2) the effect of the violation on enrollees' health and access to health services;

(3) if only one enrollee is affected, the effect of the violation on that enrollee's health;

(4) whether the violation is an isolated incident or part of a pattern of violations; and

(5) the economic benefits derived by the health maintenance organization or a participating provider by virtue of the violation.

Reasonable notice in writing to the health maintenance organization shall be given of the intent to levy the penalty and the reasons therefor, and the health maintenance organization may have 15 days within which to file a written request for an administrative hearing and review of the commissioner of health's determination. Such administrative hearing shall be subject to judicial review pursuant to chapter 14.

Sec. 28. Minnesota Statutes 1988, section 62D.17, subdivision 4, is amended to read:

Subd. 4. (a) The commissioner of health may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of sections 62D.01 to 62D.30.

(1) The cease and desist order may direct a health maintenance organization to pay for or provide a service when that service is required by statute or rule to be provided.

(2) The commissioner may issue a cease and desist order directing a health maintenance organization to pay for a service that is required by statute or rule to be provided, only if there is a demonstrable and irreparable harm to the public or an enrollee.

(3) If the cease and desist order involves a dispute over the medical necessity of a procedure based on its experimental nature, the commissioner may issue a cease and desist order only if the following conditions are met:

(i) the commissioner has consulted with appropriate and identified experts;

(ii) the commissioner has reviewed relevant scientific and medical literature; and

(iii) the commissioner has considered all other relevant factors including whether final approval of the technology or procedure has been granted by the appropriate government agency; the availability of scientific evidence concerning the effect of the technology or procedure on health outcomes; the availability of scientific evidence that the technology or procedure is as beneficial as established alternatives; and the availability of evidence of benefit or improvement without the technology or procedure.

(b) Within 20 days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of sections 62D.01 to 62D.30 have occurred. Such hearings shall be subject to judicial review as provided by chapter 14.

If the acts or practices involve violation of the reporting requirements of section 62D.08, or if the commissioner ~~of commerce~~ has ordered the rehabilitation, liquidation, or conservation of the health maintenance organization in accordance with section 62D.18, the health maintenance organization may request an expedited hearing on the matter. The hearing shall be held within 15 days of the request. Within ten days thereafter, an administrative law judge shall issue a recommendation on the matter. The commissioner shall make a final determination on the matter within ten days of receipt of the administrative law judge's recommendation.

When a request for a stay accompanies the hearing request, the matter shall be referred to the office of administrative hearings within three working days of receipt of the request. Within ten days thereafter, an administrative law judge shall issue a recommendation to grant or deny the stay. The commissioner shall grant or deny the stay within five days of receipt of the administrative law judge's recommendation.

To the extent the acts or practices alleged do not involve (1) violations of section 62D.08~~,~~; (2) violations which may result in the financial insolvency of the health maintenance organization; (3) violations which threaten the life and health of enrollees; (4) violations which affect whole classes of enrollees; or (5) violations of benefits or service requirements mandated by law; if a timely request for a hearing is made, the cease and desist order shall be stayed for a period of 90 days from the date the hearing is requested or until a final determination is made on the order, whichever is earlier. During this stay, the respondent may show cause why the order should not become effective upon the expiration of the stay. Arguments on this issue shall be made through briefs filed with the administrative law judge no later than ten days prior to the expiration of the stay.

Sec. 29. Minnesota Statutes 1988, section 62D.18, subdivision 1, is amended to read:

Subdivision 1. **COMMISSIONER OF HEALTH; ORDER.** The commissioner of health may ~~independently order the rehabilitation or liquidation of health maintenance organizations~~ apply by verified petition to the District Court of Ramsey county or the county in which the principal office of the health maintenance organization is located for an order directing the commissioner of health to rehabilitate or liquidate a health maintenance organization. The rehabilitation or liquidation of a health maintenance organization shall be conducted under the supervision of the commissioner of health under the procedures, and with the powers granted to a rehabilitator or liquidator, in chapter 60B, except to the extent that the nature of health maintenance organizations renders the procedures or powers clearly inappropriate and as provided in ~~subdivisions 2 to 7~~ this subdivision or in chapter 60B. A health maintenance organization shall be considered an insurance company for the purposes of rehabilitation or liquidation as provided in subdivisions 4, 6, and 7.

Sec. 30. Minnesota Statutes 1988, section 62D.211, is amended to read:

62D.211 **RENEWAL FEE.**

Each health maintenance organization subject to sections 62D.01 to 62D.30 shall submit to the commissioner of health each year before ~~April 1~~ June 15 a certificate of authority renewal fee in the amount of $10,000 each plus 20 cents per person enrolled in the health maintenance organization on December 31 of the preceding year. The commissioner may adjust the renewal fee in rule under the provisions of chapter 14.

Sec. 31. Laws 1988, chapter 434, section 24, is amended to read:

Sec. 24. **REPEALER.**

Laws 1984, chapter 464, sections 29 and 40, are repealed. Section 14 is repealed June 30, ~~1990~~ 1992.

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

Sec. 32. **REPEALER.**

Minnesota Statutes 1988, sections 62D.02, subdivision 2; 62D.12, subdivision 16; and 62D.18, subdivisions 2, 3, and 5, are repealed.

Presented to the governor April 24, 1990

Signed by the governor April 26, 1990, 10:43 p.m.

CHAPTER 539—S.F.No. 2282

An act relating to contracts; providing for enforcement of certain contracts; proposing coding for new law in Minnesota Statutes, chapter 325E; proposing coding for new law as Minnesota Statutes, chapter 338.

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

Section 1. **[325E.37] TERMINATION OF SALES REPRESENTATIVES.**

Subdivision 1. **DEFINITIONS.** (a) As used in this section, the following terms have the meaning given them.

(b) "Good cause" means failure by the sales representative to substantially comply with the material and reasonable requirements imposed by the manufacturer, wholesaler, assembler, or importer, including, but not limited to:

(1) the bankruptcy or insolvency of the sales representative;

(2) assignment for the benefit of creditors or similar disposition of the assets of the sales representative's business;

(3) voluntary abandonment of the business by the sales representative;

(4) conviction or a plea of guilty or no contest to a charge of violating any law relating to the sales representative's business; or

(5) any act by or conduct of the sales representative which materially impairs the good will associated with the manufacturer's, wholesaler's, assembler's, or importer's trademark, trade name, service mark, logotype, or other commercial symbol.

(c) "Sales representative" means a person, other than an employee, who contracts with a principal to solicit wholesale orders and who is compensated, in whole or in part, by commission, but does not include a person who places orders or purchases exclusively for the person's own account for resale.

(d) "Sales representative agreement" means a contract or agreement, either express or implied, whether oral or written, for a definite or indefinite period, between a sales representative and another person or persons, whereby a sales