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State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 1853

March 18, 2009
Authored by Atkins
The bill was read for the first time and referred to the Committee on Commerce and Labor

A bill for an act

relating to commerce; regulating various licenses, forms, coverages, marketing practices, and records; classifying certain data; providing for the coordination of health insurance benefits; prescribing a criminal penalty; amending Minnesota Statutes 2008, sections 13.716, by adding a subdivision; 45.011, subdivision 1; 45.0135, subdivision 7; 58.02, subdivision 17; 59B.01; 60A.08, by adding a subdivision; 60A.198, subdivisions 1, 3; 60A.205, subdivision 1; 60A.2085, subdivisions 1, 3, 7, 8; 60A.23, subdivision 8; 60A.235; 60A.32; 60K.365; 62A.011, subdivision 3; 62A.136; 62A.315; 62A.316; 62L.02, subdivision 26; 62M.05, subdivision 3a; 65A.27, subdivision 1; 67A.191, subdivision 2; 72A.139, subdivision 2; 72A.20, subdivision 15; 82.31, subdivision 4; 82B.08, by adding a subdivision; 82B.20, subdivision 2; 256B.0571, subdivision 6; proposing coding for new law in Minnesota Statutes, chapters 62A; 72A; 82B; repealing Minnesota Statutes 2008, sections 70A.07; 79.56, subdivision 4; 325E.311; 325E.312; 325E.313; 325E.314; 325E.315; 325E.316; Minnesota Rules, parts 2742.0100; 2742.0200; 2742.0300; 2742.0400; 2742.0500.

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

Section 1. Minnesota Statutes 2008, section 13.716, is amended by adding a subdivision to read:

Subd. 8. **Insurance filings data.** Insurance filings data received by the commissioner of commerce are classified under section 60A.08, subdivision 15.

Sec. 2. Minnesota Statutes 2008, section 45.011, subdivision 1, is amended to read:

Subdivision 1. **Scope.** As used in chapters 45 to 83, 155A, 332, 332A, 345, and 359, and sections 123A.21, subdivisions 7 and 23, 123A.25; 325D.30 to 325D.42~~,~~; 326B.802 to 326B.885~~, and~~; 386.61 to 386.78~~,~~; 471.617; and 471.982, unless the context indicates otherwise, the terms defined in this section have the meanings given them.

Sec. 3. Minnesota Statutes 2008, section 45.0135, subdivision 7, is amended to read:

2.1 Subd. 7. **Assessment.** Each insurer authorized to sell insurance in the state of
2.2 Minnesota, including surplus lines carriers, and having Minnesota earned premium the
2.3 previous calendar year shall remit an assessment to the commissioner for deposit in the
2.4 insurance fraud prevention account on or before June 1 of each year. The amount of the
2.5 assessment shall be based on the insurer's total assets and on the insurer's total written
2.6 Minnesota premium, for the preceding fiscal year, as reported pursuant to section 60A.13.
2.7 The assessment is calculated ~~as follows~~ to be an amount up to the following:

	Total Assets	Assessment
2.9	Less than $100,000,000	$ 200
2.10	$100,000,000 to $1,000,000,000	$ 750
2.11	Over $1,000,000,000	$ 2,000

	Minnesota Written Premium	Assessment
2.13	Less than $10,000,000	$ 200
2.14	$10,000,000 to $100,000,000	$ 750
2.15	Over $100,000,000	$ 2,000

2.16 For purposes of this subdivision, the following entities are not considered to be
2.17 insurers authorized to sell insurance in the state of Minnesota: risk retention groups; or
2.18 township mutuals organized under chapter 67A.

2.19 **EFFECTIVE DATE.** This section is effective January 1, 2010.

2.20 Sec. 4. Minnesota Statutes 2008, section 58.02, subdivision 17, is amended to read:
2.21 Subd. 17. **Person in control.** "Person in control" means any member of senior
2.22 management, including owners or officers, and other persons who possess, directly
2.23 or indirectly, the power to direct or cause the direction of the management policies of
2.24 an applicant or licensee under this chapter, regardless of whether the person has any
2.25 ownership interest in the applicant or licensee. Control is presumed to exist if a person,
2.26 directly or indirectly, owns, controls, or holds with power to vote ten percent or more of
2.27 the voting stock of an applicant or licensee or of a person who owns, controls, or holds
2.28 with power to vote ten percent or more of the voting stock of an applicant or licensee.

2.29 Sec. 5. Minnesota Statutes 2008, section 59B.01, is amended to read:

2.30 **59B.01 SCOPE AND PURPOSE.**

2.31 (a) The purpose of this chapter is to create a legal framework within which service
2.32 contracts may be sold in this state.
2.33 (b) The following are exempt from this chapter:
2.34 (1) warranties;

3.1 (2) maintenance agreements;
3.2 (3) warranties, service contracts, or maintenance agreements offered by public
3.3 utilities, as defined in section 216B.02, subdivision 4, or an entity or operating unit owned
3.4 by or under common control with a public utility;
3.5 (4) service contracts sold or offered for sale to persons other than consumers;
3.6 (5) service contracts on tangible property where the tangible property for which the
3.7 service contract is sold has a purchase price of $250 or less, exclusive of sales tax;
3.8 (6) service contracts for home security equipment installed by a licensed technology
3.9 systems contractor; and
3.10 (7) motor club membership contracts that typically provide roadside assistance
3.11 services to motorists stranded for reasons that include, but are not limited to, mechanical
3.12 breakdown or adverse road conditions.
3.13 (c) The types of agreements referred to in paragraph (b) are not subject to chapters
3.14 60A to 79A, except as otherwise specifically provided by law.
3.15 (d) Service contracts issued by motor vehicle manufacturers covering private
3.16 passenger automobiles are only subject to sections 59B.03, subdivision 5, 59B.05, and
3.17 59B.07.
3.18 (e) All warranty service contracts are deemed to be made in Minnesota for the
3.19 purpose of arbitration.

3.20 Sec. 6. Minnesota Statutes 2008, section 60A.08, is amended by adding a subdivision
3.21 to read:
3.22 Subd. 15. **Classification of insurance filings data.** (1) All forms, rates, and related
3.23 information filed with the commissioner under section 61A.02 shall, once effective, be
3.24 public data.
3.25 (2) All forms, rates, and related information filed with the commissioner under
3.26 section 62A.02 shall, once effective, be public data.
3.27 (3) All forms, rates, and related information filed with the commissioner under
3.28 section 62C.14, subdivision 10, shall, once effective, be public data.
3.29 (4) All forms, rates, and related information filed with the commissioner under
3.30 section 70A.06 shall, once effective, be public data.
3.31 (5) All forms, rates, and related information filed with the commissioner under
3.32 section 79.56 shall, once effective, be public data.

3.33 Sec. 7. Minnesota Statutes 2008, section 60A.198, subdivision 1, is amended to read:

Subdivision 1. **License required.** A person, as defined in section 60A.02, subdivision 7, shall not act in any other manner as an agent or broker in the transaction of surplus lines insurance unless licensed under sections 60A.195 to 60A.209. A surplus lines license is not required for a licensed ~~resident~~ agent who assists in the ~~procurement~~ placement of surplus lines insurance with a surplus lines licensee pursuant to sections 60A.195 to 60A.209.

Sec. 8. Minnesota Statutes 2008, section 60A.198, subdivision 3, is amended to read:

Subd. 3. **Procedure for obtaining license.** A person licensed as an agent in this state pursuant to other law may obtain a surplus lines license by doing the following:

(a) filing an application in the form and with the information the commissioner may reasonably require to determine the ability of the applicant to act in accordance with sections 60A.195 to 60A.209;

(b) maintaining an agent's license in this state;

(c) registering with the association created pursuant to section 60A.2085;

~~(c)~~ (d) agreeing to file with the commissioner of revenue all returns required by chapter 297I and paying to the commissioner of revenue all amounts required under chapter 297I; ~~and~~

(e) agreeing to file all documents required pursuant to section 60A.2086 and to pay the stamping fee assessed pursuant to section 60A.2085, subdivision 7; and

~~(d)~~ (f) paying a fee as prescribed by section 60K.55.

Sec. 9. Minnesota Statutes 2008, section 60A.205, subdivision 1, is amended to read:

Subdivision 1. **Authorization.** A surplus lines licensee may be compensated by an eligible surplus lines insurer and the licensee may compensate a licensed ~~resident~~ agent in this state for obtaining surplus lines insurance business. A licensed ~~resident~~ agent authorized by the licensee may collect a premium on behalf of the licensee, and as between the insured and the licensee, the licensee shall be considered to have received the premium if the premium payment has been made to the agent.

Sec. 10. Minnesota Statutes 2008, section 60A.2085, subdivision 1, is amended to read:

Subdivision 1. **Association created; duties.** There is hereby created a nonprofit association to be known as the Surplus Lines Association of Minnesota. The association is not a state agency for purposes of chapter 16A, 16B, 16C, or 43A. All surplus lines licensees are members of this association. Section 60A.208~~, subdivision 5,~~ does not apply to the association created pursuant to the provisions of this section. The association shall

5.1 perform its functions under the plan of operation established under subdivision 3 and must
5.2 exercise its powers through a board of directors established under subdivision 2 as set
5.3 forth in the plan of operation. The association shall be authorized and have the duty to:
5.4 (1) receive, record, and stamp all surplus lines insurance documents that surplus
5.5 lines licensees are required to file with the association;
5.6 (2) prepare and deliver monthly to the commissioners of revenue and commerce a
5.7 report regarding surplus lines business. The report must include a list of all the business
5.8 procured during the preceding month, in the form the commissioners prescribe;
5.9 (3) educate its members regarding the surplus lines law of this state including
5.10 insurance tax responsibilities and the rules and regulations of the commissioners of
5.11 revenue and commerce relative to surplus lines insurance;
5.12 (4) communicate with organizations of agents, brokers, and admitted insurers with
5.13 respect to the proper use of the surplus lines market;
5.14 (5) employ and retain persons necessary to carry out the duties of the association;
5.15 (6) borrow money necessary to effect the purposes of the association and grant a
5.16 security interest or mortgage in its assets, including the stamping fees charged pursuant to
5.17 subdivision 7 in order to secure the repayment of any such borrowed money;
5.18 (7) enter contracts necessary to effect the purposes of the association;
5.19 (8) provide other services to its members that are incidental or related to the
5.20 purposes of the association; ~~and~~
5.21 (9) form and organize itself as a nonprofit corporation under chapter 317A, with the
5.22 powers set forth in section 317A.161 that are not otherwise limited by this section or in
5.23 its articles, bylaws, or plan of operation;
5.24 (10) file such applications and take such other action as necessary to establish and
5.25 maintain the association as tax exempt pursuant to the federal income tax code;
5.26 (11) recommend to the commissioner of commerce revisions to Minnesota law
5.27 relating to the regulation of surplus lines insurance in order to improve the efficiency
5.28 and effectiveness of that regulation; and
5.29 ~~(9)~~ (12) take other actions reasonably required to implement the provisions of this
5.30 section.

5.31 Sec. 11. Minnesota Statutes 2008, section 60A.2085, subdivision 3, is amended to read:
5.32 Subd. 3. **Plan of operation.** (a) The plan of operation shall provide for the
5.33 formation, operation, and governance of the association as a nonprofit corporation
5.34 under chapter 317A. The plan of operation must provide for the election of a board of
5.35 directors by the members of the association. The board of directors shall elect officers as

6.1 provided for in the plan of operation. The plan of operation shall establish the manner of
6.2 voting and may weigh each member's vote to reflect the annual surplus lines insurance
6.3 premium written by the member. Members employed by the same or affiliated employers
6.4 may consolidate their premiums written and delegate an individual officer or partner
6.5 to represent the member in the exercise of association affairs, including service on the
6.6 board of directors.

6.7 (b) The plan of operation shall provide for an independent audit once each year of all
6.8 the books and records of the association and a report of such independent audit shall be
6.9 made to the board of directors, the commissioner of revenue, and the commissioner of
6.10 commerce, with a copy made available to each member to review at the association office.

6.11 (c) The plan of operation and any amendments to the plan of operation shall be
6.12 submitted to the commissioner and shall be effective upon approval in writing by the
6.13 commissioner. The association and all members shall comply with the plan of operation or
6.14 any amendments to it. Failure to comply with the plan of operation or any amendments
6.15 shall constitute a violation for which the commissioner may issue an order requiring
6.16 discontinuance of the violation.

6.17 (d) If the interim board of directors fails to submit a suitable plan of operation
6.18 within 60 days following the creation of the interim board, or if at any time thereafter the
6.19 association fails to submit required amendments to the plan, the commissioner may submit
6.20 to the association a plan of operation or amendments to the plan, which the association
6.21 must follow. The plan of operation or amendments submitted by the commissioner shall
6.22 continue in force until amended by the commissioner or superseded by a plan of operation
6.23 or amendment submitted by the association and approved by the commissioner. A plan
6.24 of operation or an amendment submitted by the commissioner constitutes an order of
6.25 the commissioner.

6.26 Sec. 12. Minnesota Statutes 2008, section 60A.2085, subdivision 7, is amended to read:

6.27 Subd. 7. **Stamping fee.** The services performed by the association shall be
6.28 funded by a stamping fee assessed for each premium-bearing document submitted to
6.29 the association. The stamping fee shall be established by the board of directors of the
6.30 association from time to time. The stamping fee shall be paid by the insured to the surplus
6.31 lines licensee and remitted ~~electronically~~ to the association by the surplus lines licensee in
6.32 the manner established by the association.

6.33 Sec. 13. Minnesota Statutes 2008, section 60A.2085, subdivision 8, is amended to read:

7.1 Subd. 8. **Data classification.** Unless otherwise classified by statute, a temporary
7.2 classification under section 13.06, or federal law, information obtained by the
7.3 commissioner from the association is public, except that any data identifying insureds or
7.4 the Social Security number of a licensee or any information derived therefrom is private
7.5 data on individuals or nonpublic data as defined in section 13.02, subdivisions 9 and 12.

7.6 Sec. 14. Minnesota Statutes 2008, section 60A.23, subdivision 8, is amended to read:
7.7 Subd. 8. **Self-insurance or insurance plan administrators who are vendors**
7.8 **of risk management services.** (1) **Scope.** This subdivision applies to any vendor of
7.9 risk management services and to any entity which administers, for compensation, a
7.10 self-insurance or insurance plan. This subdivision does not apply (a) to an insurance
7.11 company authorized to transact insurance in this state, as defined by section 60A.06,
7.12 subdivision 1, clauses (4) and (5); (b) to a service plan corporation, as defined by section
7.13 62C.02, subdivision 6; (c) to a health maintenance organization, as defined by section
7.14 62D.02, subdivision 4; (d) to an employer directly operating a self-insurance plan for
7.15 its employees' benefits; (e) to an entity which administers a program of health benefits
7.16 established pursuant to a collective bargaining agreement between an employer, or group
7.17 or association of employers, and a union or unions; or (f) to an entity which administers a
7.18 self-insurance or insurance plan if a licensed Minnesota insurer is providing insurance
7.19 to the plan and if the licensed insurer has appointed the entity administering the plan as
7.20 one of its licensed agents within this state.
7.21 (2) **Definitions.** For purposes of this subdivision the following terms have the
7.22 meanings given them.
7.23 (a) "Administering a self-insurance or insurance plan" means (i) processing,
7.24 reviewing or paying claims, (ii) establishing or operating funds and accounts, or (iii)
7.25 otherwise providing necessary administrative services in connection with the operation of
7.26 a self-insurance or insurance plan.
7.27 (b) "Employer" means an employer, as defined by section 62E.02, subdivision 2.
7.28 (c) "Entity" means any association, corporation, partnership, sole proprietorship,
7.29 trust, or other business entity engaged in or transacting business in this state.
7.30 (d) "Self-insurance or insurance plan" means a plan for the benefit of employees
7.31 or members of an association providing life, medical or hospital care, accident, sickness
7.32 or disability insurance ~~for the benefit of employees or members of an association~~, or
7.33 pharmacy benefits, or a plan providing liability coverage for any other risk or hazard,
7.34 which is or is not directly insured or provided by a licensed insurer, service plan
7.35 corporation, or health maintenance organization.

8.1 (e) "Vendor of risk management services" means an entity providing for
8.2 compensation actuarial, financial management, accounting, legal or other services for the
8.3 purpose of designing and establishing a self-insurance or insurance plan for an employer.
8.4 (3) **License.** No vendor of risk management services or entity administering a
8.5 self-insurance or insurance plan may transact this business in this state unless it is licensed
8.6 to do so by the commissioner. An applicant for a license shall state in writing the type of
8.7 activities it seeks authorization to engage in and the type of services it seeks authorization
8.8 to provide. The license may be granted only when the commissioner is satisfied that the
8.9 entity possesses the necessary organization, background, expertise, and financial integrity
8.10 to supply the services sought to be offered. The commissioner may issue a license subject
8.11 to restrictions or limitations upon the authorization, including the type of services which
8.12 may be supplied or the activities which may be engaged in. The license fee is $1,500
8.13 for the initial application and $1,500 for each three-year renewal. All licenses are for
8.14 a period of three years.
8.15 (4) **Regulatory restrictions; powers of the commissioner.** To assure that
8.16 self-insurance or insurance plans are financially solvent, are administered in a fair and
8.17 equitable fashion, and are processing claims and paying benefits in a prompt, fair,
8.18 and honest manner, vendors of risk management services and entities administering
8.19 insurance or self-insurance plans are subject to the supervision and examination by the
8.20 commissioner. Vendors of risk management services, entities administering insurance or
8.21 self-insurance plans, and insurance or self-insurance plans established or operated by
8.22 them are subject to the trade practice requirements of sections 72A.19 to 72A.30. In lieu
8.23 of an unlimited guarantee from a parent corporation for a vendor of risk management
8.24 services or an entity administering insurance or self-insurance plans, the commissioner
8.25 may accept a surety bond in a form satisfactory to the commissioner in an amount equal to
8.26 120 percent of the total amount of claims handled by the applicant in the prior year. If at
8.27 any time the total amount of claims handled during a year exceeds the amount upon which
8.28 the bond was calculated, the administrator shall immediately notify the commissioner.
8.29 The commissioner may require that the bond be increased accordingly.
8.30 No contract entered into after July 1, 2001, between a licensed vendor of risk
8.31 management services and a group authorized to self-insure for workers' compensation
8.32 liabilities under section 79A.03, subdivision 6, may take effect until it has been filed
8.33 with the commissioner, and either (1) the commissioner has approved it or (2) 60 days
8.34 have elapsed and the commissioner has not disapproved it as misleading or violative of
8.35 public policy.

9.1 (5) **Rulemaking authority.** To carry out the purposes of this subdivision, the
9.2 commissioner may adopt rules pursuant to sections 14.001 to 14.69. These rules may:
9.3 (a) establish reporting requirements for administrators of insurance or self-insurance
9.4 plans;
9.5 (b) establish standards and guidelines to assure the adequacy of financing, reinsuring,
9.6 and administration of insurance or self-insurance plans;
9.7 (c) establish bonding requirements or other provisions assuring the financial integrity
9.8 of entities administering insurance or self-insurance plans; or
9.9 (d) establish other reasonable requirements to further the purposes of this
9.10 subdivision.

9.11 Sec. 15. Minnesota Statutes 2008, section 60A.235, is amended to read:

9.12 **60A.235 STANDARDS FOR DETERMINING WHETHER CONTRACTS**
9.13 **ARE HEALTH PLAN CONTRACTS OR STOP LOSS CONTRACTS.**

9.14 Subdivision 1. **Findings and purpose.** The purpose of this section is to establish
9.15 a standard for the determination of whether an insurance policy or other evidence or
9.16 coverage should be treated as a policy of accident and sickness insurance or a stop loss
9.17 policy for the purpose of the regulation of the business of insurance. The laws regulating
9.18 the business of insurance in Minnesota impose distinctly different requirements upon
9.19 accident and sickness insurance policies and stop loss policies. In particular, the regulation
9.20 of accident and sickness insurance in Minnesota includes measures designed to reform the
9.21 health insurance market, to minimize or prohibit selective rating or rejection of employee
9.22 groups or individual group members based upon health conditions, and to provide access
9.23 to affordable health insurance coverage regardless of preexisting health conditions. The
9.24 health care reform provisions enacted in Minnesota will only be effective if they are
9.25 applied to all insurers and health carriers who in substance, regardless of purported form,
9.26 engage in the business of issuing health insurance coverage to employees of an employee
9.27 group. This section applies to insurance companies and health carriers and the policies or
9.28 other evidence of coverage that they issue. This section does not apply to employers or the
9.29 benefit plans they establish for their employees.

9.30 Subd. 2. **Definitions.** For purposes of this section, the terms defined in this
9.31 subdivision have the meanings given.

9.32 (a) "Attachment point" means the claims amount incurred by an insured group
9.33 beyond which the insurance company or health carrier incurs a liability for payment.

9.34 (b) "Direct coverage" means coverage under which an insurance company or health
9.35 carrier assumes a direct obligation to an individual, under the policy or evidence of

10.1 coverage, with respect to health care expenses incurred by the individual or a member
10.2 of the individual's family.
10.3 (c) "Expected claims" means the amount of claims that, in the absence of a stop loss
10.4 policy or other insurance or evidence of coverage, are projected to be incurred ~~under~~ by an
10.5 employer-sponsored plan covering health care expenses.
10.6 (d) "Expected plan claims" means the expected claims less the projected claims in
10.7 excess of the specific attachment point, adjusted to be consistent with the employer's
10.8 aggregate contract period.
10.9 (e) "Health plan" means a health plan as defined in section 62A.011 and includes
10.10 group coverage regardless of the size of the group.
10.11 (f) "Health carrier" means a health carrier as defined in section 62A.011.
10.12 Subd. 3. **Health plan policies issued as stop loss coverage.** (a) An insurance
10.13 company or health carrier issuing or renewing an insurance policy or other evidence of
10.14 coverage, that provides coverage to an employer for health care expenses incurred under
10.15 an employer-sponsored plan provided to the employer's employees, retired employees,
10.16 or their dependents, shall issue the policy or evidence of coverage as a health plan if the
10.17 policy or evidence of coverage:
10.18 (1) has a specific attachment point for claims incurred per individual that is lower
10.19 than ~~$10,000~~ $20,000; or
10.20 (2) has an aggregate attachment point, for groups of 50 or fewer, that is lower than
10.21 the ~~sum~~ greater of:
10.22 ~~(i) 140 percent of the first $50,000 of expected plan claims;~~
10.23 ~~(ii) 120 percent of the next $450,000 of expected plan claims; and~~
10.24 ~~(iii) 110 percent of the remaining expected plan claims.~~
10.25 (i) $4,000 times the number of group members;
10.26 (ii) 120 percent of expected claims; or
10.27 (iii) $20,000; or
10.28 (3) has an aggregate attachment point for groups of 51 or more that is lower than
10.29 110 percent of expected claims.
10.30 (b) An insurer shall determine the number of persons in a group, for the purposes
10.31 of this section, on a consistent basis, at least annually. Where the insurance policy or
10.32 evidence of coverage applies to a contract period of more than one year, the dollar
10.33 amounts set forth in paragraph (a), clauses (1) and (2), must be multiplied by the length
10.34 of the contract period expressed in years.
10.35 (c) The commissioner may adjust the constant dollar amounts provided in paragraph
10.36 (a), clauses (1) ~~and,~~, (2), and (3), on January 1 of any year, based upon changes in

11.1 the medical component of the Consumer Price Index (CPI). Adjustments must be in
11.2 increments of $100 and must not be made unless at least that amount of adjustment is
11.3 required. The commissioner shall publish any change in these dollar amounts at least
11.4 ~~three~~ six months before their effective date.

11.5 (d) A policy or evidence of coverage issued by an insurance company or health
11.6 carrier that provides direct coverage of health care expenses of an individual including a
11.7 policy or evidence of coverage administered on a group basis is a health plan regardless of
11.8 whether the policy or evidence of coverage is denominated as stop loss coverage.

11.9 Subd. 3a. **Actuarial certification.** An insurer shall file with the commissioner
11.10 annually on or before March 15, an actuarial certification certifying that the insurer is in
11.11 compliance with sections 60A.235 and 60A.236. The certification shall be in a form and
11.12 manner, and shall contain information, specified by the commissioner. A copy of the
11.13 certification shall be retained by the insurer at its principal place of business.

11.14 Subd. 4. **Compliance.** (a) An insurance company or health carrier that is required to
11.15 issue a policy or evidence of coverage as a health plan under this section shall, even if the
11.16 policy or evidence of coverage is denominated as stop loss coverage, comply with all the
11.17 laws of this state that apply to the health plan, including, but not limited to, chapters 62A,
11.18 62C, 62D, 62E, 62L, and 62Q.

11.19 (b) With respect to an employer who had been issued a policy or evidence of
11.20 coverage denominated as stop loss coverage before ~~June 2, 1995~~ the effective date of this
11.21 section, compliance with this section is required as of the first renewal date occurring on
11.22 or after ~~June 2, 1995~~ August 1, 2009, and applies to policies issued or renewed on or
11.23 after that date.

11.24 Subd. 5. **Stop loss insurance.** "Stop loss insurance" is subject to the filing
11.25 requirements of section 62A.02.

11.26 Sec. 16. Minnesota Statutes 2008, section 60A.32, is amended to read:

11.27 **60A.32 RATE FILING FOR CROP HAIL INSURANCE.**

11.28 Subdivision 1. **Authority.** An insurer issuing policies of insurance against crop
11.29 damage by hail in this state shall file its insurance rates with the commissioner using the
11.30 expedited filing procedure under subdivision 2. The insurance rates must be filed before
11.31 February 1 of the year in which a policy is issued.

11.32 Subd. 2. **Compliance certifications.** In addition to the proposed rates, an insurer
11.33 shall file with the Department of Commerce on a form prescribed by the commissioner a
11.34 written certification, signed by an officer of the insurer, that the rates comply with section

12.1 70A.04. Rates filed under this procedure are effective upon the date of receipt or on a
12.2 subsequent date requested by the insurer.
12.3 Subd. 3. **Fee.** In order to be effective, the filing must be accompanied by payment of
12.4 the applicable filing fee.

12.5 Sec. 17. Minnesota Statutes 2008, section 60K.365, is amended to read:

12.6 **60K.365 PRODUCER TRAINING REQUIREMENTS FOR LONG-TERM**
12.7 **CARE INSURANCE PRODUCTS.**

12.8 (a) An individual may not sell, solicit, or negotiate long-term care insurance
12.9 unless the individual is licensed as an insurance producer for accident and health or
12.10 sickness insurance or life insurance and has completed an initial training course and
12.11 ongoing training every 24 months thereafter. The training must meet the requirements of
12.12 paragraph (b).

12.13 (b) The initial training course required by this section must be no less than eight
12.14 hours, and the ongoing training courses required by this section must be no less than four
12.15 hours every 24 months. The courses must be approved by the commissioner and may be
12.16 approved as continuing education courses under section 60K.56. The courses must consist
12.17 of topics related to long-term care insurance, long-term care services, and qualified state
12.18 long-term care insurance partnership programs, including, but not limited to:

12.19 (1) state and federal regulations and requirements and the relationship between
12.20 qualified state long-term care insurance partnership programs and other public and private
12.21 coverage of long-term care services, including Medicaid/Minnesota medical assistance;

12.22 (2) available long-term care services and providers;

12.23 (3) changes or improvements in long-term care services or providers;

12.24 (4) alternatives to the purchase of private long-term care insurance;

12.25 (5) the effect of inflation on benefits and the importance of inflation protection; and

12.26 (6) consumer suitability standards and guidelines.

12.27 The training required by this section must not include training that is insurer or
12.28 company product specific or that includes any sales or marketing information, materials,
12.29 or training, other than those required by state or federal law.

12.30 (c) Insurers shall obtain verification that a producer has received the training
12.31 required by this section before a producer is permitted to sell, solicit, or negotiate the
12.32 insurer's long-term care insurance products. Insurers shall maintain records verifying that
12.33 the producer has received the training contained in this section and make that verification
12.34 available to the commissioner upon request.

13.1 (d) The satisfaction of these initial training requirements in any state shall be deemed
13.2 to satisfy the initial training requirements of this section.

13.3 ~~(e) Nonresident producers selling partnership policies shall be expected to~~
13.4 ~~demonstrate knowledge about unique aspects of the Minnesota medical assistance system.~~
13.5 ~~An insurer offering partnership products in Minnesota shall maintain records verifying that~~
13.6 ~~its nonresident producers have attained the required training and make that verification~~
13.7 ~~available to the commissioner upon request.~~

13.8 Sec. 18. Minnesota Statutes 2008, section 62A.011, subdivision 3, is amended to read:

13.9 Subd. 3. **Health plan.** "Health plan" means a policy or certificate of accident and
13.10 sickness insurance as defined in section 62A.01 offered by an insurance company licensed
13.11 under chapter 60A; a subscriber contract or certificate offered by a nonprofit health
13.12 service plan corporation operating under chapter 62C; a health maintenance contract or
13.13 certificate offered by a health maintenance organization operating under chapter 62D; a
13.14 health benefit certificate offered by a fraternal benefit society operating under chapter
13.15 64B; or health coverage offered by a joint self-insurance employee health plan operating
13.16 under chapter 62H. Health plan means individual and group coverage, unless otherwise
13.17 specified. Health plan does not include coverage that is:

13.18 (1) limited to disability or income protection coverage;

13.19 (2) automobile medical payment coverage;

13.20 (3) supplemental to liability insurance;

13.21 (4) designed solely to provide payments on a per diem, fixed indemnity, or
13.22 non-expense-incurred basis;

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

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

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

13.26 (8) accident-only coverage;

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

13.28 (10) issued as a supplement to Medicare, as defined in sections 62A.3099 to
13.29 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health
13.30 maintenance organizations or those policies, contracts, or certificates governed by section
13.31 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section
13.32 1395, et seq., as amended;

13.33 (11) workers' compensation insurance; or

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

14.4 Sec. 19. Minnesota Statutes 2008, section 62A.136, is amended to read:

14.5 **62A.136 HEARING, DENTAL, AND VISION PLAN COVERAGE.**

14.6 The following provisions do not apply to health plans as defined in section 62A.011,
14.7 subdivision 3, clause (6), providing hearing, dental, or vision coverage only: sections
14.8 62A.041; 62A.0411; 62A.047; 62A.149; 62A.151; 62A.152; 62A.154; 62A.155; 62A.17,
14.9 subdivision 6; 62A.21, subdivision 2b; 62A.26; 62A.28; 62A.285; 62A.30; 62A.304;
14.10 62A.3093; and 62E.16.

14.11 Sec. 20. Minnesota Statutes 2008, section 62A.315, is amended to read:

14.12 **62A.315 EXTENDED BASIC MEDICARE SUPPLEMENT PLAN;**
14.13 **COVERAGE.**

14.14 The extended basic Medicare supplement plan must have a level of coverage so that
14.15 it will be certified as a qualified plan pursuant to section 62E.07, and will provide:

14.16 (1) coverage for all of the Medicare Part A inpatient hospital deductible and
14.17 coinsurance amounts, and 100 percent of all Medicare Part A eligible expenses for
14.18 hospitalization not covered by Medicare;

14.19 (2) coverage for the daily co-payment amount of Medicare Part A eligible expenses
14.20 for the calendar year incurred for skilled nursing facility care;

14.21 (3) coverage for the coinsurance amount or in the case of hospital outpatient
14.22 department services paid under a prospective payment system, the co-payment amount, of
14.23 Medicare eligible expenses under Medicare Part B regardless of hospital confinement, and
14.24 the Medicare Part B deductible amount;

14.25 (4) 80 percent of the usual and customary hospital and medical expenses and
14.26 supplies described in section 62E.06, subdivision 1, not to exceed any charge limitation
14.27 established by the Medicare program or state law, the usual and customary hospital
14.28 and medical expenses and supplies, described in section 62E.06, subdivision 1, while
14.29 in a foreign country; and prescription drug expenses, not covered by Medicare. An
14.30 outpatient prescription drug benefit must not be included for sale or issuance in a Medicare
14.31 supplement policy or certificate issued on or after January 1, 2006;

14.32 (5) coverage for the reasonable cost of the first three pints of blood, or equivalent
14.33 quantities of packed red blood cells as defined under federal regulations under Medicare
14.34 Parts A and B, unless replaced in accordance with federal regulations;

15.1 (6) 100 percent of the cost of immunizations not otherwise covered under Part
15.2 D of the Medicare program and routine screening procedures for cancer, including
15.3 mammograms and pap smears;

15.4 ~~(7) preventive medical care benefit: coverage for the following preventive health~~
15.5 ~~services not covered by Medicare:~~

15.6 ~~(i) an annual clinical preventive medical history and physical examination that may~~
15.7 ~~include tests and services from clause (ii) and patient education to address preventive~~
15.8 ~~health care measures;~~

15.9 ~~(ii) preventive screening tests or preventive services, the selection and frequency of~~
15.10 ~~which is determined to be medically appropriate by the attending physician.~~

15.11 ~~Reimbursement shall be for the actual charges up to 100 percent of the~~
15.12 ~~Medicare-approved amount for each service as if Medicare were to cover the service as~~
15.13 ~~identified in American Medical Association current procedural terminology (AMA CPT)~~
15.14 ~~codes to a maximum of $120 annually under this benefit. This benefit shall not include~~
15.15 ~~payment for any procedure covered by Medicare;~~

15.16 ~~(8) at-home recovery benefit: coverage for services to provide short-term at-home~~
15.17 ~~assistance with activities of daily living for those recovering from an illness, injury, or~~
15.18 ~~surgery:~~

15.19 ~~(i) for purposes of this benefit, the following definitions shall apply:~~

15.20 ~~(A) "activities of daily living" include, but are not limited to, bathing, dressing,~~
15.21 ~~personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally~~
15.22 ~~self-administered, and changing bandages or other dressings;~~

15.23 ~~(B) "care provider" means a duly qualified or licensed home health aide/homemaker,~~
15.24 ~~personal care aide, or nurse provided through a licensed home health care agency or~~
15.25 ~~referred by a licensed referral agency or licensed nurses registry;~~

15.26 ~~(C) "home" means a place used by the insured as a place of residence, provided~~
15.27 ~~that the place would qualify as a residence for home health care services covered by~~
15.28 ~~Medicare. A hospital or skilled nursing facility shall not be considered the insured's~~
15.29 ~~place of residence;~~

15.30 ~~(D) "at-home recovery visit" means the period of a visit required to provide at-home~~
15.31 ~~recovery care, without limit on the duration of the visit, except each consecutive four~~
15.32 ~~hours in a 24-hour period of services provided by a care provider is one visit;~~

15.33 ~~(ii) coverage requirements and limitations:~~

15.34 ~~(A) at-home recovery services provided must be primarily services that assist in~~
15.35 ~~activities of daily living;~~

~~(B) the insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;~~

~~(C) coverage is limited to:~~

~~(I) no more than the number and type of at-home recovery visits certified as medically necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;~~

~~(II) the actual charges for each visit up to a maximum reimbursement of $100 per visit;~~

~~(III) $4,000 per calendar year;~~

~~(IV) seven visits in any one week;~~

~~(V) care furnished on a visiting basis in the insured's home;~~

~~(VI) services provided by a care provider as defined in this section;~~

~~(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;~~

~~(VIII) at-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit;~~

~~(iii) coverage is excluded for:~~

~~(A) home care visits paid for by Medicare or other government programs; and~~

~~(B) care provided by unpaid volunteers or providers who are not care providers.~~

(7) coverage of cost sharing for all Medicare Part A eligible hospice care and respite care expenses; and

(8) coverage for Medicare Part A or B home health care services and medical supplies.

Sec. 21. Minnesota Statutes 2008, section 62A.316, is amended to read:

62A.316 BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.

(a) The basic Medicare supplement plan must have a level of coverage that will provide:

(1) coverage for all of the Medicare Part A inpatient hospital coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare, after satisfying the Medicare Part A deductible;

(2) coverage for the daily co-payment amount of Medicare Part A eligible expenses for the calendar year incurred for skilled nursing facility care;

17.1 (3) coverage for the coinsurance amount, or in the case of outpatient department
17.2 services paid under a prospective payment system, the co-payment amount, of Medicare
17.3 eligible expenses under Medicare Part B regardless of hospital confinement, subject to
17.4 the Medicare Part B deductible amount;

17.5 (4) 80 percent of the hospital and medical expenses and supplies incurred during
17.6 travel outside the United States as a result of a medical emergency;

17.7 (5) coverage for the reasonable cost of the first three pints of blood, or equivalent
17.8 quantities of packed red blood cells as defined under federal regulations under Medicare
17.9 Parts A and B, unless replaced in accordance with federal regulations;

17.10 (6) 100 percent of the cost of immunizations not otherwise covered under Part D of
17.11 the Medicare program and routine screening procedures for cancer screening including
17.12 mammograms and pap smears; ~~and~~

17.13 (7) 80 percent of coverage for all physician prescribed medically appropriate and
17.14 necessary equipment and supplies used in the management and treatment of diabetes
17.15 not otherwise covered under Part D of the Medicare program. Coverage must include
17.16 persons with gestational, type I, or type II diabetes. Coverage under this clause is subject
17.17 to section 62A.3093, subdivision 2~~.~~;

17.18 (8) coverage of cost sharing for all Medicare Part A eligible hospice care and respite
17.19 care expenses; and

17.20 (9) coverage for Medicare Part A or B home health care services and medical
17.21 supplies subject to the Medicare Part B deductible amount.

17.22 (b) ~~Only~~ The following ~~optional~~ benefit riders ~~may be added to~~ must be offered
17.23 with this plan:

17.24 (1) coverage for all of the Medicare Part A inpatient hospital deductible amount;

17.25 (2) ~~a minimum of 80 percent of eligible medical expenses and supplies not covered~~
17.26 ~~by Medicare Part B~~ 100 percent of the Medicare Part B excess charges coverage for
17.27 all of the difference between the actual Medicare Part B charges as billed, not to
17.28 exceed any charge limitation established by the Medicare program or state law, and the
17.29 Medicare-approved Part B charge; and

17.30 (3) coverage for all of the Medicare Part B annual deductible~~;~~.

17.31 ~~(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and~~
17.32 ~~customary prescription drug expenses. An outpatient prescription drug benefit must not~~
17.33 ~~be included for sale or issuance in a Medicare policy or certificate issued on or after~~
17.34 ~~January 1, 2006;~~

17.35 ~~(5) preventive medical care benefit coverage for the following preventative health~~
17.36 ~~services not covered by Medicare:~~

18.1 ~~(i) an annual clinical preventive medical history and physical examination that may~~
18.2 ~~include tests and services from clause (ii) and patient education to address preventive~~
18.3 ~~health care measures;~~
18.4 ~~(ii) preventive screening tests or preventive services, the selection and frequency of~~
18.5 ~~which is determined to be medically appropriate by the attending physician.~~
18.6 ~~Reimbursement shall be for the actual charges up to 100 percent of the~~
18.7 ~~Medicare-approved amount for each service, as if Medicare were to cover the service as~~
18.8 ~~identified in American Medical Association current procedural terminology (AMA CPT)~~
18.9 ~~codes, to a maximum of $120 annually under this benefit. This benefit shall not include~~
18.10 ~~payment for a procedure covered by Medicare;~~
18.11 ~~(6) coverage for services to provide short-term at-home assistance with activities of~~
18.12 ~~daily living for those recovering from an illness, injury, or surgery:~~
18.13 ~~(i) For purposes of this benefit, the following definitions apply:~~
18.14 ~~(A) "activities of daily living" include, but are not limited to, bathing, dressing,~~
18.15 ~~personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally~~
18.16 ~~self-administered, and changing bandages or other dressings;~~
18.17 ~~(B) "care provider" means a duly qualified or licensed home health aide/homemaker,~~
18.18 ~~personal care aid, or nurse provided through a licensed home health care agency or~~
18.19 ~~referred by a licensed referral agency or licensed nurses registry;~~
18.20 ~~(C) "home" means a place used by the insured as a place of residence, provided~~
18.21 ~~that the place would qualify as a residence for home health care services covered by~~
18.22 ~~Medicare. A hospital or skilled nursing facility shall not be considered the insured's~~
18.23 ~~place of residence;~~
18.24 ~~(D) "at-home recovery visit" means the period of a visit required to provide at-home~~
18.25 ~~recovery care, without limit on the duration of the visit, except each consecutive four~~
18.26 ~~hours in a 24-hour period of services provided by a care provider is one visit;~~
18.27 ~~(ii) Coverage requirements and limitations:~~
18.28 ~~(A) at-home recovery services provided must be primarily services that assist in~~
18.29 ~~activities of daily living;~~
18.30 ~~(B) the insured's attending physician must certify that the specific type and frequency~~
18.31 ~~of at-home recovery services are necessary because of a condition for which a home care~~
18.32 ~~plan of treatment was approved by Medicare;~~
18.33 ~~(C) coverage is limited to:~~
18.34 ~~(I) no more than the number and type of at-home recovery visits certified as~~
18.35 ~~necessary by the insured's attending physician. The total number of at-home recovery~~

19.1 ~~visits shall not exceed the number of Medicare-approved home care visits under a~~
19.2 ~~Medicare-approved home care plan of treatment;~~
19.3 ~~(II) the actual charges for each visit up to a maximum reimbursement of $40 per visit;~~
19.4 ~~(III) $1,600 per calendar year;~~
19.5 ~~(IV) seven visits in any one week;~~
19.6 ~~(V) care furnished on a visiting basis in the insured's home;~~
19.7 ~~(VI) services provided by a care provider as defined in this section;~~
19.8 ~~(VII) at-home recovery visits while the insured is covered under the policy or~~
19.9 ~~certificate and not otherwise excluded;~~
19.10 ~~(VIII) at-home recovery visits received during the period the insured is receiving~~
19.11 ~~Medicare-approved home care services or no more than eight weeks after the service date~~
19.12 ~~of the last Medicare-approved home health care visit;~~
19.13 ~~(iii) Coverage is excluded for:~~
19.14 ~~(A) home care visits paid for by Medicare or other government programs; and~~
19.15 ~~(B) care provided by family members, unpaid volunteers, or providers who are~~
19.16 ~~not care providers;~~
19.17 ~~(7) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and~~
19.18 ~~customary prescription drug expenses to a maximum of $1,200 paid by the issuer annually~~
19.19 ~~under this benefit. An issuer of Medicare supplement insurance policies that elects to~~
19.20 ~~offer this benefit rider shall also make available coverage that contains the rider specified~~
19.21 ~~in clause (4). An outpatient prescription drug benefit must not be included for sale or~~
19.22 ~~issuance in a Medicare policy or certificate issued on or after January 1, 2006.~~

19.23 Sec. 22. **[62A.3163] MEDICARE SUPPLEMENT PLAN WITH 50 PERCENT**
19.24 **PART A DEDUCTIBLE COVERAGE.**
19.25 The Medicare supplement plan with 50 percent Part A deductible coverage must
19.26 have a level of coverage that will provide:
19.27 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for
19.28 365 days after Medicare benefits end;
19.29 (2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible
19.30 amount per benefit period;
19.31 (3) coverage for the coinsurance amount for each day used from the 21st through
19.32 the 100th day in a Medicare benefit period for post-hospital skilled nursing care eligible
19.33 under Medicare Part A;
19.34 (4) coverage for cost sharing for all Medicare Part A eligible hospice and respite
19.35 care expenses;

20.1 (5) coverage under Medicare Part A or B for the reasonable cost of the first three
20.2 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal
20.3 regulations;
20.4 (6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare
20.5 Part B, after the policyholder pays the Medicare Part B deductible;
20.6 (7) coverage of 100 percent of the cost sharing for Medicare Part B preventive
20.7 services and diagnostic procedures for cancer screening described in section 62A.30 after
20.8 the policyholder pays the Medicare Part B deductible;
20.9 (8) coverage of 80 percent of the hospital and medical expenses and supplies
20.10 incurred during travel outside of the United States as a result of a medical emergency; and
20.11 (9) coverage for 100 percent of the Medicare Part A or B home health care services
20.12 and medical supplies after the policyholder pays the Medicare Part B deductible.

20.13 Sec. 23. **[62A.3164] MEDICARE SUPPLEMENT PLAN WITH $20 AND $50**
20.14 **CO-PAYMENT MEDICARE PART B COVERAGE.**
20.15 The Medicare supplement plan with $20 and $50 co-payment Medicare Part B
20.16 coverage must have a level of coverage that will provide:
20.17 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for
20.18 365 days after Medicare benefits end;
20.19 (2) coverage for the Medicare Part A inpatient hospital deductible amount per
20.20 benefit period;
20.21 (3) coverage for the coinsurance amount for each day used from the 21st through
20.22 the 100th day in a Medicare benefit period for post-hospital skilled nursing care eligible
20.23 under Medicare Part A;
20.24 (4) coverage for the cost sharing for all Medicare Part A eligible hospice and respite
20.25 care expenses;
20.26 (5) coverage for Medicare Part A or B of the reasonable cost of the first three pints
20.27 of blood, or equivalent quantities of packed red blood cells, as defined under federal
20.28 regulations, unless replaced according to federal regulations;
20.29 (6) coverage for 100 percent of the cost sharing otherwise applicable under Medicare
20.30 Part B except for the lesser of $20 or the Medicare Part B coinsurance or co-payment
20.31 for each covered health care provider office visit and the lesser of $50 or the Medicare
20.32 Part B coinsurance or co-payment for each covered emergency room visit; however, this
20.33 co-payment shall be waived if the insured is admitted to any hospital and the emergency
20.34 visit is subsequently covered as a Medicare Part A expense;

21.1 (7) coverage of 100 percent of the cost sharing for Medicare Part B preventive
21.2 services and diagnostic procedures for cancer screening described in section 62A.30 after
21.3 the policyholder pays the Medicare Part B deductible;
21.4 (8) coverage of 80 percent of the hospital and medical expenses and supplies
21.5 incurred during travel outside of the United States as a result of a medical emergency; and
21.6 (9) coverage for Medicare Part A or B home health care services and medical
21.7 supplies after the policyholder pays the Medicare Part B deductible.

21.8 Sec. 24. **[62A.3165] MEDICARE SUPPLEMENT PLAN WITH HIGH**
21.9 **DEDUCTIBLE COVERAGE.**
21.10 The Medicare supplement plan will pay 100 percent coverage upon payment of the
21.11 annual high deductible. The annual deductible shall consist of out-of-pocket expenses,
21.12 other than premiums, for services covered. This plan must have a level of coverage that
21.13 will provide:
21.14 (1) 100 percent of Medicare Part A hospitalization coinsurance plus coverage for
21.15 365 days after Medicare benefits end;
21.16 (2) coverage for 100 percent of the Medicare Part A inpatient hospital deductible
21.17 amount per benefit period;
21.18 (3) coverage for 100 percent of the coinsurance amount for each day used from the
21.19 21st through the 100th day in a Medicare benefit period for post-hospital skilled nursing
21.20 care eligible under Medicare Part A;
21.21 (4) coverage for 100 percent of cost sharing for all Medicare Part A eligible
21.22 expenses and respite care;
21.23 (5) coverage for 100 percent, under Medicare Part A or B, of the reasonable cost of
21.24 the first three pints of blood, or equivalent quantities of packed red blood cells, as defined
21.25 under federal regulations, unless replaced according to federal regulations;
21.26 (6) except for coverage provided in this clause, coverage for 100 percent of the cost
21.27 sharing otherwise applicable under Medicare Part B;
21.28 (7) coverage of 100 percent of the cost sharing for Medicare Part B preventive
21.29 services and diagnostic procedures for cancer screening described in section 62A.30 after
21.30 the policyholder pays the Medicare Part B deductible;
21.31 (8) coverage of 100 percent of the hospital and medical expenses and supplies
21.32 incurred during travel outside of the United States as a result of a medical emergency;
21.33 (9) coverage for 100 percent of Medicare Part A and B home health care services
21.34 and medical supplies; and

22.1 (10) the basis for the deductible shall be $1,860 and shall be adjusted annually from
22.2 2010 by the secretary of the United States Department of Health and Human Services to
22.3 reflect the change in the Consumer Price Index for all urban consumers for the 12-month
22.4 period ending with August of the preceding year, and rounded to the nearest multiple of
22.5 $10.

22.6 Sec. 25. **[62A.70] DEFINITIONS.**

22.7 Subdivision 1. **Application and scope.** For purposes of sections 62A.70 to
22.8 62A.735, the terms in subdivisions 2 to 15 have the meanings given them, unless the
22.9 context clearly indicates otherwise.

22.10 Subd. 2. **Allowable expense.** (a) "Allowable expense," except as set forth in
22.11 paragraphs (b) to (h) or where a statute requires a different definition, means any health
22.12 care expense, including coinsurance or co-payments and without reduction for any
22.13 applicable deductible, that is covered in full or in part by any of the plans covering the
22.14 person.

22.15 (b) If a plan is advised by a covered person that all plans covering the person are
22.16 high-deductible health plans and the person intends to contribute to a health savings
22.17 account established in accordance with section 223 of the Internal Revenue Code of 1986,
22.18 the primary high-deductible health plan's deductible is not an allowable expense, except
22.19 for any health care expense incurred that may not be subject to the deductible as described
22.20 in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

22.21 (c) An expense or a portion of an expense that is not covered by any of the plans is
22.22 not an allowable expense.

22.23 (d) Any expense that a provider by law or in accordance with a contractual
22.24 agreement is prohibited from charging a covered person is not an allowable expense.

22.25 (e) The following are examples of expenses that are not allowable expenses:

22.26 (1) if a person is confined in a private hospital room, the difference between the cost
22.27 of a semiprivate room in the hospital and the private room is not an allowable expense,
22.28 unless one of the plans provides coverage for private hospital room expenses;

22.29 (2) if a person is covered by two or more plans that compute the person's
22.30 benefit payments on the basis of usual and customary fees or relative value schedule
22.31 reimbursement or other similar reimbursement methodology, any amount charged by the
22.32 provider in excess of the highest reimbursement amount for a specified benefit is not an
22.33 allowable expense;

23.1 (3) if a person is covered by two or more plans that provide benefits or services on
23.2 the basis of negotiated fees, any amount in excess of the highest of the negotiated fees
23.3 is not an allowable expense; and
23.4 (4) if a person is covered by one plan that calculates its benefits or services on the
23.5 basis of usual and customary fees or relative value schedule reimbursement or other
23.6 similar reimbursement methodology and another plan that provides its benefits or services
23.7 on the basis of negotiated fees, the primary plan's payment arrangement is the allowable
23.8 expense for all plans. However, if the provider has contracted with the secondary plan
23.9 to provide the benefit or service for a specific negotiated fee or payment amount that
23.10 is different than the primary plan's payment arrangement and if the provider's contract
23.11 permits, that negotiated fee or payment is the allowable expense used by the secondary
23.12 plan to determine its benefits.
23.13 (f) The definition of "allowable expense" may exclude certain types of coverage or
23.14 benefits such as dental care, vision care, prescription drugs, or hearing aids. A plan that
23.15 limits the application of COB to certain coverages or benefits may limit the definition
23.16 of allowable expense in its contract to expenses that are similar to the expenses that it
23.17 provides. When COB is restricted to specific coverages or benefits in a contract, the
23.18 definition of allowable expense includes similar expenses to which COB applies.
23.19 (g) When a plan provides benefits in the form of services, the reasonable cash value
23.20 of each service is considered an allowable expense and a benefit paid.
23.21 (h) The amount of the reduction may be excluded from allowable expense when a
23.22 covered person's benefits are reduced under a primary plan because the covered person:
23.23 (1) does not comply with the plan provisions concerning second surgical opinions or
23.24 precertification of admissions or services; or
23.25 (2) has a lower benefit because the covered person did not use a preferred provider.
23.26 Subd. 3. **Birthday.** "Birthday" refers only to month and day in a calendar year and
23.27 does not include the year in which the individual is born.
23.28 Subd. 4. **Claim.** "Claim" means a request that benefits of a plan be provided or paid.
23.29 The benefits claimed may be in the form of:
23.30 (1) services, including supplies;
23.31 (2) payment for all or a portion of the expenses incurred;
23.32 (3) a combination of clauses (1) and (2); or
23.33 (4) an indemnification.
23.34 Subd. 5. **Closed panel plan.** "Closed panel plan" means a plan that provides health
23.35 benefits to covered persons primarily in the form of services through a panel of providers
23.36 that have contracted with or are employed by the plan, and that excludes benefits for

24.1 services provided by other providers, except in cases of emergency or referral by a panel
24.2 member.

24.3 Subd. 6. **Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA.**
24.4 "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means
24.5 coverage provided under a right of continuation pursuant to federal law.

24.6 Subd. 7. **Coordination of benefits or COB.** "Coordination of benefits" or "COB"
24.7 means a provision establishing an order in which plans pay their claims, and permitting
24.8 secondary plans to reduce their benefits so that the combined benefits of all plans do not
24.9 exceed total allowable expenses.

24.10 Subd. 8. **Custodial parent.** "Custodial parent" means:

24.11 (1) the parent awarded custody of a child by a court decree; or

24.12 (2) in the absence of a court decree, the parent with whom the child resides more
24.13 than one-half of the calendar year without regard to any temporary visitation.

24.14 Subd. 9. **Group-type contract.** (a) "Group-type contract" means a contract that
24.15 is not available to the general public and is obtained and maintained only because of
24.16 membership in or a connection with a particular organization or group, including blanket
24.17 coverage.

24.18 (b) "Group-type contract" does not include an individually underwritten and issued
24.19 guaranteed renewable policy even if the policy is purchased through payroll deduction at
24.20 a premium savings to the insured since the insured would have the right to maintain or
24.21 renew the policy independently of continued employment with the employer.

24.22 Subd. 10. **High-deductible health plan.** "High-deductible health plan" has the
24.23 meaning given the term under section 223 of the Internal Revenue Code of 1986, as
24.24 amended by the Medicare Prescription Drug, Improvement, and Modernization Act of
24.25 2003.

24.26 Subd. 11. **Hospital indemnity benefits.** "Hospital indemnity benefits" means
24.27 benefits not related to expenses incurred. The term does not include reimbursement-type
24.28 benefits even if they are designed or administered to give the insured the right to elect
24.29 indemnity-type benefits at the time of claim.

24.30 Subd. 12. **Plan.** (a) "Plan" means a form of coverage with which coordination
24.31 is allowed. Separate parts of a plan for members of a group that are provided through
24.32 alternative contracts that are intended to be part of a coordinated package of benefits are
24.33 considered one plan and there is no COB among the separate parts of the plan.

24.34 (b) If a plan coordinates benefits, its contract must state the types of coverage that
24.35 will be considered in applying the COB provision of that contract. Whether the contract
24.36 uses the term "plan" or some other term such as "program," the contractual definition may

25.1 be no broader than the definition of "plan" in this subdivision. The definition of "plan" in
25.2 the model COB provision in section 62A.73 is an example.
25.3 (c) "Plan" includes:
25.4 (1) group and nongroup insurance contracts and subscriber contracts;
25.5 (2) uninsured arrangements of group or group-type coverage;
25.6 (3) group and nongroup coverage through closed panel plans;
25.7 (4) group-type contracts;
25.8 (5) the medical care components of long-term care contracts, such as skilled nursing
25.9 care; and
25.10 (6) Medicare or other governmental benefits, as permitted by law, except as provided
25.11 in paragraph (d), clause (8). That part of the definition of plan may be limited to the
25.12 hospital, medical, and surgical benefits of the governmental program.
25.13 (d) "Plan" does not include:
25.14 (1) hospital indemnity coverage benefits or other fixed indemnity coverage;
25.15 (2) accident-only coverage;
25.16 (3) specified disease or specified accident coverage;
25.17 (4) limited benefit health coverage;
25.18 (5) school accident-type coverages that cover students for accidents only, including
25.19 athletic injuries, either on a 24-hour basis or on a "to and from school" basis;
25.20 (6) benefits provided in long-term care insurance policies for nonmedical services,
25.21 for example, personal care, adult day care, homemaker services, assistance with activities
25.22 of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit
25.23 without regard to expenses incurred or the receipt of services;
25.24 (7) Medicare supplement policies;
25.25 (8) a state plan under Medicaid; or
25.26 (9) a governmental plan, which, by law, provides benefits that are in excess of those
25.27 of any private insurance plan or other nongovernmental plan.
25.28 Subd. 13. **Policyholder.** "Policyholder" means the primary insured named in a
25.29 nongroup insurance policy.
25.30 Subd. 14. **Primary plan.** "Primary plan" means a plan whose benefits for a person's
25.31 health care coverage must be determined without taking the existence of any other plan
25.32 into consideration. A plan is a primary plan if:
25.33 (1) the plan either has no order of benefit determination rules, or its rules differ from
25.34 those permitted by sections 62A.70 to 62A.735; or

26.1 (2) all plans that cover the person use the order of benefit determination rules
26.2 required by sections 62A.70 to 62A.735, and under those rules the plan determines its
26.3 benefits first.

26.4 Subd. 15. **Secondary plan.** "Secondary plan" means a plan that is not a primary
26.5 plan.

26.6 Sec. 26. **[62A.705] MODEL COB CONTRACT PROVISION.**

26.7 Subdivision 1. **Use.** Section 62A.73 contains a model COB provision for use in
26.8 contracts. The use of this model COB provision is subject to the provisions of subdivisions
26.9 2, 3, and 4, and to the provisions of section 62A.71.

26.10 Subd. 2. **Description.** Section 62A.735 is a plain language description of the COB
26.11 process that explains to the covered person how health plans will implement coordination
26.12 of benefits. It is not intended to replace or change the provisions that are set forth in
26.13 the contract. Its purpose is to explain the process by which the two or more plans will
26.14 pay for or provide benefits.

26.15 Subd. 3. **Changes.** The COB provision contained in section 62A.73 and the plain
26.16 language explanation in section 62A.735 do not have to use the specific words and format
26.17 shown in section 62A.73 or 62A.735. Changes may be made to fit the language and style of
26.18 the rest of the contract or to reflect differences among plans that provide services, that pay
26.19 benefits for expenses incurred, and that indemnify. No substantive changes are permitted.

26.20 Subd. 4. **Reduction of benefits limited.** A COB provision may not be used that
26.21 permits a plan to reduce its benefits on the basis that:

26.22 (1) another plan exists and the covered person did not enroll in that plan;

26.23 (2) a person is or could have been covered under another plan, except with respect to
26.24 Medicare part B; or

26.25 (3) a person has elected an option under another plan providing a lower level of
26.26 benefits than another option that could have been elected.

26.27 Subd. 5. **Always excess or always secondary language; limitations.** No plan may
26.28 contain a provision that its benefits are "always excess" or "always secondary" except in
26.29 accordance with the rules permitted by sections 62A.70 to 62A.735.

26.30 Subd. 6. **Closed panel plans.** Under the terms of a closed panel plan, benefits are not
26.31 payable if the covered person does not use the services of a closed panel provider. In most
26.32 instances, COB does not occur if a covered person is enrolled in two or more closed panel
26.33 plans and obtains services from a provider in one of the closed panel plans because the
26.34 other closed panel plan (the one whose providers were not used) has no liability. However,
26.35 COB may occur during the plan year when the covered person receives emergency

27.1 services that would have been covered by both plans. Then the secondary plan shall use
27.2 the provisions of section 62A.715 to determine the amount it should pay for the benefit.
27.3 Subd. 7. **Uses limited.** No plan may use a COB provision or any other provision
27.4 that allows it to reduce its benefits with respect to any other coverage its insured may have
27.5 that does not meet the definition of plan under section 62A.70, subdivision 12.

27.6 Sec. 27. **[62A.71] RULES FOR COORDINATION OF BENEFITS.**
27.7 Sections 62A.711 and 62A.712 establish the rules for determining the order of
27.8 benefit payments when a person is covered by two or more plans.

27.9 Sec. 28. **[62A.711] GENERAL COORDINATION RULES.**
27.10 Subdivision 1. **Primary plan pays or provides benefits.** The primary plan shall
27.11 pay or provide its benefits as if the secondary plan or plans did not exist.
27.12 Subd. 2. **Primary plan that is closed panel plan and secondary plan that is not.**
27.13 If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan,
27.14 the secondary plan shall pay or provide benefits as if it were the primary plan when a
27.15 covered person uses a nonpanel provider, except for emergency services or authorized
27.16 referrals that are paid or provided by the primary plan.
27.17 Subd. 3. **Multiple plans treated as single plan.** When multiple contracts providing
27.18 coordinated coverage are treated as a single plan under sections 62A.70 to 62A.735,
27.19 this section applies only to the plan as a whole, and coordination among the component
27.20 contracts is governed by the terms of the contracts. If more than one carrier pays or
27.21 provides benefits under the plan, the carrier designated as primary within the plan is
27.22 responsible for the plan's compliance with sections 62A.70 to 62A.735.
27.23 Subd. 4. **Coverage under more than one secondary plan.** If a person is covered
27.24 by more than one secondary plan, the order of benefit determination rules of sections
27.25 62A.70 to 62A.735 decide the order in which secondary plans benefits are determined in
27.26 relation to each other. Each secondary plan must take into consideration the benefits of the
27.27 primary plan or plans and the benefits of any other plan, which, under the rules of sections
27.28 62A.70 to 62A.735, has its benefits determined before those of that secondary plan.
27.29 Subd. 5. **Noncomplying plan.** Except as provided in subdivision 6, a plan that does
27.30 not contain order of benefit determination provisions that are consistent with sections
27.31 62A.70 to 62A.735 is always the primary plan unless the provisions of both plans,
27.32 regardless of the provisions of this subdivision, state that the complying plan is primary.
27.33 Subd. 6. **Supplementary coverage.** Coverage that is obtained by virtue of
27.34 membership in a group and designed to supplement a part of a basic package of benefits

28.1 may provide that the supplementary coverage is excess to any other parts of the plan
28.2 provided by the contract holder. Examples of these types of situations are major medical
28.3 coverages that are superimposed over base plan hospital and surgical benefits, and
28.4 insurance-type coverages that are written in connection with a closed panel plan to provide
28.5 out-of-network benefits.

28.6 Subd. 7. **Secondary plans.** A plan may take into consideration the benefits paid or
28.7 provided by another plan only when, under the rules of sections 62A.70 to 62A.735, it
28.8 is secondary to that other plan.

28.9 Sec. 29. **[62A.712] GENERAL ORDER OF BENEFITS RULES.**

28.10 Subdivision 1. **Order of application of rules.** Each plan shall determine its order of
28.11 benefits using the first of the rules set out in subdivisions 2 to 7 that apply.

28.12 Subd. 2. **Nondependent or dependent.** (a) Subject to paragraph (b), the plan
28.13 that covers the person other than as a dependent, for example as an employee, member,
28.14 subscriber, policyholder, or retiree, is the primary plan and the plan that covers the person
28.15 as a dependent is the secondary plan.

28.16 (b) If the person is a Medicare beneficiary, and, as a result of the provisions of title
28.17 XVIII of the Social Security Act and implementing regulations, Medicare is secondary to
28.18 the plan covering the person as a dependent; and primary to the plan covering the person
28.19 as other than a dependent, for example, a retired employee, then the order of benefits
28.20 is reversed so that the plan covering the person as an employee, member, subscriber,
28.21 policyholder, or retiree is the secondary plan and the other plan covering the person as
28.22 a dependent is the primary plan.

28.23 Subd. 3. **Dependent child.** (a) Unless there is a court decree stating otherwise, plans
28.24 covering a dependent child shall determine the order of benefits as set out in paragraphs
28.25 (b) to (d):

28.26 (b) For a dependent child whose parents are married or are living together, whether
28.27 or not they have ever been married, the plan of the parent whose birthday falls earlier in
28.28 the calendar year is the primary plan; or if both parents have the same birthday, the plan
28.29 that has covered the parent longest is the primary plan.

28.30 (c) For a dependent child whose parents are divorced or separated or are not living
28.31 together, whether or not they have ever been married:

28.32 (1) if a court decree states that one of the parents is responsible for the dependent
28.33 child's health care expenses or health care coverage and the plan of that parent has actual
28.34 knowledge of those terms, that plan is primary. If the parent with responsibility has no
28.35 health care coverage for the dependent child's health care expenses, but that parent's

29.1 spouse does, that parent's spouse's plan is the primary plan. This clause does not apply
29.2 with respect to any plan year during which benefits are paid or provided before the entity
29.3 has actual knowledge of the court decree provision;

29.4 (2) if a court decree states that both parents are responsible for the dependent
29.5 child's health care expenses or health care coverage, the provisions of paragraph (b) shall
29.6 determine the order of benefits;

29.7 (3) if a court decree states that the parents have joint custody without specifying that
29.8 one parent has responsibility for the health care expenses or health care coverage of the
29.9 dependent child, the provisions of paragraph (b) shall determine the order of benefits; or

29.10 (4) if there is no court decree allocating responsibility for the child's health care
29.11 expenses or health care coverage, the order of benefits for the child are as follows:

29.12 (i) the plan covering the custodial parent;

29.13 (ii) the plan covering the custodial parent's spouse;

29.14 (iii) the plan covering the noncustodial parent; and then

29.15 (iv) the plan covering the noncustodial parent's spouse.

29.16 (d) For a dependent child covered under more than one plan of individuals who are
29.17 not the parents of the child, the order of benefits shall be determined, as applicable, under
29.18 this subdivision as if those individuals were parents of the child.

29.19 Subd. 4. **Active employee or retired or laid-off employee.** (a) The plan that covers
29.20 a person as an active employee, that is an employee who is neither laid off nor retired,
29.21 or as a dependent of an active employee is the primary plan. The plan covering that
29.22 same person as a retired or laid-off employee or as a dependent of a retired or laid-off
29.23 employee is the secondary plan.

29.24 (b) If the other plan does not have this rule, and as a result, the plans do not agree on
29.25 the order of benefits, this rule is ignored.

29.26 (c) This rule does not apply if the rule in paragraph (a) can determine the order of
29.27 benefits.

29.28 Subd. 5. **COBRA or state continuation coverage.** (a) If a person whose coverage
29.29 is provided pursuant to COBRA or under a right of continuation pursuant to state or other
29.30 federal law is covered under another plan, the plan covering the person as an employee,
29.31 member, subscriber, or retiree or covering the person as a dependent of an employee,
29.32 member, subscriber, or retiree is the primary plan and the plan covering that same person
29.33 pursuant to COBRA or under a right of continuation pursuant to state or other federal
29.34 law is the secondary plan.

29.35 (b) If the other plan does not have this rule, and if, as a result, the plans do not agree
29.36 on the order of benefits, this rule is ignored.

30.1 (c) This rule does not apply if the rule in paragraph (a) can determine the order of
30.2 benefits.
30.3 Subd. 6. **Longer or shorter length of coverage.** (a) If subdivisions 1 to 5 do not
30.4 determine the order of benefits, the plan that covered the person for the longer period of
30.5 time is the primary plan and the plan that covered the person for the shorter period of
30.6 time is the secondary plan.
30.7 (b) To determine the length of time a person has been covered under a plan, two
30.8 successive plans must be treated as one if the covered person was eligible under the second
30.9 plan within 24 hours after coverage under the first plan ended.
30.10 (c) The start of a new plan does not include:
30.11 (1) a change in the amount or scope of a plan's benefits;
30.12 (2) a change in the entity that pays, provides, or administers the plan's benefits; or
30.13 (3) a change from one type of plan to another, such as, from a single-employer
30.14 plan to a multiple-employer plan.
30.15 (d) The person's length of time covered under a plan is measured from the person's
30.16 first date of coverage under that plan. If that date is not readily available for a group
30.17 plan, the date the person first became a member of the group must be used as the date
30.18 from which to determine the length of time the person's coverage under the present plan
30.19 has been in force.
30.20 Subd. 7. **Allowable expenses shared equally between plans.** If none of the rules
30.21 in subdivisions 1 to 6 determine the order of benefits, the allowable expenses must be
30.22 shared equally between the plans.

30.23 Sec. 30. **[62A.715] PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN**
30.24 **TO CALCULATE BENEFITS AND PAY A CLAIM.**
30.25 In determining the amount to be paid by the secondary plan on a claim, should
30.26 the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it
30.27 would have paid on the claim in the absence of other health care coverage and apply that
30.28 calculated amount to any allowable expense under its plan that is unpaid by the primary
30.29 plan. The secondary plan may reduce its payment by the amount so that, when combined
30.30 with the amount paid by the primary plan, the total benefits paid or provided by all plans
30.31 for the claim do not exceed 100 percent of the total allowable expense for that claim. In
30.32 addition, the secondary plan shall credit to its plan deductible any amounts it would have
30.33 credited to its deductible in the absence of other health care coverage.

30.34 Sec. 31. **[62A.72] NOTICE TO COVERED PERSONS.**

31.1 A plan shall, in its explanation of benefits provided to covered persons, include
31.2 the following language: "If you are covered by more than one health benefit plan, you
31.3 should file all your claims with each plan."

31.4 Sec. 32. **[62A.725] MISCELLANEOUS PROVISIONS.**

31.5 Subdivision 1. **Secondary plan providing benefits in the form of services.** A
31.6 secondary plan that provides benefits in the form of services may recover the reasonable
31.7 cash value of the services from the primary plan, to the extent that benefits for the services
31.8 are covered by the primary plan and have not already been paid or provided by the primary
31.9 plan. This provision does not require a plan to reimburse a covered person in cash for the
31.10 value of services provided by a plan that provides benefits in the form of services.

31.11 Subd. 2. **Order of benefits for noncomplying plans.** (a) A plan with order of
31.12 benefit determination rules that comply with sections 62A.70 to 62A.735 may coordinate
31.13 its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit
31.14 determination rules that are inconsistent with those contained in sections 62A.70 to
31.15 62A.735 on the following basis:

31.16 (1) if the complying plan is the primary plan, it shall pay or provide its benefits first;

31.17 (2) if the complying plan is the secondary plan, it shall pay or provide its benefits
31.18 first, but the amount of the benefits payable must be determined as if the complying
31.19 plan were the secondary plan. In such a situation, the payment must be the limit of the
31.20 complying plan's liability; and

31.21 (3) if the noncomplying plan does not provide the information needed by the
31.22 complying plan to determine its benefits within a reasonable time after it is requested to
31.23 do so, the complying plan shall assume that the benefits of the noncomplying plan are
31.24 identical to its own, and shall pay its benefits accordingly. If, within two years of payment,
31.25 the complying plan receives information as to the actual benefits of the noncomplying
31.26 plan, it shall adjust payments accordingly.

31.27 (b) If the noncomplying plan reduces its benefits so that the covered person receives
31.28 less in benefits than the covered person would have received had the complying plan paid
31.29 or provided its benefits as the secondary plan and the noncomplying plan paid or provided
31.30 its benefits as the primary plan, and governing state law allows the right of subrogation set
31.31 forth in paragraph (c), then the complying plan shall advance to the covered person or on
31.32 behalf of the covered person an amount equal to the difference.

31.33 (c) In no event shall the complying plan advance more than the complying plan
31.34 would have paid had it been the primary plan less any amount it previously paid for
31.35 the same expense or service. In consideration of the advance, the complying plan is

32.1 subrogated to all rights of the covered person against the noncomplying plan. The
32.2 advance by the complying plan is without prejudice to any claim it may have against a
32.3 noncomplying plan in the absence of subrogation.

32.4 Subd. 3. **COB and subrogation provisions.** COB differs from subrogation.
32.5 Provisions for one may be included in health care benefits contracts without compelling
32.6 the inclusion or exclusion of the other.

32.7 Subd. 4. **No agreement between plans; obligation to pay claim.** If the plans
32.8 cannot agree on the order of benefits within 30 calendar days after the plans have received
32.9 all of the information needed to pay the claim, the plans shall immediately pay the claim
32.10 in equal shares and determine their relative liabilities following payment, except that no
32.11 plan is required to pay more than it would have paid had it been the primary plan.

32.12 Sec. 33. **[62A.73] MODEL COB CONTRACT PROVISIONS.**
32.13 **COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS**

32.14 The Coordination of Benefits (COB) provision applies when a person has health care
32.15 coverage under more than one **Plan**. **Plan** is defined below.

32.16 The order of benefit determination rules govern the order in which each **Plan** will
32.17 pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary**
32.18 **plan** must pay benefits in accordance with its policy terms without regard to the possibility
32.19 that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan**
32.20 is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays to that
32.21 payments from all **Plans** does not exceed 100 percent of the total **Allowable expense**.

32.22 **DEFINITIONS**

32.23 A. A **Plan** is any of the following that provides benefits or services for medical or
32.24 dental care or treatment. If separate contracts are used to provide coordinated coverage for
32.25 members of a group, the separate contracts are considered parts of the same plan and there
32.26 is no COB among those separate contracts.

32.27 (1) **Plan** includes: group and nongroup insurance contracts, health maintenance
32.28 organization (HMO) contracts, closed panel plans or other forms of group or group-type
32.29 coverage (whether insured or uninsured); medical care components of long-term care
32.30 contracts, such as skilled nursing care; and Medicare or any other federal governmental
32.31 plan, as permitted.

32.32 (2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity
32.33 coverage; accident-only coverage; specified disease or specified accident coverage;
32.34 limited benefit health coverage, as defined by state law; school accident-type coverage;
32.35 benefits for nonmedical components of long-term care policies; Medicare supplement

33.1 policies; Medicaid policies; or coverage under other federal governmental plans, unless
33.2 permitted by law.

33.3 Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts
33.4 and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

33.5 B. **This plan** means, in a **COB** provision, the part of the contract providing the
33.6 health care benefits to which the **COB** provision applies and which may be reduced
33.7 because of the benefits of other plans. Any other part of the contract providing health care
33.8 benefits is separate from this plan. A contract may apply one **COB** provision to certain
33.9 benefits, such as dental benefits, coordinating only with similar benefits, and may apply
33.10 another **COB** provision to coordinate other benefits.

33.11 C. The order of benefit determination rules determine whether **This plan** is a
33.12 **Primary plan** or **Secondary plan** when the person has health care coverage under more
33.13 than one **Plan**.

33.14 When **This plan** is primary, it determines payment for its benefits first before those
33.15 of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is
33.16 secondary, it determines its benefits after those of another **Plan** and may reduce the benefits
33.17 it pays so that all **Plan** benefits do not exceed 100 percent of the total **Allowable expense**.

33.18 D. **Allowable expense** is a health care expense, including deductibles, coinsurance,
33.19 and copayments, that is covered at least in part by any **Plan** covering the person. When a
33.20 **Plan** provides benefits in the form of services, the reasonable cash value of each service
33.21 will be considered an **Allowable expense** and a benefit paid. An expense that is not
33.22 covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any
33.23 expense that a provider by law or in accordance with a contractual agreement is prohibited
33.24 from charging a covered person is not an **Allowable expense**.

33.25 The following are examples of expenses that are not **Allowable expenses**:

33.26 (1) The difference between the cost of a semiprivate hospital room and a private
33.27 hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for
33.28 private hospital room expenses.

33.29 (2) If a person is covered by two or more **Plans** that compute their benefit payments
33.30 on the basis of usual and customary fees or relative value schedule reimbursement
33.31 methodology or other similar reimbursement methodology, any amount in excess of the
33.32 highest reimbursement amount for a specific benefit is not an **Allowable expense**.

33.33 (3) If a person is covered by two or more **Plans** that provide benefits or services on
33.34 the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is
33.35 not an **Allowable expense**.

34.1 (4) If a person is covered by one **Plan** that calculates its benefits or services on the
34.2 basis of usual and customary fees or relative value schedule reimbursement methodology
34.3 or other similar reimbursement methodology and another **Plan** that provides its benefits
34.4 or services on the basis of negotiated fees, the **Primary plan's** payment arrangement
34.5 shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted
34.6 with the **Secondary plan** to provide the benefit or service for a specific negotiated fee
34.7 or payment amount that is different than the **Primary plan's** payment arrangement and
34.8 if the provider's contract permits, the negotiated fee or payment shall be the **Allowable**
34.9 **expense** used by the **Secondary plan** to determine its benefits.

34.10 (5) The amount of any benefit reduction by the **Primary plan** because a
34.11 covered person has failed to comply with the **Plan** provisions is not an **Allowable**
34.12 **expense**. Examples of these types of plan provisions include second surgical opinions,
34.13 precertification of admissions, and preferred provider arrangements.

34.14 E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons
34.15 primarily in the form of services through a panel of providers that have contracted with
34.16 or are employed by the **Plan**, and that excludes coverage for services provided by other
34.17 providers, except in cases of emergency or referral by a panel member.

34.18 F. **Custodial parent** is the parent awarded custody by a court decree or, in the
34.19 absence of a court decree, is the parent with whom the child resides more than one-half
34.20 of the calendar year excluding any temporary visitation.

34.21 **ORDER OF BENEFIT DETERMINATION RULES**

34.22 When a person is covered by two or more **Plans**, the rules for determining the
34.23 order of benefit payments are as follows:

34.24 A. The **Primary plan** pays or provides its benefits according to its terms of coverage
34.25 and without regard to the benefits of coverage under any other **Plan**.

34.26 B. (1) Except as provided in paragraph (2), a **Plan** that does not contain a
34.27 coordination of benefits provision that is consistent with this regulation is always primary
34.28 unless the provisions of both **Plans** state that the complying plan is primary.

34.29 (2) Coverage that is obtained by virtue of membership in a group that is designed
34.30 to supplement a part of a basic package of benefits and provides that this supplementary
34.31 coverage shall be excess to any other parts of the **Plan** provided by the contract holder.
34.32 Examples of these types of situations are major medical coverages that are superimposed
34.33 over base plan hospital and surgical benefits, and insurance-type coverages that are written
34.34 in connection with a **Closed panel plan** to provide out-of-network benefits.

34.35 C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating
34.36 payment of its benefits only when it is secondary to that other **Plan**.

35.1 D. Each **Plan** determines its order of benefits using the first of the following rules
35.2 that apply:
35.3 (1) Nondependent or Dependent. The **Plan** that covers the person other than as a
35.4 dependent, for example as an employee, member, policyholder, subscriber, or retiree is
35.5 the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary**
35.6 **plan**. However, if the person is a Medicare beneficiary and, as a result of federal law,
35.7 Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the
35.8 **Plan** covering the person as other than a dependent (e.g., a retired employee); then the
35.9 order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as
35.10 an employee, member, policyholder, subscriber, or retiree is the **Secondary plan** and the
35.11 other **Plan** is the **Primary plan**.
35.12 (2) Dependent Child Covered Under More Than One Plan. Unless there is a court
35.13 decree stating otherwise, when a dependent child is covered by more than one **Plan** the
35.14 order of benefits is determined as follows:
35.15 (a) For a dependent child whose parents are married or are living together, whether
35.16 or not they have ever been married:
35.17 • The **Plan** of the parent whose birthday falls earlier in the calendar year is the
35.18 **Primary plan**; or
35.19 • If both parents have the same birthday, the **Plan** that has covered the parent the
35.20 longest is the **Primary plan**.
35.21 (b) For a dependent child whose parents are divorced or separated or not living
35.22 together, whether or not they have ever been married:
35.23 (i) If a court decree states that one of the parents is responsible for the dependent
35.24 child's health care expenses or health care coverage and the **Plan** of that parent has
35.25 actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years
35.26 commencing after the **Plan** is given notice of the court decree;
35.27 (ii) If a court decree states that both parents are responsible for the dependent child's
35.28 health care expenses or health care coverage, the provisions of subparagraph (a) above
35.29 shall determine the order of benefits;
35.30 (iii) If a court decree states that the parents have joint custody without specifying
35.31 that one parent has responsibility for the health care expenses or health care coverage of
35.32 the dependent child, the provisions of subparagraph (a) above shall determine the order
35.33 of benefits; or
35.34 (iv) If there is no court decree allocating responsibility for the dependent child's
35.35 health care expenses or health care coverage, the order of benefits for the child are as
35.36 follows:

36.1 • The **Plan** covering the **Custodial parent**;

36.2 • The **Plan** covering the spouse of the **Custodial parent**;

36.3 • The **Plan** covering the **noncustodial parent**; and then

36.4 • The **Plan** covering the spouse of the **noncustodial parent**.

36.5 (c) For a dependent child covered under more than one **Plan** of individuals who are
36.6 the parents of the child, the provisions of subparagraph (a) or (b) above shall determine
36.7 the order of benefits as if those individuals were the parents of the child.

36.8 (3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a
36.9 person as an active employee, that is, an employee who is neither laid off nor retired, is the
36.10 **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is
36.11 the **Secondary plan**. The same would hold true if a person is a dependent of an active
36.12 employee and that same person is a dependent of a retired or laid-off employee. If the
36.13 other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order
36.14 of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can
36.15 determine the order of benefits.

36.16 (4) COBRA or State Continuation Coverage. If a person whose coverage is provided
36.17 pursuant to COBRA or under a right of continuation provided by state or other federal law
36.18 is covered under another **Plan**, the **Plan** covering the person as an employee, member,
36.19 subscriber, or retiree or covering the person as a dependent of an employee, member,
36.20 subscriber, or retiree is the **Primary plan** and the COBRA or state or other federal
36.21 continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule,
36.22 and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This
36.23 rule does not apply if the rule labeled D(1) can determine the order of benefits.

36.24 (5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an
36.25 employee, member, policyholder, subscriber, or retiree longer is the **Primary plan** and the
36.26 **Plan** that covered the person the shorter period of time is the **Secondary plan**.

36.27 (6) If the preceding rules do not determine the order of benefits, the **Allowable**
36.28 **expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In
36.29 addition, **This plan** will not pay more than it would have paid had it been the **Primary**
36.30 **plan**.

36.31 **EFFECT ON THE BENEFITS OF THIS PLAN**

36.32 A. When **This plan** is secondary, it may reduce its benefits so that the total benefits
36.33 paid or provided by all **Plans** during a plan year are not more than the total **Allowable**
36.34 **expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will
36.35 calculate the benefits it would have paid in the absence of other health care coverage and
36.36 apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by

37.1 the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so
37.2 that, when combined with the amount paid by the **Primary plan**, the total benefits paid or
37.3 provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that
37.4 claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it
37.5 would have credited to its deductible in the absence of other health care coverage.

37.6 B. If a covered person is enrolled in two or more **Closed panel plans** and if, for
37.7 any reason, including the provision of service by a nonpanel provider, benefits are not
37.8 payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other
37.9 **Closed panel plans**.

37.10 **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

37.11 Certain facts about health care coverage and services are needed to apply these **COB**
37.12 rules and to determine benefits payable under **This plan** and other **Plans**. [Organization
37.13 responsibility for **COB** administration] may get the facts it needs from or give them to
37.14 other organizations or persons for the purpose of applying these rules and determining
37.15 befits payable under **This plan** and other **Plans** covering the person claiming benefits.
37.16 [Organization responsibility for **COB** administration] need not tell, or get the consent
37.17 of, any person to do this. Each person claiming benefits under **This plan** must give
37.18 [Organization responsibility for **COB** administration] any facts it needs to apply those
37.19 rules and determine benefits payable.

37.20 **FACILITY OF PAYMENT**

37.21 A payment made under another **Plan** may include an amount that should have been
37.22 paid under **This plan**. If it does, [Organization responsibility for **COB** administration]
37.23 may pay that amount to the organization that made that payment. That amount will then be
37.24 treated as though it were a benefit paid under **This plan**. [Organization responsibility for
37.25 **COB** administration] will not have to pay that amount again. The term "payment made"
37.26 includes providing benefits in the form of services, in which case "payment made" means
37.27 the reasonable cash value of the benefits provided in the form of services.

37.28 **RIGHT OF RECOVERY**

37.29 If the amount of the payments made by [Organization responsibility for **COB**
37.30 administration] is more than it should have paid under this **COB** provision, it may recover
37.31 the excess from one or more of the persons it has paid or for whom it has paid; or any
37.32 other person or organization that may be responsible for the benefits or services provided
37.33 for the covered person. The "amount of the payments made" includes the reasonable cash
37.34 value of any benefits provided in the form of services.

38.1 Sec. 34. **[62A.735] CONSUMER EXPLANATORY BOOKLET.**

38.2 **COORDINATION OF BENEFITS**

38.3 **IMPORTANT NOTICE**
38.4 **This is a summary of only a few of the provisions of your health plan to help**
38.5 **you understand coordination of benefits, which can be very complicated.**
38.6 **This is not a complete description of all of the coordination rules and**
38.7 **procedures, and does not change or replace the language contained in your**
38.8 **insurance contract, which determines your benefits.**

38.9 **Double Coverage**

38.10 It is common for family members to be covered by more than one health care plan.
38.11 This happens, for example, when a husband and wife both work and choose to have
38.12 family coverage through both employers.

38.13 When you are covered by more than one health plan, state law permits your insurers
38.14 to follow a procedure called "coordination of benefits" to determine how much each
38.15 should pay when you have a claim. The goal is to make sure that the combined payments
38.16 of all plans do not add up to more than your covered health care expenses.

38.17 Coordination of benefits (COB) is complicated, and covers a wide variety of
38.18 circumstances. This is only an outline of some of the most common ones. If your
38.19 situation is not described, read your evidence of coverage or contact your state insurance
38.20 department.

38.21 **Primary or Secondary?**

38.22 You will be asked to identify all the plans that cover members of your family. We
38.23 need this information to determine whether we are the "primary" or "secondary" benefit
38.24 payer. The primary plan always pays first when you have a claim.

38.25 Any plan that does not contain your state's COB rules will always be primary.

38.26 **When This Plan is Primary**

38.27 If you or a family member are covered under another plan in addition to this one,
38.28 we will be primary when:

38.29 **Your Own Expenses**

38.30 • The claim is for your own health care expenses, unless you are covered by
38.31 Medicare and both you and your spouse are retired.

38.32 **Your Spouse's Expenses**

38.33 • The claim is for your spouse, who is covered by Medicare, and you are not both
38.34 retired.

38.35 **Your Child's Expenses**

38.36 • The claim is for the health care expenses of your child who is covered by this
38.37 plan and

39.1 • You are married and your birthday is earlier in the year than your spouse's or you
39.2 are living with another individual, regardless of whether or not you have ever been
39.3 married to that individual, and your birthday is earlier than that other individual's
39.4 birthday. This is known as the "birthday rule";

39.5 or

39.6 • You are separated or divorced and you have informed us of a court decree that
39.7 makes you responsible for the child's health care expenses;

39.8 or

39.9 • There is no court decree, but you have custody of the child.

39.10 **Other Situations**

39.11 We will be primary when any other provisions of state or federal law require us to be.

39.12 **How We Pay Claims When We Are Primary**

39.13 When we are the primary plan, we will pay the benefits in accordance with the terms
39.14 of your contract, just as if you had no other health care coverage under any other plan.

39.15 **How We Pay Claims When We Are Secondary**

39.16 We will be secondary whenever the rules do not require us to be primary.

39.17 **How We Pay Claims When We Are Secondary**

39.18 When we are the secondary plan, we do not pay until after the primary plan has
39.19 paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as
39.20 explained below. An "allowable expense" is a healthcare expense covered by one of the
39.21 plans, including copayments, coinsurance, and deductibles.

39.22 • If there is a difference between the amount the plans allow, we will base our
39.23 payment on the higher amount. However, if the primary plan has a contract with the
39.24 provider, our combined payments will not be more than the amount called for in our
39.25 contract or the amount called for in the contract of the primary plan, whichever is higher.
39.26 Health maintenance organizations (HMOs) and preferred provider organizations (PPOs)
39.27 usually have contracts with their providers.

39.28 • We will determine our payment by subtracting the amount the primary plan
39.29 paid from the amount we would have paid if we had been primary. We may reduce our
39.30 payment by any amount so that, when combined with the amount paid by the primary
39.31 plan, the total benefits paid do not exceed the total allowable expense for your claim.
39.32 We will credit any amount we would have paid in the absence of your other health care
39.33 coverage toward our own plan deductible.

39.34 • If the primary plan covers similar kinds of health care expenses, but allows
39.35 expenses that we do not cover, we may pay for those expenses.

40.1 <u>• We will not pay an amount the primary plan did not cover because you did not</u>
40.2 <u>follow its rules and procedures. For example, if your plan has reduced its benefit because</u>
40.3 <u>you did not obtain precertification, as required by that plan, we will not pay the amount</u>
40.4 <u>of the reduction, because it is not an allowable expense.</u>

40.5 **<u>Questions About Coordination of Benefits?</u>**

40.6 **<u>Contact Your State Insurance Department</u>**

40.7 Sec. 35. Minnesota Statutes 2008, section 62L.02, subdivision 26, is amended to read:

40.8 Subd. 26. **Small employer.** (a) "Small employer" means, with respect to a calendar
40.9 year and a plan year, a person, firm, corporation, partnership, association, or other entity
40.10 actively engaged in business<u> in Minnesota</u>, including a political subdivision of the state,
40.11 that employed an average of no fewer than two nor more than 50 current employees on
40.12 business days during the preceding ~~calendar year~~ <u>12 months </u>and that employs at least
40.13 two current employees on the first day of the plan year. If an employer has only one
40.14 eligible employee who has not waived coverage, the sale of a health plan to or for that
40.15 eligible employee is not a sale to a small employer and is not subject to this chapter
40.16 and may be treated as the sale of an individual health plan. A small employer plan
40.17 may be offered through a domiciled association to self-employed individuals and small
40.18 employers who are members of the association, even if the self-employed individual
40.19 or small employer has fewer than two current employees. Entities that are treated as a
40.20 single employer under subsection (b), (c), (m), or (o) of section 414 of the federal Internal
40.21 Revenue Code are considered a single employer for purposes of determining the number
40.22 of current employees. Small employer status must be determined on an annual basis as
40.23 of the renewal date of the health benefit plan. The provisions of this chapter continue to
40.24 apply to an employer who no longer meets the requirements of this definition until the
40.25 annual renewal date of the employer's health benefit plan. If an employer was not in
40.26 existence throughout the preceding calendar year, the determination of whether the
40.27 employer is a small employer is based upon the average number of current employees that
40.28 it is reasonably expected that the employer will employ on business days in the current
40.29 calendar year. For purposes of this definition, the term employer includes any predecessor
40.30 of the employer. An employer that has more than 50 current employees but has 50 or
40.31 fewer employees, as "employee" is defined under United States Code, title 29, section
40.32 1002(6), is a small employer under this subdivision.

40.33 (b) Where an association, as defined in section 62L.045, comprised of employers
40.34 contracts with a health carrier to provide coverage to its members who are small employers,
40.35 the association and health benefit plans it provides to small employers, are subject to

41.1 section 62L.045, with respect to small employers in the association, even though the
41.2 association also provides coverage to its members that do not qualify as small employers.
41.3 (c) If an employer has employees covered under a trust specified in a collective
41.4 bargaining agreement under the federal Labor-Management Relations Act of 1947,
41.5 United States Code, title 29, section 141, et seq., as amended, or employees whose health
41.6 coverage is determined by a collective bargaining agreement and, as a result of the
41.7 collective bargaining agreement, is purchased separately from the health plan provided
41.8 to other employees, those employees are excluded in determining whether the employer
41.9 qualifies as a small employer. Those employees are considered to be a separate small
41.10 employer if they constitute a group that would qualify as a small employer in the absence
41.11 of the employees who are not subject to the collective bargaining agreement.

41.12 Sec. 36. Minnesota Statutes 2008, section 62M.05, subdivision 3a, is amended to read:
41.13 Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, an
41.14 initial determination on all requests for utilization review must be communicated to the
41.15 provider and enrollee in accordance with this subdivision within ten business days of the
41.16 request, provided that all information reasonably necessary to make a determination on the
41.17 request has been made available to the utilization review organization.
41.18 (b) When an initial determination is made to certify, notification must be provided
41.19 promptly by telephone to the provider. The utilization review organization shall send
41.20 written notification to the provider or shall maintain an audit trail of the determination
41.21 and telephone notification. For purposes of this subdivision, "audit trail" includes
41.22 documentation of the telephone notification, including the date; the name of the person
41.23 spoken to; the enrollee; the service, procedure, or admission certified; and the date of
41.24 the service, procedure, or admission. If the utilization review organization indicates
41.25 certification by use of a number, the number must be called the "certification number."
41.26 For purposes of this subdivision, notification may also be made by facsimile to a verified
41.27 number or by electronic mail to a secure electronic mailbox. These electronic forms of
41.28 notification satisfy the "audit trail" requirement of this paragraph.
41.29 (c) When an initial determination is made not to certify, notification must be
41.30 provided by telephone, by facsimile to a verified number, or by electronic mail to a
41.31 secure electronic mailbox within one working day after making the determination to
41.32 the attending health care professional and hospital ~~and a written~~ as applicable. Written
41.33 notification must also be sent to the hospital~~,~~ as applicable and attending health care
41.34 professional~~, and enrollee~~ if notification occurred by telephone. For purposes of this
41.35 subdivision, notification may be made by facsimile to a verified number or by electronic

42.1 mail to a secure electronic mailbox. Written notification must be sent to the enrollee and
42.2 may be sent by United States mail, facsimile to a verified number, or by electronic mail to
42.3 a secure mailbox. The written notification must include the principal reason or reasons
42.4 for the determination and the process for initiating an appeal of the determination. Upon
42.5 request, the utilization review organization shall provide the provider or enrollee with the
42.6 criteria used to determine the necessity, appropriateness, and efficacy of the health care
42.7 service and identify the database, professional treatment parameter, or other basis for the
42.8 criteria. Reasons for a determination not to certify may include, among other things,
42.9 the lack of adequate information to certify after a reasonable attempt has been made to
42.10 contact the provider or enrollee.

42.11 (d) When an initial determination is made not to certify, the written notification must
42.12 inform the enrollee and the attending health care professional of the right to submit an
42.13 appeal to the internal appeal process described in section 62M.06 and the procedure
42.14 for initiating the internal appeal.

42.15 Sec. 37. Minnesota Statutes 2008, section 65A.27, subdivision 1, is amended to read:

42.16 Subdivision 1. **Scope.** For purposes of sections 65A.27 to ~~65A.30~~ 65A.302, the
42.17 following terms have the meanings given.

42.18 Sec. 38. Minnesota Statutes 2008, section 67A.191, subdivision 2, is amended to read:

42.19 Subd. 2. **Homeowner's risks.** A township mutual fire insurance company may issue
42.20 policies known as "homeowner's insurance" as defined in section 65A.27, subdivision
42.21 4, only in combination with a policy issued by an insurer authorized to sell property
42.22 and casualty insurance in this state. All portions of the combination policy providing
42.23 homeowner's insurance, including those issued by a township mutual insurance company,
42.24 ~~shall be~~ are subject to the provisions of chapter 65A and sections 72A.20 and 72A.201.

42.25 Sec. 39. Minnesota Statutes 2008, section 72A.139, subdivision 2, is amended to read:

42.26 Subd. 2. **Definitions.** (a) As used in this section, "commissioner" means the
42.27 commissioner of commerce for health plan companies and other insurers regulated by
42.28 that commissioner and the commissioner of health for health plan companies regulated by
42.29 that commissioner.

42.30 (b) As used in this section, a "genetic test" means a presymptomatic test of a person's
42.31 genes, gene products, or chromosomes for the purpose of determining the presence or
42.32 absence of a gene or genes that exhibit abnormalities, defects, or deficiencies, including
42.33 carrier status, that are known to be the cause of a disease or disorder, or are determined to

43.1 be associated with a statistically increased risk of development of a disease or disorder.
43.2 "Genetic test" does not include a cholesterol test or other test not conducted for the
43.3 purpose of determining the presence or absence of a person's gene or genes.
43.4 (c) As used in this section, "health plan" has the meaning given in section 62Q.01,
43.5 subdivision 3, and includes a plan providing the coverage described in section 62A.011,
43.6 subdivision 3, clause (10).
43.7 (d) As used in this section, "health plan company" has the meaning given in section
43.8 62Q.01, subdivision 4.
43.9 (e) As used in this section, "individual" means an applicant for coverage or a person
43.10 already covered by the health plan company or other insurer.

43.11 Sec. 40. Minnesota Statutes 2008, section 72A.20, subdivision 15, is amended to read:
43.12 Subd. 15. **Practices not held to be discrimination or rebates.** Nothing in
43.13 subdivision 8, 9, or 10, or in section 72A.12, subdivisions 3 and 4, shall be construed as
43.14 including within the definition of discrimination or rebates any of the following practices:
43.15 (1) in the case of any contract of life insurance or annuity, paying bonuses to
43.16 policyholders or otherwise abating their premiums in whole or in part out of surplus
43.17 accumulated from nonparticipating insurance, provided that any bonuses or abatement
43.18 of premiums shall be fair and equitable to policyholders and for the best interests of the
43.19 company and its policyholders;
43.20 (2) in the case of life insurance policies issued on the industrial debit plan, making
43.21 allowance, to policyholders who have continuously for a specified period made premium
43.22 payments directly to an office of the insurer, in an amount which fairly represents the
43.23 saving in collection expense;
43.24 (3) readjustment of the rate of premium for a group insurance policy based on the
43.25 loss or expense experienced thereunder, at the end of the first or any subsequent policy
43.26 year of insurance thereunder, which may be made retroactive only for such policy year;
43.27 (4) in the case of an individual or group health insurance policy, the payment of
43.28 differing amounts of reimbursement to insureds who elect to receive health care goods
43.29 or services from providers designated by the insurer~~, provided that each insurer shall on~~
43.30 ~~or before August 1 of each year file with the commissioner summary data regarding the~~
43.31 ~~financial reimbursement offered to providers so designated~~.
43.32 ~~Any insurer which proposes to offer an arrangement authorized under this clause~~
43.33 ~~shall disclose prior to its initial offering and on or before August 1 of each year thereafter~~
43.34 ~~as a supplement to its annual statement submitted to the commissioner pursuant to section~~
43.35 ~~60A.13, subdivision 1, the following information:~~

44.1 ~~(a) the name which the arrangement intends to use and its business address;~~
44.2 ~~(b) the name, address, and nature of any separate organization which administers the~~
44.3 ~~arrangement on the behalf of the insurers; and~~
44.4 ~~(c) the names and addresses of all providers designated by the insurer under this~~
44.5 ~~clause and the terms of the agreements with designated health care providers.~~
44.6 ~~The commissioner shall maintain a record of arrangements proposed under this~~
44.7 ~~clause, including a record of any complaints submitted relative to the arrangements.~~
44.8 If the commissioner requests copies of contracts with a provider under this clause
44.9 and the provider requests a determination, all information contained in the contracts that
44.10 the commissioner determines may place the provider or health care plan at a competitive
44.11 disadvantage is nonpublic data.

44.12 Sec. 41. **[72A.204] PROHIBITED USES OF SENIOR-SPECIFIC**
44.13 **CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS.**
44.14 Subdivision 1. **Purpose and scope.** The purpose of this section is to set forth
44.15 standards to protect consumers from misleading and fraudulent marketing practices with
44.16 respect to the use of senior-specific certifications and professional designations in:
44.17 (1) the solicitation, sale, or purchase of a life insurance or annuity product; or
44.18 (2) the provision of advice in connection with the solicitation, sale, or purchase of a
44.19 life insurance or annuity product.
44.20 Subd. 2. **Insurance producer.** For purposes of this section, "insurance producer"
44.21 means a person required to be licensed under the laws of this state to sell, solicit, or
44.22 negotiate insurance, including annuities.
44.23 Subd. 3. **Prohibited uses of senior-specific certifications and professional**
44.24 **designations.** (a) It is an unfair and deceptive act or practice in the business of insurance
44.25 for an insurance producer to use a senior-specific certification or professional designation
44.26 that indicates or implies in such a way as to mislead a client or prospective client that the
44.27 insurance producer has special certification or training in advising or servicing seniors in
44.28 connection with the solicitation, sale, or purchase of a life insurance or annuity product or
44.29 in the provision of advice as to the value of or the advisability of purchasing or selling a
44.30 life insurance or annuity product, either directly or indirectly, including the provision of
44.31 advice through publications or writings or by issuing or promulgating analyses or reports
44.32 related to a life insurance or annuity product.
44.33 (b) The prohibited use of senior-specific certifications or professional designations
44.34 includes, but is not limited to, the following:

45.1 (1) use of a certification or professional designation by an insurance producer who
45.2 has not actually earned or is otherwise ineligible to use such certification or designation;
45.3 (2) use of a nonexistent or self-conferred certification or professional designation;
45.4 (3) use of a certification or professional designation that indicates or implies a level
45.5 of occupational qualifications obtained through education, training, or experience that the
45.6 insurance producer using the certification or designation does not have; and
45.7 (4) use of a certification or professional designation that was obtained from a
45.8 certifying or designating organization that:
45.9 (i) is primarily engaged in the business of instruction in sales or marketing;
45.10 (ii) does not have reasonable standards or procedures for ensuring the competency of
45.11 its certificants or designees;
45.12 (iii) does not have reasonable standards or procedures for monitoring and
45.13 disciplining its certificants or designees for improper or unethical conduct; or
45.14 (iv) does not have reasonable continuing education requirements for its certificants
45.15 or designees in order to maintain the certificate or designation.
45.16 (c) There is a rebuttable presumption that a certifying or designating organization is
45.17 not disqualified solely for the purposes of paragraph (b), clause (4), when the certification
45.18 or designation issued from the organization does not primarily apply to sales or marketing
45.19 and when the organization or the certification or designation in question has been
45.20 accredited by:
45.21 (1) the American National Standards Institute (ANSI);
45.22 (2) the National Commission for Certifying Agencies; or
45.23 (3) any organization that is on the United States Department of Education list
45.24 entitled "Accrediting Agencies Recognized for Title IV Purposes."
45.25 (d) In determining whether a combination of words or an acronym standing for a
45.26 combination of words constitutes a certification or professional designation indicating or
45.27 implying that a person has special certification or training in advising or servicing seniors,
45.28 factors to be considered must include:
45.29 (1) use of one or more words such as "senior," "retirement," "elder," or like words
45.30 combined with one or more words such as "certified," "registered," "chartered," "adviser,"
45.31 "specialist," "consultant," "planner," or like words, in the name of the certification or
45.32 professional designation; and
45.33 (2) the manner in which those words are combined.
45.34 (e) For purposes of this section, a job title within an organization that is licensed or
45.35 registered by a state or federal financial services regulatory agency is not a certification or

46.1 professional designation, unless it is used in a manner that would confuse or mislead a
46.2 reasonable consumer, when the job title:
46.3 (1) indicates seniority or standing within the organization; or
46.4 (2) specifies an individual's area of specialization within the organization.
46.5 (f) For purposes of paragraph (e), "financial services regulatory agency" includes,
46.6 but is not limited to, an agency that regulates insurers, insurance producers, broker-dealers,
46.7 investment advisers, or investment companies as defined under the Investment Company
46.8 Act of 1940.

46.9 Sec. 42. Minnesota Statutes 2008, section 82.31, subdivision 4, is amended to read:
46.10 Subd. 4. **Corporate and partnership licenses.** (a) A corporation applying for
46.11 a license shall have at least one officer individually licensed to act as broker for the
46.12 corporation. The corporation broker's license shall extend no authority to act as broker
46.13 to any person other than the corporate entity. Each officer who intends to act as a broker
46.14 shall obtain a license.
46.15 (b) A partnership applying for a license shall have at least one partner individually
46.16 licensed to act as broker for the partnership. Each partner who intends to act as a broker
46.17 shall obtain a license.
46.18 (c) Applications for a license made by a corporation shall be verified by the president
46.19 and one other officer. Applications made by a partnership shall be verified by at least
46.20 two partners.
46.21 (d) Any partner or officer who ceases to act as broker for a partnership or corporation
46.22 shall notify the commissioner upon said termination. The individual licenses of all
46.23 salespersons acting on behalf of a corporation or partnership, are automatically ineffective
46.24 upon the revocation or suspension of the license of the partnership or corporation.
46.25 The commissioner may suspend or revoke the license of an officer or partner without
46.26 suspending or revoking the license of the corporation or partnership.
46.27 (e) The application of all officers of a corporation or partners in a partnership who
46.28 intend to act as a broker on behalf of a corporation or partnership shall accompany the
46.29 initial license application of the corporation or partnership. Officers or partners intending
46.30 to act as brokers subsequent to the licensing of the corporation or partnership shall procure
46.31 an individual real estate broker's license prior to acting in the capacity of a broker. No
46.32 corporate officer, or partner, who maintains a salesperson's license may exercise any
46.33 authority over any trust account administered by the broker nor may they be vested with
46.34 any supervisory authority over the broker.

47.1 (f) The corporation or partnership applicant shall make available upon request, such
47.2 records and data required by the commissioner for enforcement of this chapter.
47.3 (g) The commissioner may require further information, as the commissioner deems
47.4 appropriate, to administer the provisions and further the purposes of this chapter.

47.5 Sec. 43. **[82B.071] RECORDS.**
47.6 Subdivision 1. **Examination of records.** The commissioner may make examinations
47.7 within or without this state of each real estate appraiser's records at such reasonable time
47.8 and in such scope as is necessary to enforce the provisions of this chapter.
47.9 Subd. 2. **Retention.** Licensees shall keep a separate work file for each appraisal
47.10 assignment, which is to include copies of all contracts engaging his or her services for
47.11 the real estate appraisal, appraisal reports, and all data, information, and documentation
47.12 assembled and formulated by the appraiser to support the appraiser's opinions and
47.13 conclusions and to show compliance with USPAP, for a period of five years after
47.14 preparation, or at least two years after final disposition of any judicial proceedings in
47.15 which the appraiser provided testimony or was the subject of litigation related to the
47.16 assignment, whichever period expires last. Appropriate work file access and retrieval
47.17 arrangements must be made between any trainee and supervising appraiser if only one
47.18 party maintains custody of the work file.

47.19 Sec. 44. Minnesota Statutes 2008, section 82B.08, is amended by adding a subdivision
47.20 to read:
47.21 Subd. 3a. **Initial application.** The initial application for licensing of a trainee
47.22 real property appraiser must identify the name and address of the supervisory appraiser
47.23 or appraisers. Trainee real property appraisers licensed prior to the effective date of this
47.24 provision must identify the name and address of their supervisory appraiser or appraisers
47.25 at the time of license renewal. A trainee must notify the commissioner in writing within
47.26 ten days of terminating or changing their relationship with any supervisory appraiser.
47.27 The initial application for licensing of a certified residential real property appraiser
47.28 and certified general real property appraiser who intends to act in the capacity of a
47.29 supervisory appraiser must identify the name and address of the trainee real property
47.30 appraiser or appraisers they intend to supervise. A certified residential real property
47.31 appraiser and certified general real property appraiser licensed and acting in the capacity
47.32 of a supervisory appraiser prior to the effective date of this provision must, at the time of
47.33 license renewal, identify the name and address of any trainee real property appraiser or
47.34 appraisers under their supervision.

48.1 Sec. 45. **[82B.093] TRAINEE REAL PROPERTY APPRAISER.**

48.2 (a) A trainee real property appraiser shall be subject to direct supervision by a
48.3 certified residential real property appraiser or certified general real property appraiser in
48.4 good standing.

48.5 (b) A trainee real property appraiser is permitted to have more than one supervising
48.6 appraiser.

48.7 (c) The scope of practice for the trainee real property appraiser classification is the
48.8 appraisal of those properties which the supervising appraiser is permitted by his or her
48.9 current credential and that the supervising appraiser is qualified and competent to appraise.

48.10 (d) A trainee real property appraiser must have a supervisor signature on each
48.11 appraisal that he or she signs, or must be named in the appraisal as providing significant
48.12 real property appraisal assistance to receive credit for experience hours on his or her
48.13 experience log.

48.14 (e) The trainee real property appraiser must maintain copies of appraisal reports he
48.15 or she signed or copies of appraisal reports where he or she was named as providing
48.16 significant real property appraisal assistance.

48.17 (f) The trainee real property appraiser must maintain copies of work files relating to
48.18 appraisal reports he or she signed.

48.19 (g) Separate appraisal logs must be maintained for each supervising appraiser.

48.20 Sec. 46. **[82B.094] SUPERVISION OF TRAINEE REAL PROPERTY**
48.21 **APPRAISERS.**

48.22 (a) A certified residential real property appraiser or a certified general real property
48.23 appraiser, in good standing, may engage a trainee real property appraiser to assist in the
48.24 performance of real estate appraisals, provided that the certified residential real property
48.25 appraiser or a certified general real property appraiser:

48.26 (1) has not been the subject of any license or certificate suspension or revocation or
48.27 has not been prohibited from supervising activities in this state or any other state within
48.28 the previous two years;

48.29 (2) has no more than three trainee real property appraisers working under supervision
48.30 at any one time;

48.31 (3) actively and personally supervises the trainee real property appraiser, which
48.32 includes ensuring that research of general and specific data has been adequately conducted
48.33 and properly reported, application of appraisal principles and methodologies has been
48.34 properly applied, that the analysis is sound and adequately reported, and that any analyses,

49.1 opinions, or conclusions are adequately developed and reported so that the appraisal
49.2 report is not misleading;
49.3 (4) discusses with the trainee real property appraiser any necessary and appropriate
49.4 changes that are made to a report, involving any trainee appraiser, before it is transmitted
49.5 to the client. Changes not discussed with the trainee real property appraiser that are made
49.6 by the supervising appraiser must be provided in writing to the trainee real property
49.7 appraiser upon completion of the appraisal report;
49.8 (5) accompanies the trainee real property appraiser on the inspections of the subject
49.9 properties and drive-by inspections of the comparable sales on all appraisal assignments
49.10 for which the trainee will perform work until the trainee appraiser is determined to be
49.11 competent, in accordance with the competency rule of USPAP for the property type;
49.12 (6) accepts full responsibility for the appraisal report by signing and certifying
49.13 that the report complies with USPAP; and
49.14 (7) reviews and signs the trainee real property appraiser's appraisal report or reports
49.15 or if the trainee appraiser is not signing the report, states in the appraisal the name of the
49.16 trainee and scope of the trainee's significant contribution to the report.
49.17 (b) The supervising appraiser must review and sign the applicable experience log
49.18 required to be kept by the trainee real property appraiser.
49.19 (c) The supervising appraiser must notify the commissioner within ten days when
49.20 the supervision of a trainee real property appraiser has terminated or when the trainee
49.21 appraiser is no longer under the supervision of the supervising appraiser.
49.22 (d) The supervising appraiser must maintain a separate work file for each appraisal
49.23 assignment.
49.24 (e) The supervising appraiser must verify that any trainee real property appraiser that
49.25 is subject to supervision is properly licensed and in good standing with the commissioner.

49.26 Sec. 47. Minnesota Statutes 2008, section 82B.20, subdivision 2, is amended to read:
49.27 Subd. 2. **Conduct prohibited.** No person may:
49.28 (1) obtain or try to obtain a license under this chapter by knowingly making a
49.29 false statement, submitting false information, refusing to provide complete information
49.30 in response to a question in an application for license, or through any form of fraud or
49.31 misrepresentation;
49.32 (2) fail to meet the minimum qualifications established by this chapter;
49.33 (3) be convicted, including a conviction based upon a plea of guilty or nolo
49.34 contendere, of a crime that is substantially related to the qualifications, functions, and

50.1 duties of a person developing real estate appraisals and communicating real estate
50.2 appraisals to others;
50.3 (4) engage in an act or omission involving dishonesty, fraud, or misrepresentation
50.4 with the intent to substantially benefit the license holder or another person or with the
50.5 intent to substantially injure another person;
50.6 (5) engage in a violation of any of the standards for the development or
50.7 communication of real estate appraisals as provided in this chapter;
50.8 (6) fail or refuse without good cause to exercise reasonable diligence in developing
50.9 an appraisal, preparing an appraisal report, or communicating an appraisal;
50.10 (7) engage in negligence or incompetence in developing an appraisal, in preparing
50.11 an appraisal report, or in communicating an appraisal;
50.12 (8) willfully disregard or violate any of the provisions of this chapter or the rules of
50.13 the commissioner for the administration and enforcement of the provisions of this chapter;
50.14 (9) accept an appraisal assignment when the employment itself is contingent upon
50.15 the appraiser reporting a predetermined estimate, analysis, or opinion, or where the fee
50.16 to be paid is contingent upon the opinion, conclusion, or valuation reached, or upon the
50.17 consequences resulting from the appraisal assignment;
50.18 (10) violate the confidential nature of governmental records to which the person
50.19 gained access through employment or engagement as an appraiser by a governmental
50.20 agency;
50.21 (11) offer, pay, or give, and no person shall accept, any compensation or other thing
50.22 of value from a real estate appraiser by way of commission-splitting, rebate, finder's fee,
50.23 or otherwise in connection with a real estate appraisal. This prohibition does not apply
50.24 to transactions among persons licensed under this chapter if the transactions involve
50.25 appraisals for which the license is required;
50.26 (12) engage or authorize a person, except a person licensed under this chapter, to act
50.27 as a real estate appraiser on the appraiser's behalf;
50.28 (13) violate standards of professional practice;
50.29 (14) make an oral appraisal report without also making a written report within a
50.30 reasonable time after the oral report is made;
50.31 (15) represent a market analysis to be an appraisal report;
50.32 (16) give an appraisal in any circumstances where the appraiser has a conflict of
50.33 interest, as determined under rules adopted by the commissioner; or
50.34 (17) engage in other acts the commissioner by rule prohibits.
50.35 No person, including a mortgage originator, appraisal management company, real
50.36 estate broker or salesperson, appraiser, or other licensee, registrant, or certificate holder

51.1 regulated by the commissioner may improperly influence or attempt to improperly
51.2 influence the development, reporting, result, or review of a real estate appraisal. Prohibited
51.3 acts include blacklisting, boycotting, intimidation, coercion, and any other means that
51.4 impairs or may impair the independent judgment of the appraiser, including but not
51.5 limited to the withholding or threatened withholding of payment for an appraisal fee, or
51.6 the conditioning of the payment of any appraisal fee upon the opinion, conclusion, or
51.7 valuation to be reached, or a request that the appraiser report a predetermined opinion,
51.8 conclusion, or valuation, or the desired valuation of any person, or withholding or
51.9 threatening to withhold future work in order to obtain a desired value on a current or
51.10 proposed appraisal assignment.

51.11 Sec. 48. Minnesota Statutes 2008, section 256B.0571, subdivision 6, is amended to
51.12 read:

51.13 Subd. 6. **Partnership policy.** "Partnership policy" means a long-term care insurance
51.14 policy that meets the requirements under subdivision 10 and was issued on or after the
51.15 effective date of the state plan amendment implementing the partnership program in
51.16 Minnesota. Policies that are exchanged or that have riders or endorsements or disclosure
51.17 notices added on or after the effective date of the state plan amendment as authorized by
51.18 the commissioner of commerce qualify as a partnership policy.

51.19 Sec. 49. **REPEALER.**

51.20 Minnesota Statutes 2008, sections 70A.07; 79.56, subdivision 4; 325E.311;
51.21 325E.312; 325E.313; 325E.314; 325E.315; and 325E.316, and Minnesota Rules, parts
51.22 2742.0100; 2742.0200; 2742.0300; 2742.0400; and 2742.0500, are repealed.

51.23 Sec. 50. **EFFECTIVE DATE; APPLICATION.**

51.24 (a) Sections 20 to 24 are effective June 1, 2010, and apply to plans issued on or
51.25 after that date.

51.26 (b) A contract that provides health care benefits and that was issued before the
51.27 effective date of Minnesota Statutes, sections 62A.70 to 62A.735, shall be brought into
51.28 compliance with Minnesota Statutes, sections 62A.70 to 62A.735 by:

51.29 (1) the later of:

51.30 (i) the next anniversary date or renewal date of the contract; or

51.31 (ii) 12 months following the effective date of Minnesota Statutes, sections 62A.70
51.32 to 62A.735; or

52.1 (2) the expiration of any applicable collectively bargained contract pursuant to
52.2 which it was written.

52.3 (c) For the transition period between the adoption of Minnesota Statutes, sections
52.4 62A.70 to 62A.735, and the time frame for which plans are to be in compliance pursuant
52.5 to this paragraph, a plan that is subject to the prior COB requirements shall not be
52.6 considered a noncomplying plan by a plan subject to the new COB requirements and if
52.7 there is a conflict between the prior COB requirements under the prior rule and the new
52.8 COB requirements under Minnesota Statutes, sections 62A.70 to 72A.735, the prior COB
52.9 requirements shall apply.

70A.07 RATES AND FORMS OPEN TO INSPECTION.

All rates, supplementary rate information, and forms furnished to the commissioner under this chapter shall, within ten days after their effective date, be open to public inspection at any reasonable time.

79.56 FILING RATES AND RATING INFORMATION.

Subd. 4. **Public inspection.** All filings shall be open to public inspection during normal business hours at the offices of the Department of Commerce.

325E.311 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 325E.311 to 325E.316, the terms in subdivisions 2 to 6 have the meanings given them.

Subd. 2. **Caller.** "Caller" means a person, corporation, firm, partnership, association, or legal or commercial entity that attempts to contact, or that contacts, a residential subscriber in this state by using a telephone or a telephone line.

Subd. 3. **Caller identification service.** "Caller identification service" means a telephone service that permits telephone subscribers to see the telephone number of incoming telephone calls.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 5. **Residential subscriber.** "Residential subscriber" means a person who has subscribed to residential telephone services from a telephone company or the other persons living or residing with the subscribing person.

Subd. 6. **Telephone solicitation.** "Telephone solicitation" means any voice communication over a telephone line for the purpose of encouraging the purchase or rental of, or investment in, property, goods, or services, whether the communication is made by a live operator, through the use of an automatic dialing-announcing device as defined in section 325E.26, subdivision 2, or by other means. Telephone solicitation does not include communications:

(1) to any residential subscriber with that subscriber's prior express invitation or permission; or

(2) by or on behalf of any person or entity with whom a residential subscriber has a prior or current business or personal relationship.

Telephone solicitation also does not include communications if the caller is identified by a caller identification service and the call is:

(i) by or on behalf of an organization that is identified as a nonprofit organization under state or federal law, unless the organization is a debt management services provider defined in section 332A.02;

(ii) by a person soliciting without the intent to complete, and who does not in fact complete, the sales presentation during the call, but who will complete the sales presentation at a later face-to-face meeting between the solicitor who makes the call and the prospective purchaser; or

(iii) by a political party as defined under section 200.02, subdivision 6.

325E.312 TELEPHONE SOLICITATIONS.

Subdivision 1. **Persons included in no-call list.** No caller shall make or cause to be made any telephone solicitation to the telephone line of any residential subscriber in this state who is on the no-call list established and maintained under section 325E.313.

Subd. 2. **Identification of caller.** Any caller who makes a telephone solicitation to a residential subscriber in this state shall state the caller's identity clearly at the beginning of the call and, if requested, the caller's telephone number.

Subd. 3. **Interference with caller identification.** No caller who makes a telephone solicitation to a residential subscriber in this state shall knowingly use any method to block or otherwise deliberately circumvent the subscriber's use of a caller identification service.

325E.313 NO-CALL LIST.

Subdivision 1. **Establishment of list.** The commissioner shall establish and maintain a list of telephone numbers of residential subscribers who object to receiving telephone solicitations. The commissioner may fulfill the requirements of this subdivision by contracting with an agent for the establishment and maintenance of the list. The list must be established by January 1, 2003.

Subd. 2. **Operation and maintenance of list.** (a) Each local exchange company must inform its residential subscribers of the opportunity to provide notification to the commissioner or its contractor that the subscriber objects to receiving telephone solicitations. The notification must be made in the manner prescribed by the commissioner.

(b) Any residential subscriber may contact the commissioner or the commissioner's agent and give notice, in the manner prescribed by the commissioner, that the subscriber objects to receiving telephone solicitations. The commissioner shall add the telephone number of any subscriber who gives notice of objection to the list maintained pursuant to subdivision 1 within 90 days of the date the notice is received.

(c) The commissioner shall allow consumers to give notice under this subdivision by mail or electronically.

(d) The commissioner shall establish the procedures by which a person wishing to make telephone solicitations may obtain access to the list. Those procedures shall, to the extent practicable, allow for access to paper or electronic copies of the list.

Subd. 3. **Use of federal list.** If, pursuant to United States Code, title 15, section 6102(a), the Federal Trade Commission establishes a national list of telephone numbers of subscribers who object to receiving telephone solicitations, the commissioner may consider the Federal Trade Commission as its agent for the establishment and maintenance of a list.

325E.314 ACQUISITION AND USE OF LIST.

(a) A caller who makes a telephone solicitation to the telephone line of any residential subscriber must, at the time of the call, have obtained access to a current version of the list at least once in the 90 days prior to the call. A caller who complies with this requirement is not liable for any violation of section 325E.312 relating to a solicitation made to a subscriber during the first 30 days after the caller first obtained a copy of the list including that subscriber's telephone number that has not been superseded by a later list obtained by the caller that does not include the subscriber's telephone number.

(b) If the Federal Trade Commission establishes a national do-not-call list as described in section 325E.313, subdivision 2, a person or entity who is required by law to obtain a copy of the national list may meet its requirement through proof of purchase of the Minnesota numbers from the federal list.

325E.315 RELEASE OF INFORMATION.

Information contained in the list established under section 325E.313 shall be used only for the purposes of compliance with sections 325E.311 to 325E.316 or in a proceeding or action under section 325E.316. The information contained in the list is private data on individuals or nonpublic data as defined in section 13.02.

325E.316 PENALTIES.

Subdivision 1. **Enforcement by commissioner.** In enforcing sections 325E.311 to 325E.316, the commissioner has all powers provided by section 45.027, including, but not limited to, the power to impose a civil penalty to a maximum of $1,000 for each solicitation that violates section 325E.312.

Subd. 2. **Defenses.** (a) In any action or proceeding against a person under this section, it shall be a defense that the defendant has established and implemented, with due care, reasonable practices and procedures to effectively prevent telephone solicitations in violation of section 325E.312.

(b) No provider of caller identification service shall be held liable for violations of section 325E.312 committed by other persons or entities.

Subd. 3. **Time limitations.** No action or proceeding may be brought under this section:

(1) more than two years after the person bringing the action knew or should have known of the alleged violation; or

(2) more than two years after the termination of any proceeding or action by the state of Minnesota, whichever is later.

Subd. 4. **Jurisdiction.** A court of this state may exercise personal jurisdiction over any nonresident or the nonresident's executor or administrator as to an action or proceeding authorized by this section according to the provisions of section 543.19.

Subd. 5. **Other remedies.** The remedies, duties, prohibitions, and penalties of this section are not exclusive and are in addition to all other causes of action, remedies, and penalties provided by law.